SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS: CIVIL TERM: PART LL1

- -X

ERION BELLI

Plaintiff,

- against -

MACQUESTEN CONSTRUCTION MANAGEMENT, LLC and VAN SINDEREN PLAZA HOUSING DEVELOPMENT FUND CORPORATION,

DEFENDANTS.

INDEX NUMBER: 521799/2019

Trial

- -X

Supreme Court
360 Adams Street
Brooklyn, New York 11201
April 24, 2026

B E F O R E :

HONORABLE DEVIN P. COHEN,
Justice of the Supreme Court

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(Appearances Continued on the next page.

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LAURA DELVAC
SENIOR COURT REPORTER

* * *

COURT OFFICER: All rise Labor Law Part 1 is now in session. The Honorable Devin P. Cohen presiding.

THE COURT: Good morning.

MR. DAUTI: Good morning, your Honor.

THE COURT: Good morning.

MR. FRANKLIN: Good morning.

THE COURT: The witness is ready?

MR. DAUTI: Yes.

THE COURT: Do we have exhibits that have to be pre-marked?

MR. DAUTI: Yes.

THE CLERK: Just this.

THE COURT: Have they been marked?

MR. FRANKLIN: Just demonstratives.

MR. DAUTI: And Judge, this one the witness has brought and wants to show the jury for low back pain, but counsel is objecting to it.

MR. FRANKLIN: It has a lot of writing on it.

MR. DAUTI: There's no writing on this side.

MR. FRANKLIN: I'm looking at a bunch of writing.

THE COURT: There's writing all about it.

MR. DAUTI: It's an explanation about low back pain.

THE COURT: You can't do that, that's what testimony is for. You can use a medical illustration for something that actually happened. You can't give someone a treatise.

MR. DAUTI: Thank you, your Honor.

THE CLERK: 26, 27 and 28, and 29 these are particular sections.

MR. BENSON: I would just write disc.

MR. DAUTI: She said where to put it.

MR. BENSON: Oh.

(Pause in the proceedings.)

COURT OFFICER: All rise, jury entering.

(Whereupon, the jury entered the courtroom.)

THE COURT: You can all be seated, thanks.

Good morning, good to see you again. Plaintiff is ready to produce your next witness.

MR. DAUTI: Yes, your Honor, we calling Dr. Ali Guy.

THE COURT: Calling Dr. Guy.

(Whereupon, Dr. Guy enter the courtroom and took the witness stand.)

THE CLERK: Raise your right hand. Do you swear or affirm that the testimony you're about to give will be the truth, the whole truth and nothing but the truth?

THE WITNESS: Yes.

THE CLERK: In a loud clear voice, state your name and address for the record?

THE WITNESS: Dr. Ali Guy.

THE COURT: Good morning, doctor.

THE WITNESS: Good morning, your Honor.

THE CLERK: State your name and address for the record?

THE WITNESS: My name is Dr. Ali Guy, A-L-I, last name G-U-Y. Office address is 7 Gramercy Park West, Suite 1-A, New York, New York 10003.

THE CLERK: Thank you so much. You may be seated.

THE WITNESS: Thank you.

THE COURT: Your witness.

MR. DAUTI: Thank you, your Honor.

DIRECT EXAMINATION BY

MR. DAUTI:

THE COURT: Don't walk away from the mic.

MR. DAUTI: Thank you.

Q Good morning, Dr. Guy.

A Good morning, sir.

Q Are you ready?

A Yes.

Q Doctor, are you a physician duly licensed to practice medicine in the State of New York?

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

Q When were you licensed?

A 1985.

Q Can you tell this jury a little bit about your educational background?

A Yes, my under graduate, I went to Queens College, Flushing, New York, I did that three and a half years of training there, and then I did the last semester in medical school in the Dominican Republic. I graduated from University of Northeast Dominican Republic June of 1981.

Thereafter, I did three separate residencies, I did one and a half years of internal medicine at Mount Sinai School of Medicine, and Mount Sinai Medical Center, and I did one year of general surgery at Cabrini Medical Center in Manhattan, New York, I completed a three year residency training program in the field of physical medicine and rehabilitation, at Mount Sinai School of Medicine, and I am board certified in the field of physical medicine and rehabilitation, and I was the former Director of the Department of Rehab Medicine at Maimonides Medical Center, in Brooklyn, New York, for five years, and my duties were to teach the orthopedic residents, the internal medicine residents, general surgical residents and supervise the work of ten other doctors in my department and to do consultations for other doctors in my hospital.

And from 1990 to 2006, I was a director of NYU Hospital for Joint Diseases in Manhattan, where my duties were to take care of the patients assigned to the clinic, this would be patients with births defects, multiple traumatic injuries, spinal cord injuries, and my duties were to take care of the patients and to teach the residents from NYU, prepare them for the boards, part one and part two, and from 2006, I was promoted to Clinical Instructor of Physical Medicine and Rehabilitation at NYU School of Medicine, and NYU Medical Center, again, teaching, taking care of patients.

In 2019, I was promoted to Clinical Assistant Professor

of Physical Medicine and Rehabilitation at NYU School of Medicine, and NYU Medical Center, and I am also the Director of the Department of Physical Medicine and Rehabilitation at Mental Alliance which is an Article 28 facility in the Bronx. Article 28 is like a small hospital, we have about 30 different doctors, we have four operating rooms.

My duties are to be involved with quality assurance, that means if any mistakes are made, it comes to my attention. I investigate and teach and reprimand whoever made the mistake and also teaching other doctors and physician assistants in the hospital, in the facility rather.

And I'm also the Director of the Pain Service at the North Queens Surgi Center, it's in Bayside, New York, where my duties are to supervise the work of 50 other doctors to teach, and to review records and to discipline where it needs to be done.

And I'm also an Official Physician Mentor for the New York State Education Department Office of Professional Medical Conduct, where my duties are to go into doctors who have committed certain mistakes but not bad enough to consider revocation or have their licenses suspended. I go in and I teach in order to be able to do that, you have to be in good medical standing, you have to be affiliated with a major teaching hospital, and you have to have a clean record and you have to know all of the standards of care and all of the

guidelines for the different treatments that were rendered.

And I was also a captain within the New York Guard where my duties were to take care of the soldiers and certify them they're able and fit to perform their duties, and I believe that's essentially it.

Q That was a lot, thank you.

Doctor, what is physical medicine and rehabilitation?

A Yes, it's a medical specialty founded shortly after World War II, by Howard Rusk, that's why the Rusk Institute at NYU is named after him, and this specialty deals with traumatic injuries covering the whole body, from head to toe, and it splashes into just about every medical specialty, it deals with orthopedic surgery, neurosurgery, internal medicine, general surgery, neurology, muscle nerve physiology, pain management, both interventional like epidurals and nerve blocks and also pharmacological, medications for pain.

It deals with life expectancy through diagnostics, it deals with the interpretations of various radiological diagnostic studies such as CAT scans, MRIs, X-rays, it deals with the stability and impairment and life care plans, which is a special plan that designates what the patient's future prognosis or future look into the future is, and what the future medical needs would be.

Q And how does physical medicine and rehabilitation differ from neurology and orthopedics?

A Initially, the specialty was called orthopedic medicine and rehabilitation, but because all of the chaos and confusion between orthopedic surgery and this field the name was changed to physical medicine and rehabilitation, we do essentially everything an orthopedic surgeons does, except we try not to do surgery. We get involved after they, the orthopedic surgeons does the surgery such as, hip, and knee, shoulder surgeries, and once the factor has been successfully set, we then get involved with the rehabilitation phase and the management of the pain.

How it differs from neurology is neurologists concentrate more on central neurology, neurology of the brain. We concentrate more on peripheral neurology that would be neurology of the spine, nerve roots that come off the spine, disc herniations, and pain management, electrodiagnostics, and we refer patients back and forth to each other, but this is the major difference between the two.

Q Doctor, I believe you testified during that long presentation of your educational background that you are board certified in the field of physical medicine and rehabilitation; correct?

A Yes.

Q What is the significance of that?

A First of all, in order to become board certified in physical medicine and rehabilitation, you have to have training in other fields, that's why you have for prerequisite of at

least one year of general surgery and at least one year of internal medicine, because the specialty covers all of those areas, and then you have to pass the monthly examination given by your teachers, and you have to pass the annual exams given by your department.

Once you finish your three year training program, you have to sit and take an eight hour written examination, you get tested on orthopedic surgery, neurosurgery, muscle and nerve physiology, electrodiagnostics, and pain management interpretations of X-rays, CAT scans, MRIs, and other principals of physical medicine and rehabilitation.

Once you pass that, then you have to be in private practice at least 18 months, be sponsored by two other doctors that know you work closely, preferably your former teachers and then fly to the Mayo Clinic in Minnesota where all of the elite doctors that write textbooks, that do research, test you orally for half a day to a full day.

Again, they test you on interpretations of X-rays, MRIs, CAT scans, and principals of neurosurgery, neurology orthopedic surgery, muscle and nerve physiology, pain management interventional and noninterventional.

Once you pass your exams, which I did the first time around, you are given a title of a Diplomate of the American Board of Physical Medicine and Rehabilitation, and you're considered board certified, that means you're considered to be

an expert in the field of physical medicine and rehabilitation by the elite doctors that do all of the research and write textbooks and that's basically it.

Q Doctor, are you the recipient of any awards?

A Yes. According to U.S. World News and Report in the year of 2023 and 2024, I was voted among the best doctors in the country, and in the past, I've received a lot of merits and remunerations for being a very good doctor to have these, you have to have a clean records, no malpractice convictions, no disciplinary proceedings, and you have to be doing research and be involved with a teaching position in a major teaching hospital.

Q Doctor, do you have to be an orthopedic surgeon to show that that certain orthopedic surgeries are warranted to give an opinion whether orthopedic surgeries are needed?

MR. FRANKLIN: Objection to the form.

THE COURT: Sustained.

Q Doctor, do you have any training in the field of orthopedic surgery?

A Yes, when I was doing my residency, in the field of general surgery, we had orthopedic rounds almost every single day, and we covered the emergency room, there's orthopedic trauma, every single day, we covered the surgical intensive care unit, orthopedic cases every single day.

When I covered the floors, again, there were orthopedic

surgical cases every single day which we presented to our teachers and in the field of physical medicine and rehabilitation, we had weekly rounds with orthopedic surgeons and physical medicine and rehabilitation, rounds.

We would get teaching from orthopedic attendings that are board certified, both from the orthopedic perspective and from the physical medicine and rehabilitation perspective, which he would present cases on admission every single day and our teachers would teach us the orthopedic surgical aspects of the case and psychiatric aspects of the case, and so we had a lot of combined teaching courses almost every single day, orthopedic surgery, and physical medicine and rehabilitation.

Q Doctor, what is a life care plan?

A A life care plan is a special plan that is performed by two experts, a certified life care planner, and a board certified doctor of physical medicine and rehabilitation, a life care planner, certified, has a two week training program in, doing the life care plan, and they do most of their information from one of the treating doctors, and these people are not doctors, they cannot order X-rays, they cannot do any procedures, they cannot prescribe medications, they get all of the information from a patient's treating physician.

So if the patient's treating physicians' information is correct, their report will be correct and if it's incorrect, their report will be incorrect.

However, a board certified doctor of physical medicine and rehabilitation, known as a physiatrist, not a podiatrist or psychiatrist, a physiatrist, we have over ten years training doing these things. It's basically the medical guidelines, and based on the standards of care.

So everything that goes into a life care plan follows these guidelines, and it projects if the patient is disabled, if the patient is totally disabled, or partially disabled, and if the injuries are permanent and progressive, and what the future medical needs and expenses for that patient will be, the future medical needs and expenses, we do a lot of it ourselves, I do a lot of those procedures myself and the other expenses I get from reviewing hundreds and hundreds and thousands of medical records.

When you review the medical records, they come with a medical bills as well, that goes into the North Queens Surgi Center where I'm the Chief of Pain Service also at Medicine Alliance Article 28 in the Bronx when I'm the Chief the Physical Medicine and Rehabilitation, and I review --

MR. FRANKLIN: Objection to the narrative, your Honor.

THE COURT: Yeah, that's fair.

Q Okay, doctor, next question.

A Yes.

Q For how long have you been practicing physical medicine

and rehabilitation?

A Since 1988, over 35 years.

Q And are you actively treating patients?

A Yes.

Q And you mentioned that the Article 28 Facility in the Bronx?

A Yes.

Q And anywhere else?

A My office in Gramercy Park, my office in Westbury, Long Island.

Q So, doctor, if you were not in court today, now, what would you be doing?

A Taking care of patients in my office.

Q And you testify in court?

A I testify on the average eight to ten times per year for my patients, and that's for all of my office locations, and that constitutes less than one percent of all of the patients that I treat.

Q And you testify mainly for plaintiffs; correct?

A Yes, I do both sides, but mainly for my patients, yes.

Q Are you being compensated for your time here today?

A I am.

Q At what rate?

A $5,000 for half a day.

Q And have you been called upon to testify in court

before?

A Many times.

Q And have you been accepted as an expert to testify in the field of physical medicine and rehabilitation before in the courts of the State of New York?

A Yes, every time that I have come to court and testified and have given my credentials, yes, never turned down.

MR. DAUTI: Your Honor, at this point we ask at this point we deem Dr. Guy as a properly qualified expert to testify in the field of physical medicine and rehabilitation.

MR. FRANKLIN: Voir dire, your Honor.

THE COURT: Voir dire, sure.

VOIR DIRE EXAMINATION BY
MR. FRANKLIN:

Q Doctor, you're not a psychiatrist?

A I am not a psychiatrist, no sir.

Q You're not a certified life care planner?

A I am not, and I don't have to be.

Q Okay. And you're not a surgeon?

A I do surgery.

Q You're not an orthopedic surgeons?

A I'm not an orthopedic surgeon.

Q You're not board certified as a neurosurgeon?

A I'm not a neurosurgeon, no.

Q You're not a brain surgeon?

A I'm not a brain surgeon, no.

MR. FRANKLIN: Okay, that's all.

THE COURT: Okay. None of those are challenges to his ability to be qualified as a physical medicine and rehabilitation doctor, but I think my question actually is, is he here to testify as a physiatrist or as on the life care plan or something else?

MR. DAUTI: Your Honor, he's here to testify as a life care planner, but also as an expert in the field of physical medicine and rehabilitation.

THE COURT: I understand, but if you, he doesn't need to be, I think I agree with the proposition, he doesn't have to be certified as a life care planner, if he's already a physician, so, I don't think that question is really the issue.

But if you are asking for him to be qualified as an expert as a life care planner, then you haven't asked that question. I'm certainly happy to, is in response to your question, I'm happy to deem him an expert in the physical medicine and rehabilitation.

MR. DAUTI: Thank you, your Honor.

At the same time we also ask he be deemed as an expert duly qualified to testify in the field of life care planning.

THE COURT: So the question, I guess would be, is he doing, you have a separate economist as well or not?

MR. DAUTI: Yes, he will not talk about the economical aspect of it, he will only talk the cost of medication and future treatment.

THE COURT: And the plan for future treatment?

MR. DAUTI: Yes, correct.

MR. FRANKLIN: No foundation, your Honor.

THE COURT: That's wrong, you can state an objection or you can consent.

MR. FRANKLIN: I don't consent, it's objection.

THE COURT: No problem, over your objection, he's qualified, again, as a physician, as a physician qualified to give a life care plan, which is different from someone who may do nothing but life care planning, but as a physician with experience in the areas, either referring or performing the procedures, I think he's qualified, and we allow other physicians to do this all the time without a life care planner.

MR. DAUTI: Thank you, Judge.

CONTINUED DIRECT EXAMINATION BY

MR. DAUTI:

Q Can you explain to the jury what a life care plan is?

A A life care plan is a special plan that is put together by a physician, usually, by a board certified doctor, physical

medicine and rehabilitation.

You take the patient's history, you examine the patient, review all of the pertinent medical records, MRIs, EMGs operative reports, you come to a final diagnosis, and you come to a prognosis, prognosis means a look into the future, as to what the patient may need based on his injuries and based on his diagnosis, how often he will need these services and what these services will cost for the rest of his life.

Q Doctor, did there come a time that at the request of my office, you examined Erion Belli?

A Yes.

Q When was that?

A December 18, 2023.

Q And when you first met with him, at your office, on December 18, 2023, did you take a history?

A I did.

Q And you feel free, you have, you have your documents with you, doctor?

A Do I do.

Q You can feel free to look at them to refresh your recollection.

A Okay.

Q So, what was the history that you got from speaking with him?

A He was 42 years of age at the time, he was relative,

6/29/19, while working on a job as a plumber foreman, he had a slip and fall on some wet slippery oilily floor, he injured his mainly his lower back.

MR. FRANKLIN: Objection, your Honor.

THE COURT: Sustained, I think the Plaintiff was 36 at the time of the loss, and maybe 42 now, but I think he was 36 at the time of the loss.

MR. DAUTI: My recollection your Honor, is he should be around 44, you might be right, he's 44 now, your Honor, I believe he was born in 1981.

THE COURT: What I was told when you came in, was that he was, so then he was 38, perhaps.

MR. DAUTI: Correct, at the time of the accident, correct, your Honor.

THE COURT: 38 at the time of loss, not 42.

MR. DAUTI: 37, 38, your Honor.

MR. FRANKLIN: Objection to the hearsay narrative on the liability.

THE COURT: It's not offered for the truth of how his accident happened, and I have already ruled on this objection yesterday, I can't remember if it was to you or Miss Goode, that dimensions of an oil slick or anything else are not the subject of the damages portion of the trial.

To the extent they are offered by brief background, I will remind the jury I overruled your objection. I will

remind the jury again to the extent any witness testifies about real particulars about how the accident happened, what you know, was it vegetable oil or motor oil or you know jet fuel or, was it a, you know, one foot circle or ten foot circle, not relevant to your determination on damages. If they're being offered by way of sort of brief background, I don't have a problem with it, but this witness was not an eyewitness to the accident, none of the other physicians were an eyewitness to the accident, neither plaintiffs nor defendants and so it's just based on the history that was given, and it's useful only in that it helps you determine the amount of damages, and not because it affects your view of how the accident happened.

With that, the witness can answer the question.

MR. DAUTI: Thank you.

Q Doctor, can you please continue, what the part of the history that you took that day regarding the injuries that he told you that he suffered in this accident?

A Yes, it was mainly his lower back and his left knee, and he had surgery to his left knee by Dr. Wilen, he had two back surgeries the first surgery was Dr. Babu, which helped a little bit initially, but the pain came back, he had a second lumbar surgery, a fusion surgery by Dr. Shiau that helped him the most.

When I saw him he still complained to me of left knee

pain, made worse with bad weather, prolonged sitting and standing, and he complained to me of lower back with radiation down both lower extremities with numbness and tingling.

Q Doctor, was there a clinical examination done?

A There was.

Q And what did this examination consist of?

A The pain level was eight out of ten, ten is the most severe, and zero absolute, means there's no pain, so eight out of ten means there's severe pain, the left knee was tender over the medial and lateral joint line, there was crepitus, grinding sensation, and there were two arthroscopic surgical scars, and the back showed diffuse tenderness, diffuse spasm, spasm is defined as a prolonged involuntary contraction of a muscle. Involuntarily means the patient has no control over it.

Normally when you touch a muscle, it's soft to touch. Once a muscle gets injured, it become hard and tight, the fibers shorten, that is the body's way of protecting the body from recurrent injury the back showed there was tenderness, spasm, there was a surgical scar in the midline about three inches, there was a two inch surgical scar in the left flank, and the range of motion was diminished, backward extension bending back was 15 degrees out of 30, that's one half of normal, bending forward was 60 degrees out of 90, this was measured with a goniometer, which is like a protractor, and bending from side to side was 20 degrees out of 30, and straight leg raising, which

is a test to see if there's nerve root problem in the back or any disc problem in the back was abnormal, it was 70 degrees out of 90, so when the patient is laying flat on the examination table I take my right hand, I put it behind his right ankle, and put my left hand behind his left hamstring with his knee straight I slowly bring it up, once I feel resistance and I stop and record the abnormality it was 70 out of 90, normally it's 90 out of 90 or better.

The range of motion for his left knee was 125 degrees out of 140, so normally is 140 degrees of flexion bending all the way back that's what his right knee showed. His left knee was diminished because he had surgery and stiffness and muscle power testing for both legs was four plus out of five, normally it's five out of five, then comes five minus out of fine, then comes four plus out of five, so it was two grades weaker than normal.

Sensation to pinprick and touch was diminished to the left dorsal foot, that is the L5 nerve root distribution, all of the nerves that go to your legs and your feet, they come from the nerve roots from the lower back, from anatomy, a physician knows what area is covered by which nerve root so, the top of the left foot is covered by the fifth lumbar nerve root, and his gait, the way he walked was slow, antalgic reduced with use of straight cane, antalgic means he walked with a limp.

Q Doctor, did you review any records as part of that

first examination of Erion?

A Yes, I did.

Q Could you tell us what records you reviewed?

A I reviewed records from doctor Daniel Wilen, from Downstate Medical Center, I reviewed his operative report, I reviewed records from surgeon Dr. Ramesh Babu, from the Northwell Health Lenox Hill Hospital, I reviewed various MRIs of the lumbar spine, and I reviewed records, EMG records reports from Dr. Hassan, showed there was nerve damage, he did three different EMGs, I reviewed records from medical and wellness practice, and records from Dr. Richard Radna, R-A-D-N-A, board certified neurosurgeon.

Q And as a result of the review of those records, what did you learn?

A The patient had two back surgeries, one left knee surgery and he still had ongoing pathology, although he was made better, but he was not made whole, and it was not made normal.

Once you have a disc herniation, once and you have surgery, you will never be able to be 100 percent normal, and I can explain later on with my models and my chart.

Q Doctor, so following the examination of Erion on that date and following the review of his medical records, were you able to come up with a diagnosis?

A Yes.

Q And what was the diagnosis?

A L4-L5 disc herniation, a disc herniation means a complete tear of a disc, a bulge means a partial tear of a disc, L4-5 disc herniation, L2, through S1 disc bulges, bilateral lumbar radiculopathy, and that means damage to the nerve roots, and he had two back surgeries, initially it was laminectomy, discectomy, foraminotomy, the second one was a fusion and decompressive surgery with fusion, and he had left knee arthroscopic surgery because of a left knee torn medial, and lateral meniscal tears and chondromalacia. He had permanent scarring to his lower back, left flank and left knee, and persistent lumbar radiculopathy.

Q Doctor, you mentioned, I believe, the EMG studies --

A Yes.

Q -- that you reviewed, and I think you mentioned there were three?

A Yes.

Q Could you please share with the jury what is the significance of these EMG studies?

A EMG stands for electromyography.

MR. FRANKLIN: Objection, cumulative.

THE COURT: Overruled, as long as he's just explaining what it is, and not getting into the entire treatment.

A So an EMG stands for electromyography, and it is a test typically done by a board certified neurologist or board

certified doctor of physical medicine and rehabilitation, and it checks to see if there's any muscle or nerve damage.

It has three parts, the first two parts are called the motor conduction study and sensory conduction study, and the third part is called the needle EMG, you insert sterile needles into various muscles in the legs and back and are hooked to a computer, and a screen that shows the abnormal findings and it tells you if there's a nerve damage and where exactly it is.

The first two parts check the peripheral nerves and the needle portion checks the actual nerve roots from the lower back, the first one was normal, means he did not have any prior preexisting problems, and the next one began to show the pathology, mostly L4-L5, and the third one was mostly bilateral L5-S1 after the surgery.

Q And doctor, following the review of the medical records and the examination of Erion on December 18, 2023, were you able to come up with any plan for his future needs as far as treatment is related?

A Yes, I think it would best help how I arrived at my plan, would a little explanation of the anatomy and the physiology --

Q Yeah, if there's anything that helps the jury by explaining to them, feel free to do it, but I don't believe we will be able to use any boards for illustration purposes that you may have brought with you.

THE COURT: You can't use the ones, you can't use the one we talked about. I don't know if you can use any of the ones that show prior films or something like that, you can use.

MR. DAUTI: The one he brought.

THE COURT: The one we talked about, he cannot use.

THE WITNESS: Can I use models?

MR. DAUTI: Models yes, I think they are in evidence already.

THE WITNESS: May I be allowed to use the models?

MR. DAUTI: Yes, those four things. We also have a model of the spine if that would be helpful.

THE WITNESS: That would be helpful.

MR. DAUTI: It's already in evidence.

COURT OFFICER: (Handing.)

Q Doctor, did, if you're using any of those models that you have in front of you to explain anything to the jury, please do us a favor and refer to what is the Exhibit Number on top of it, so we have a clear record?

A Yes, this model, I can explain from where I'm sitting, but these other models they're hard to be seen unless I can stand and show them in close by.

Q As far as standing, we will do it only with the permission of the Judge, let's start with the one you can do it there, I believe that's Exhibit 23 in evidence?

A Yes.

Q The model of the spine?

A Right.

May I be allowed to stand?

THE COURT: If you need to stand.

THE WITNESS: Yes.

A This is Exhibit Number 23, so this is a model of the lumbar spine, lumbar means lower back, the lower back have five vertebrae, L5, L4, L3, L2 L1. Each area is numbered according to its anatomic location, so if I use the word L4-L5, it means the space between the fourth and fifth vertebra, that would be this disc. If I use the term L5-S1, that would be the space between the fifth vertebra and the first sacrum, so between each vertebra, we have a structure called a disc, a disc has two portions --

MR. FRANKLIN: Objection, this is cumulative.

THE COURT: I don't know how you mean cumulative, this witness has not said this before. Did this witness consult with the Plaintiff for he described the patient as a patient, did he consult with the Plaintiff as a patient?

MR. DAUTI: Your Honor, he consulted --

THE COURT: Yes or no, did he consult with the Plaintiff as a patient?

MR. DAUTI: Yes.

THE COURT: If he consulted with the Plaintiff as a

patient and, sir, did you make your planning recommendations for the Plaintiff's future PMR needs, or pain management needs, did you make those recommendations to the Plaintiff or only to counsel?

THE WITNESS: To the patient.

THE COURT: Then he has to be treated as a treating physician in which case, in which case it's not cumulative. He's a treating physician, he's entitled to say his findings.

Go ahead.

THE WITNESS: May I continue?

THE COURT: Yes.

A Now I'm going to use model that's labeled Exhibit Number 28, so when we look at a disc, picture the disc as a jelly doughnut, outside we have fibrocartilage material, there are 100 rings of a fibrocartilage material called the annulus fibrosus, A-N-N-U-L-U-S, F-I-B-R-O-S-U-S, and inside, we have a gelatinous material called nucleus pulposus N-U-C-L-E-U-S, P-U-L-P-O-L-S-U-S, it is this fluid filled structure that gives us our ability to bend forward, backwards, sideways and when we jump, it is this structure that prevents bone from hitting bone and causing a bone break.

Right behind the disc is the spinal canal, where the spinal cord runs from the brain all the way down to your lower back, it ends between the first and second lumbar vertebra, it

continues with branches of nerve roots that are called the cauda equina, resemble a horses's tail.

Each nerve root gives you how a sensation to different portions in the leg, so we have three pathological conditions to a disc, this is a normal disc, and a bulge is a partial tear, a protrusion is a complete tear of a disc. When a disc material doesn't pass the border of the vertebra. If it does like here, it's called a herniation, herniation is defined as a complete tear of a disc.

Now, once you have a disc herniation or a disc bulge, the water content of the disc leaks out, look at the size of this disc, look at the size of this disc, it's degenerated, the water has leaked out. So the body begins to form bony projections called osteophytes, to stabilize the injured area, but you lose flexibility, you lose range of motion --

MR. FRANKLIN: Objection, narrative.

A -- and stiffness in --

THE COURT: Objection, sorry?

MR. FRANKLIN: Narrative.

THE COURT: He was asked a narrative question, but I will ask, I will ask, unless this was part of the planning process, meaning unless this was part of his, I'm sorry, to talk about you doctor, unless this was part of the planning process, unless these are particular parts of the considerations that went into the future care plan that he

discussed with the patient, meaning in our case the Plaintiff, then, then it does start to get, you know, sort of beyond the scope of what he's here for.

MR. DAUTI: Yes, your Honor, let me address this.

Q Doctor, I know that you do a lot of teaching; correct?

A I do.

Q So I understand that you have to fight the urge of being a teacher here in front of the jury, and I know you're trying to explain the background information, but we need to move things along and please let's just, you know, give us basically what the jury needs to know, and then let's move on to the specific case of Erion Belli.

THE COURT: Let me try to address, I think what the portion of Defendant's ongoing objection that I think I find sympathy with, or you know, concurrence with, is that at the end of the day, we had a spine surgeon already here and I believe we're going to have an orthopedist come later and so, the extent to which, the extent to which the anatomy or the planning or whatever impacted the exam that you did of the Plaintiff, and the recommendation that you made, meaning essentially to the extent they influenced your understanding of his past treatment, so you can make recommendations about what he should be planning for in the future, certainly feel free to explain, that's the difference that you described between yourself and a nonphysician life care planner,

right, is that if you did a medical exam and a medical consultation with the Plaintiff, and then based on that, and the prior history, made a set of recommendations to the extent that those things were necessary as part of your exam or as part of your recommendations, I don't have a problem, and I don't know if Defendant does, but I'm not worried about it.

THE WITNESS: That's exactly the case.

THE COURT: I've got it, but what I'm getting at, I think you can assume the jury got most of this anatomy and physiology lesson from the spinal surgeon who testified, and so to the extent that you can sort of cut through to what your exam you described earlier some of your exam, to the extent you can finish describing your exam, describe what you read in the prior treatment records and then talk about how those two things led you to a future treatment plan for the patient, to your patient, that would be super helpful and help us make sure we get you out by lunchtime so we can do the second witness after lunch, which yesterday, we almost failed out.

THE WITNESS: Yes, your Honor.

THE COURT: So thanks.

Q So, doctor, going back to the question that we started with this, following your examination of Erion, on December 18, 2023, and after reviewing his medical records, were you able to

come up with a plan to determine his future medical needs, and was that plan and these opinions that you wrote there within a reasonable degree of medical certainty?

A Yes, sir, did you want me to give the future medical needs and the expenses or just the future medical needs?

Q I would like to have both.

A Both, yes.

THE COURT: With the understanding that that this witness will not be testifying about future inflation.

MR. DAUTI: Absolutely not.

THE COURT: Or cost changes that would come from a different witness.

MR. DAUTI: Absolutely, your Honor.

THE COURT: Fair enough, fair enough.

A So the patient will need to see an orthopedic surgeon at least six times per year to monitor the left knee injuries to look for traumatic arthritis and any other abnormal conditions to the left knee, and to see if the patient needs any surgical interventions, such as another orthopedic surgery or may be a total knee replacement. The cost for that service is $200 per visit, and the patient should be seen by a spinal surgeon at least three to four times per year, to look for, to see the area that was operated on to make sure it's stable, make sure there's no traumatic arthritis setting in, make sure there's no adjacent segmental pathology setting in.

What that means is, many times when we have surgery, at one level, especially with a fusion, the pressure --

MR. FRANKLIN: Objection, beyond the scope.

THE COURT: We just established he's a treating physician.

MR. DAUTI: Plus --

THE COURT: It's not beyond the scope of his report.

MR. FRANKLIN: Beyond the scope of what he's being offered here.

THE COURT: Both as a physical medicine and rehabilitation doctor, and as a life care planner, and so I don't think it's beyond the scope yet.

MR. DAUTI: Your Honor, he's only explaining the levels of the surgery, so.

THE COURT: In any event, I've already overruled the objection.

MR. DAUTI: I'm so --

THE COURT: You don't have to argue an objection you've already won.

Q Go ahead.

A As I said, the patient needs to see a spinal surgeon at least three to four times a year to make sure the areas that had been operated on remain stable, there's no new pathology setting in, and that there's no traumatic arthritis setting in, and

there's no, the bulges, a bulge is a partial tear. He has bulges still from the second vertebra all the way down L5-S1, he has four bulging discs. A bulge, as I said, is a partial tear, he wants to make sure there's no herniation setting in, the fusion, make sure the fusion site, that the plates and screws don't break, sometimes they do, these are things that the spinal surgeon checks for and the cost for each visit is $300 to $400, depending on the amount of time spent with the patient.

The patient is to be seen by a doctor, such as myself, at least eight to ten times a year to see if the patient needs any physical therapy, purpose of physical therapy is to decrease pain, decrease spasm, improve range of motion, improve overall function and most importantly to prevent the condition from getting progressively worse and also if the patient needs any medications for pain and spasm, and if the patient needs any new diagnostic studies such as X-rays, MRIs or CT scans, and the cost for each visit will be $200, and the patient will also need periodic MRIs of the left knee, and the lower back every two to three years to see if the condition is getting progressively worse and if it is to catch it early, early intervention means that the treatment would be very effective.

Late intervention, would probably lead to a bad treatment, because the problems already gone too far advanced, and the costs for each MRI is $1,500, the patient needs EMGs of the back and lower extremities now, and every two years to check

and see the level of nerve damage. The patient already had three EMGs before, and he will need one every two years, the cost is about $2,000 for each EMG.

The patient should have at least 40 physical therapy sessions per year, like once a week, to diminish pain, diminish spasm, improve range of motion, improve gait, improve muscle power and most importantly, to prevent this condition from getting progressively worse, and the cost for each physical therapy session is $150.

The patient would need medications for pain, spasm and inflammation, and the approximate cost is $3,000 to $5,000 per year, depending on the medications, we have oral medications and we have topical compounding cream medications that have the least amount of side effects, such as I just mentioned a few of them Capsaicin C-A-P-S-A-I-C-I-N, Salicyate, S-A-L-I-C-Y-A-T-E, menthol, M-E-N-T-H-O-L, Lidocaine, L-I-D-O-C-A-I-N-E, Gabapentin, these are all topical compounding cream medications for pain, spasm and inflammation and they have the least amount of side effects, and they cost little bit more money, they cost about 800 to $900 a month, and the patient will need a complete blood count with basic chemistry profile, liver function test to monitor the potential side effects of the medications, this will be needed every four months, and the cost is about $400 for the set.

For the next five years the patient will need --

THE COURT: Can I ask you to back up, maybe I missed something, I thought you said he had prescription medications at three to $5,000 a year?

THE WITNESS: Oral, oral medications.

THE COURT: Okay.

THE WITNESS: Oral medications, and then we have the topical compounding cream medications, those cost about 800 to 900 per month.

THE COURT: So about $10,000 a year, $9600 a year?

THE WITNESS: That's about correct, yes.

A So he will need the following interventional pain management procedures for the lower back, these will be epidural injections, medial branch block injections, radiofrequency ablation procedures. I will explain each one.

So the first one will be these will be for the next five years when you do these procedures, you have to have a fresh new MRI once per year to make sure the anatomy hasn't changed, you do an epidural injection for the lower back. When you give an epidural to the lower back, it can be done in three places in the middle of the spine, that's called intralaminar, two fingers away from the spine that's called a transforaminal, it can be done through the tailbone called a cauda epidural, that's the most effective and the safest.

So when you inject Lidocaine and cortisone into the spine area, it works a lot better than if you do it by mouth.

For example, if you take morphine, one milligram of morphine into the spine equals 100 milligrams of morphine by mouth. If you give a patient 100 milligrams of morphine by mouth, you will kill them, one milligram into the spine doesn't do anything, so we put 40 milligrams of cortisone into the spine that will be equivalent to something like 400 milligrams by mouth. If you give a patient 400 milligrams of cortisone by mouth, they will be hallucinating, they will see elephants coming through the walls and have a lot of side effects.

So when you give medications into the spine, it's much more effective, so he will need three epidural injections to the lower back per year, to diminish pain, diminish spasm, improve flexibility, it is not a cure, it's a short-term relief so he can be more functional.

Then comes the facet injections, these structures, I have a better model, these structures are called the facets, what I'm pointing to with my pen, the facets controls bending forward, backwards and sideways. When you have a disc herniation, the facets will also be inflamed, so he will need three of these injections per year, and if they work, then you go to the big guns, it's called radiofrequency ablation, you put a long needle heated up to 150 degrees Farenheit, right on top of bone, that's the sensory nerves that come from the facets to here, you burn them, they regenerate after six months to nine months, so you do two of those per year.

The epidurals costs $2,000 for each one and the outpatient surgical facility for each one for anesthesia for the recovery is $3,000.

THE COURT: So $5,000?

THE WITNESS: Five time three is $15,000, multiplied by five is $75,000.

A Then we have the facets or the medial branch block injections, each one cost $3,000, the outpatient surgical facility fee is $3,000, so each one is $6,000 times three is 18 times five is $90,000.

Next we have the radiofrequency ablation, each one cost $5,000, just those probes alone they cost $1500 just for one probe, so it's $5,000 for the radiofrequency procedure and $4,000 for the outpatient surgical facility. We do two of those per year, and each one is $9,000 times two is $18,000, and multiplied by five, comes $108,000 for five years.

Moving along, as time goes on, as traumatic arthritis and synovitis sets into the lumbar spine, this patient will be officially a candidate for another surgery as these surgeries to the spine typically last five to seven years, they don't last forever because of traumatic arthritis, loosening of the hardware, adjacent segment pathology, so future surgery will be needed.

MR. FRANKLIN: Your Honor, objection to the extent he's just reading from his report.

THE COURT: Doctor, Plaintiff's previous doctors all referred to their reports, and read extensively from them, that said, I don't remember, I can't remember if it was asked, it was asked of the other witnesses, but I can't remember if you asked, if you advised this witness if he needed to read from his report to refresh his recollection, he should just say so and he can do it.

So I apologize to the jury I don't remember if that statement was made at the beginning of this witness's testimony, but I will advise you, sir, that if you need to read from your report in order to refresh your recollection, you are entitled to do it, just tell us you're using the report to refresh your recollection.

THE WITNESS: Yes, your Honor.

THE COURT: Thanks.

A So I'm not reading from my report, so the patient will need future surgery, decompression surgery with at least two level fusion surgery, the surgeon's fee would be about $75,000, and the surgical assistant fee to assist him with the surgery will be $10,000, and one to two day hospital stay would cost about 100 $50,000 to $200,000. Those artificial replacement parts alone is covered in that 150 to $200,000. Each prosthetic disc level is about $20,000, and the plates and the screws, they are very, very expensive, and then anesthesia is $4,000, neuro monitoring fee to monitor the spine during surgery to make sure

there's no damage to the nerve roots, that's $3,000, postsurgical bracing is $1,000, and after the surgery, the patient would need additional physical therapy three times a week for four to six months, that's $150 per session.

Q Well, doctor --

THE COURT: What is the total cost for the fusion, surgery?

THE WITNESS: Fusion surgery.

THE COURT: I mean all in, instead of itemized?

THE WITNESS: Let me do in my head, your Honor.

THE COURT: Fine.

THE WITNESS: Approximately $300,000.

Q Doctor, I apologize if I didn't tell you at the beginning, there's nothing wrong with you to refer to the report you have in front of you, just the Court, the Judge wants you to basically tell us that you are looking at the report when you're looking at it?

THE COURT: You don't have to tell us each time, again, only the same thing we've asked of every other expert witness in the case. If you're testifying solely from memory, I don't think any expert has done, then fine. If you're going to refer to your report, just tell us you're going to refer to reports at various points, tell us once, not every time you do it, then we will know it from the record and the jurors will see it, and that's fine.

Q Is there anything else, if you were to look at your report, is there anything else --

A Yes.

Q -- you need to add?

A Yes, so as time goes on is as traumatic arthritis to the left knee sets in, we will benefit from one, only one more arthroscopic surgery the cost will be about $35,000, this will include the surgeon's fee.

Q Are we talking about the knee?

THE COURT: He said the knee.

MR. DAUTI: I'm sorry.

A Yes, the knee.

Q I'm sorry?

THE COURT: One scope at $35,000.

A One at $35,000, this will include the surgeon's fee, surgical assistant's fee, outpatient surgical fee. After the surgery, the patient would need additional physical therapy sessions three times a week for four to six months at a cost of $150 per session.

Next, once the patient reaches the approximate age of 60 to 63, traumatic arthritis would have set in, he will now be a candidate for total knee replacement, arthroscopic surgery will no longer help him and the fee is as follows; the surgeon fee is about $30,000, the prosthetic knee replacement part is about $25,000 to $30,000, one to two day hospital stay is about

$60,000, and anesthesia fee is about $3,000, and after the surgery, the patient will need additional physical therapy to the knee, and three times a week for four to six months and the average longevity of a knee replacement is ten years, plus or minus two years depending on how much the patient is using the leg and how much he's ambulating just checking to see if I left anything else out, I believe that's it, that covers it.

THE COURT: So what is the to the total cost of the total knee?

THE WITNESS: It's $110,000.

THE COURT: All in?

THE WITNESS: Yes, all included.

Q For the knee?

A For the knee, yes.

Q Doctor, are these future treatments that you are recommending that needed here causally related to the injuries suffered in this accident?

A Yes, sir.

Q And is that opinion of yours with a reasonable degree of medical certainty?

A Yes, sir.

Q Doctor, other than -- withdrawn.

After December 18, 2023, did you get to see Erion again?

A I did.

Q When was that?

A I saw him again May 7, 2024.

Q And what, if anything, did you discuss or do for him during that appointment?

A We discussed he had his second surgery, by Dr. Shiau, and this time it was a decompression surgery with fusion, and he told me that helped him more than the first surgery; however, he still had back pain, still had radiating pain down both legs with numbness, and tingling, he still had left knee pain, and he had been totally disabled, unable to work and he was having also problems with anxiety and depression, and that's essentially it.

Q And did you have another examination of him after that?

A I did, that was March 17, 2026, and again, I reviewed various reports, and I reviewed the operative report of Dr. Shiau, and he still have lower back pain with radiation down both lower extremities, and he still had complaints of anxiety, depression and he was followed up by the Harris Psychiatric Services for his anxiety and depression, getting medications for that.

I examined the area of chief complaint again, and I found him to still be totally disabled, and I can across with additional needs for psychiatric medications, and I believe he was on four different psychiatric medications for anxiety, for depression for insomnia.

THE COURT: Those are not meds you personally

prescribed?

THE WITNESS: No, your Honor, they are not.

Q After reviewing those records, and having this examination of Erion again, did you, did your opinion change with regard to the diagnosis compared to the previous appointment examination that you had with Erion?

A My prior diagnosis remains the same, plus the addition of reactive anxiety and depression.

Q And --

MR. FRANKLIN: Objection, foundation.

THE COURT: Sustained. I'm not clear that, I'm not clear that the witness is qualified to give a diagnosis in psychiatry. He can talk about what he read in somebody's else chart and what the cost of that is, if he knows, is but he's not qualified to give a psychiatric diagnosis, I agree with that, sustained.

MR. DAUTI: Thank you, your Honor.

Q Did you review any records during that visit regarding his mental health?

A I did.

Q And what records did you review?

A Harris Psychiatric Services.

Q And as a result of reviewing those records, were you able to see whether he was taking any medications?

A Yes.

Q After reviewing those records and seeing the diagnosis that was mentioned in those records, were you able to come up with a plan for the future healthcare needs as related to his mental health for Erion in the future?

A Yes.

MR. FRANKLIN: Objection, foundation.

THE COURT: Sustained to the extent, again, I don't think this witness can plan psychiatric treatment.

You don't personally make referrals for psychiatric treatment, do you?

THE WITNESS: Your Honor, as part of my training in physical medicine and rehabilitation, I do treat reactive anxiety, depression, I do prescribe such medications such as Lexapro, Cymbalta.

THE COURT: You do that in your own practice?

THE WITNESS: I do.

THE COURT: Then I apologize, overruled.

A Yes.

Q So we go back, did you make any recommendation regarding the future healthcare needs related to Erion's mental health for the future?

A Yes, for future --

MR. FRANKLIN: Objection.

A -- psychotropic.

MR. FRANKLIN: The question sounded like the one

that your Honor sustained, so.

THE COURT: I know, but I just had to overrule that objection and essentially reversed myself, because, first thought I understood him to say he doesn't prescribe the meds, but he said in his own practice, he does, and I guess I understand.

MR. FRANKLIN: We did voir dire him, he's not a psychiatrist.

THE COURT: He's not a psychiatrist but if in his practice, he does prescribe psychiatric medication or the anxiety medications or the things like that in the context of patients undergoing long-term rehab, then you know, if it's part of his practice, and he is allowed to do it, and his governing body allows it within the scope of practice, then, you know, then I have to let him do it, without putting too fine a point on it, I think the issue is, let's say someone goes to their internist and says they're having anxiety and their internist gives them some sort of antianxiety medication, if they do it in their practice and in their scope of practice allows it, then I'm at a loss, I have to allow the testimony.

Q So, doctor, the additional treatment that Erion needs for his mental health in the future as part of your life care plan, what are, what did you recommend here?

A He will need future medications for anxiety, depression

and insomnia and future medical expenses will be between the range of $3,000 to $4,000 per year.

Q Are these future mental healthcare needs for Erion causally related to the accident of June 29, 2019?

MR. FRANKLIN: Objection, foundation.

THE COURT: It's the same question, I think, I'm not sure of the answer, I think I will have to say it's subject to connection.

Do we know whether or not we're expecting a witness from Harris Psychiatric?

MR. DAUTI: Your Honor, like I've mentioned to you --

THE COURT: I know you're mentioned on the question.

MR. DAUTI: We are expecting, your Honor, but I cannot guarantee anything.

THE COURT: For now, subject to connection and also subject to, not subject to, but essentially, based on the witness's testimony that he treats reactive anxiety and depression as part of his rehab practice, I think I have to allow it.

I would ask doctor, if we get to a place where we are beyond what you do in your own practice, that you let us know, so I can make, again, we allow Plaintiff's life care planners on a regular basis to describe future care needs

outside of their specialty, but, but given this sort of technical nature of some of these objections, whatever point we get to something you don't do in your own practice, let us know, so I can try to make a ruling about whether it will be, whether it can be offered subject to direct psychiatric testimony or whether it can't be offered at all, whether it has to be offered with some admonitions; fair enough?

THE WITNESS: Yes, your Honor.

THE COURT: Okay.

Q Doctor, now I'm going to ask you a hypothetical question, and the question is based on the evidence that has been presented before in court here, and I ask that you say your opinion, within a reasonable degree of medical certainty, and if you cannot do so, please let us know, I want to make sure I get it right, I will read it, it's a bit lengthy.

I would like you to assume that Erion testified that on June 29, 2019, he was walking at the job site when he slipped and fell on an oily substance, he fell down on his left knee --

MR. FRANKLIN: Objection.

THE COURT: Overruled.

Q -- he fell down on the left knee and left side that struck the ground.

I would like you to assume Erion was lying down on the floor, covered in the oily substance, and he was trying to stand up, but he could not because he could not bend his knee.

I also want you to assume that Erion testified that approximately one week later as he tried to return back to work, his lower back pain got worse and worse, and the next time he managed to see a medical care provider he complained of severe knee pain and severe back pain.

I would also like you to assume that Erion never injured his lower back before and never saw a doctor before this accident for treatment of any lower back injuries or complaints.

I would also like you to assume that Erion never injured his left knee before, but he did feel some pain on his left knee approximately six months before this accident; however, the pain went away and he did not need any physical therapy or other treatment and he did not miss any time from work.

I would also like you to assume that before the accident of June 29, 2019, Erion was able to go on with his activities of daily life and he was regularly working as a plumber and plumber foreman for almost 20 years.

After assuming all of the above, and based on your examination and treatment of Erion in your review of the medical records, doctor, do you have an opinion, within a reasonable degree of medical certainty, as to the cause of the left knee and lower back injuries Erion sustained?

THE COURT: Hold on.

MR. FRANKLIN: Objection.

THE COURT: Sustained, I don't think he was asked in his consultation, and tell me if I'm wrong, I don't think he was asked to give an opinion as causation of the injuries, only whether based on the history and the presenting symptoms whether the future treatment needs would be consistent with the history and present symptoms.

I don't think he gave, tell me if I'm wrong, doctor, I don't think you gave the Plaintiff ongoing PR treatment, meaning, you were a treating doctor in that you consulted with the patient for the purpose of giving him a future essentially rehabilitative treatment plan, am I correct in assuming you didn't personally prescribe PT, you didn't personally diagnose injuries other than to confirm the diagnoses that were already made?

THE WITNESS: Your Honor, you're partially correct.

THE COURT: Tell me where I'm wrong?

THE WITNESS: I did not prescribe any physical therapy for a variety of good reasons, which --

THE COURT: Just --

THE WITNESS: I did not, I did not.

THE COURT: If he didn't make the diagnoses, he doesn't have to be called upon to judge the causation of the injuries, underlying injuries themselves, he, if I understand correctly, he is a treating physician, but that the purpose of his treatment was to review treatments given

previously, to evaluate the Plaintiff's or his patient's then current status as of the time, I know of three different exams and evaluations and to offer the Plaintiff a treatment plan going forward.

So it's not that he can't have an opinion of his own about causation, but I think that the, to the extent that the narrative asks him to diagnose anew the injuries, I don't think that's what he was consulted for, if I understand correctly.

MR. DAUTI: Your Honor, I just wanted to mention in his report that has been exchanged he basically talks about diagnosis, talks about causation.

THE COURT: There was no objection to his report.

MR. DAUTI: Absolutely not, your Honor.

MR. FRANKLIN: There were objections.

MR. DAUTI: They were exchanged before note of issue was filed.

MR. FRANKLIN: There were objections and motions.

THE COURT: This will take longer to argue, let's go outside.

(Whereupon, an off the record bench discussion was held.)

THE COURT: Okay, as I have been saying, since these issues were previously addressed in pretrial motions and the objections were previously overruled in pretrial

motions, the objection is overruled and the line of questions at this point then has to be overruled.

Q So, doctor, that means you may answer the question.

THE COURT: With respect causation.

MR. DAUTI: Please don't read the whole thing again.

THE COURT: Assuming the things that I believe you assumed in your consult and your consulting report about how the accident happened and the Plaintiff's previous medical records or lack thereof, do you have an opinion, to a reasonable degree of medical certainty, as to causation of these injuries?

THE WITNESS: I do. Your Honor.

THE COURT: You want to state that opinion please?

THE WITNESS: That's based on the accident of June 29, 2019, for a variety of good reasons.

THE COURT: I'm sorry, the question, are they caused or not caused?

THE WITNESS: They are, your Honor, they are.

THE COURT: Thanks.

Q And the same question, with same hypothetical based on your review of the medical records and examination of Erion, can you tell this Court and jury, within a reasonable degree of medical certainty, whether the injuries Erion suffered on his lower back and left knee is the result of June 29, 2019,

accident are permanent?

A They're permanent, yes, sir.

Q What is the basis of your opinion?

A Based on the history, the physical examination, and my 35-year plus knowledge of treating these types of injuries, known, what the future will be and having examined him on three different occasions, knowing that the condition has not resolved and it's ongoing, and these injuries are permanent and progressive.

Q Doctor, do you have an opinion, within a reasonable degree of medical certainty, as to Erion's ability to do any type of physical work from the date of the accident, June 29, 2019, to this date?

THE COURT: Based on history an those three exams?

MR. DAUTI: Correct.

THE COURT: Okay.

Q And review of the medical records?

THE COURT: That's what I mean by "history".

MR. DAUTI: Yes.

A Yes.

Q And what is your opinion?

A That he has not been able to work since the accident of June 29, 2019, although he tried, but he could not.

Q And do you have an opinion, within a reasonable degree of medical certainty, same question as before, but with regard

to his ability to do any physical work from now into whatever is the remainder, what would be the remainder of Erion's future work life?

A He has a permanent total disability for any type of gainful occupation.

Q Doctor, what does the future hold for him?

A He's left with a permanent injury that is progressive, means it's not going to get better, it will get progressively worse and these diagrams show that this is normal, this is an end stage disc disease, even though with surgery.

MR. DAUTI: Thank you.

THE COURT: You're welcome.

Do you want a brief recess before cross or go straight in?

MR. FRANKLIN: I'm ready to go.

THE COURT: Are the jurors ready to go or do you need a break? Great, thanks you.

CROSS-EXAMINATION BY

MR. FRANKLIN:

Q Doctor, your specialty in physical medicine and rehabilitation is a nonsurgical specialty; is that correct?

A It does have surgery as part of it, yes, I do microsurgeries of the spine, I do micro discectomies.

Q Do you recall giving testimony in the case of Alan Tyler versus the City of New York, Supreme Court case number

10968 of 2008 on July 14, 2014?

A I do not.

MR. FRANKLIN: Permission to read, your Honor.

THE COURT: If you want to give me the transcript first.

Again, ladies and gentlemen, this is the same instruction that I gave you yesterday about the weight of previous sworn testimony. Page and line?

Q Page three, line 22, excuse me, page four, and I will skip down to lines 12 to 18.

THE COURT: Thanks.

Q The question was regarding the specialty, and the answer in part was "we deal with predominantly fractures after the fracture has been set or the surgeons perform, then we get involved, we do the rehabilitation, it deals with all nonsurgical orthopedic and neurosurgical problems, it deals with diagnosis and treatment of spinal conditions, disc herniations, joint problems nerve problems," et cetera.

Was that your testimony, doctor?

A That's partially true, it's exactly what I said earlier but the specialty keeps on evolving, most medical specialties don't stay stagnated, they evolve, we have new discovery, we have new medications, we have new procedures, so now, I have been doing micro discectomies of the spine for the past several years and most physiatrists now are taught this as well along

with interventional pain management procedures.

Q Alright, doctor, you got your medical training in the Dominican Republic?

A My medical school, yes, that is correct.

Q And okay, unlike U.S. medical schools, the medical schools of the Dominican Republic are not accredited by the Liaison Committee on Medical Education that is the nationally recognized --

MR. DAUTI: Objection.

THE COURT: Sustained, first of all, he received residency training in the United States, and second of all, he passed, he already testified that he passed the medical licensing exams in the United States and he was accepted as an expert.

You cannot now try to claim he doesn't have an appropriate accredited training or license, and I'm not sure you want to go down the road with some of the defense experts either.

MR. FRANKLIN: I will move on.

THE COURT: You passed the step one, step two exams?

THE WITNESS: Yes, at the time I took it, it was called ECFMG, which is a combination of step one and two.

THE COURT: You passed them and got an accredited license in the United States?

THE WITNESS: Yes.

THE COURT: Your M.D. was recognized in the United States?

THE WITNESS: Yes, your Honor.

THE COURT: Alright.

Q Now, you've testified for more than a dozen years, right, doctor?

A Yes.

Q Have you ever had your testimony rejected?

THE COURT: His testimony meaning based on an objection to a question or whether he has been rejected as an expert.

MR. FRANKLIN: Just opinions rejected in, during court, during trial.

MR. DAUTI: Objection.

THE COURT: Sustained, not relevant, I have no idea what he may have testified to, but I reject, I rejected testimony today, I've rejected testimony yesterday. Every time I sustain an objection, testimony has been rejected.

If you mean whether he has ever been found not to be qualified as an expert, I'm happy to undertake that although the time to make that point would have been when I was being asked to qualify him as an expert.

If you're trying to say he has been, that there have been Frye Diallo questions raised about his testimony,

again, then that would be the appropriate subject of a motion in limine.

If you mean some jury once found differently from what he opined, again it happens to every, not every expert I have encountered, at various points.

Q Now, doctor, have you in the past offered opinions on the topic of, I guess, brain surgery?

A I may have.

Q And you're not a brain surgeon; correct?

A I'm not a brain surgeon.

Q And have you in the past offered opinions on the topic of psychiatry?

A Psychiatric conditions are part of my specialty, especially reactive anxiety and depression, is part of my boards, it's part of my training, I prescribe and treat patients in my office with psychiatric issues.

Q Have you offered opinions regarding traumatic brain injuries?

A I have, it's part of my specialty, traumatic brain injuries.

Q Do you treat traumatic brain injuries?

A I do.

Q And do you do perform surgeries on the brain?

A On the brain, I do not.

Q Would you agree that a physician whose actually

treating the patient is in the best position to give an opinion regarding the patient's condition?

A Generally speaking, yes, sir.

THE COURT: Sustained. This witness has been deemed to be a treating physician, he consulted for the purpose of treatment planning with this Plaintiff three times.

MR. FRANKLIN: Okay.

THE COURT: That's different and I would agree, that's different from a consulting expert who is not called upon to give direct advice or care to a patient or a Plaintiff or claimant or anything else.

Q Doctor, let me just ask you, you saw the Plaintiff three times.

On the day of May 7, 2024, did you prescribe any treatment to Mr. Belli?

A Prescribe any treatment, no, sir, I did not.

Q Did you do a physical examination?

A I did, let me just make sure, let me just make sure -- no, sir, just review of records.

Q And you spoke to him?

THE COURT: Are we talking about the first visit?

MR. FRANKLIN: May 27, 2024.

A I did not speak to him on that date.

Q Did you even see him on that date?

A No.

Q You did not see him three times, you saw him two times?

A That is correct.

THE COURT: That may be my error, I thought it was three visits.

Q You saw Mr. Belli once in 2023, and then the next time you saw him was three years later?

A That is correct, yes.

Q And you call yourself treating Mr. Belli?

A I gave him medical advice, I gave him his diagnosis, I told him what his condition is, so that is considered, when you give advice.

THE COURT: It's not up to him, it's a legal determination for the purposes of the scope of his testimony, whether he's deemed a treating physician or not.

MR. FRANKLIN: I understand.

THE COURT: Apparently you don't, because I've already ruled on it.

MR. FRANKLIN: I'm trying to understand the scope of what was done during each of these visits, your Honor.

THE COURT: The last question was an argumentative question "you call yourself".

MR. FRANKLIN: Okay.

Q Doctor, did you prescribe any treatment when you last saw Mr. Belli on March 17, 2026?

A I did not.
Q What did you do during that visit?
A I took a history, I did a physical examination, I are reviewed his current complaints, and I told him what he needs to do, and he needs to continue with the Harris Psychiatric Services for his anxiety and depression, and I again reviewed with him his condition is permanent and progressive, and he needs all of the treatment, I told him on the first visit and on the March 17th, 2026, visit as well.
Q Who set up that meeting?
A I have no idea, patient came to my office, I saw I am -- I took a history, I have no idea who set it up.
Q Was the primary purpose of that meeting so you could come up with a plan of cost?
A No, the plan and cost was already done on my December 18th, '23 evaluation.
Q I'm now talking about your March 17th.
THE COURT: He answered the question, he said on that occasion, it was not the primary purpose.
MR. FRANKLIN: Okay.
Q I'm asking about the psychotropic medication costs?
A That is correct, that was added on the March 17th, 2026, evaluation.
Q Was that the primary purpose of that medication?
A I don't know if that was or it was not.

Q I just want to make sure, doctor, you don't have a master's or Ph.D. in vocational rehabilitation?

A I don't, and I don't have need one.

Q Let me ask you about what you have contained in your 2023 report.

Now, prior to meeting with Mr. Belli in December 18, 2023, you reviewed a number of medical records; correct?

A Before I saw him or when I saw him?

Q Well, before you saw him.

A I don't know. When I saw him, I had all of the medical records in my possession.

Q Were you given the medical records at the time that you meet with him?

A They were sent to my office, they were waiting for me at the time of my evaluation with the patient.

Q My question to you is, prior to taking the history from Mr. Belli, had you reviewed his file?

A I don't do it that way, no. I do it at the same time I see the patient.

Q Okay, after, let's focus on the time that you saw Mr. Belli, when you saw Mr. Belli, did you have the emergency department records?

A I did not.

Q Have you ever seen the emergency department records?

A Before coming here, I was told what the ER records

indicated.

THE COURT: Have you seen them?

THE WITNESS: I have not seen them, no.

Q You were told by the attorney?

A Yes.

Q Prior to offering your December 18th, 2023, report, had you reviewed any medical records indicating that Mr. Belli has arthritis?

A No.

Q As sit here, do you know if Mr. Belli has arthritis?

A He now has traumatic arthritis clinically, yes.

Q Do you know if he had arthritis prior to June 29, 2019, the date of the accident, to your knowledge?

A No.

Q Is your knowledge based on records or what is your knowledge based on?

A Based on records and the history.

Q And those records do not include early treatment records?

THE COURT: You mean other than the emergency department?

MR. FRANKLIN: I will withdraw that.

THE COURT: Sure.

Q Doctor, did you review an MRI from September 16, 2019, three months post accident of the lumbar back?

A One second, 2019, no, I did not.
Q Was the first MRI report that you reviewed from 2020?
A That is correct.
Q What date?
A 8/27/2020.
Q Is that what you wrote in your report?
A Let me see what I wrote in my report, you have a -- a typo, it says May 27, 2020.
Q Is the typo in your report or is the typo what you just stated?
MR. DAUTI: I don't understand.
A The typo is in my report, first page second paragraph from the bottom.
Q Okay, so you didn't see an MRI on May 27, 2020, your testimony is you saw one on August 27, 2020?
A The report was on August 27, 2020, that is correct.
Q And that was the first MRI you saw of Mr. Belli's lower back?
A That is correct.
Q As you sit here now, you don't know what the contents of any earlier MRI reports are?
A That is correct.
Q Okay. Doctor, did you review an X-ray of Mr. Belli's left knee on the date of June 30, 2019, the day after the accident?

A I did not.

Q As you sit here today, have you reviewed an X-ray of the left knee from 6/30/2019?

A Let me check.

THE COURT: That was part of the emergency department record?

MR. DAUTI: That is correct.

A I did not.

THE COURT: I don't mean to, I'm not trying to cut you off, I think he stipulated he didn't see the emergency department record himself.

MR. FRANKLIN: Okay.

THE COURT: Meaning any portion of it, you didn't receive any portion of it, I think that's fine.

Q Doctor, have you reviewed the operative report by Dr. Daniel Wilen for the surgery to the left knee on June 24, 2020?

A I believe I did, let me just pull it up here, yes, it's right in front of me.

Q Is it in your report?

A It's the report.

Q What page?

MR. DAUTI: Objection, your Honor.

THE COURT: Overruled.

A Right here, page one.

Q Of which report, doctor?

A Surgery performed on June 24, 2020, at Downstate Medical Center by Dr. Daniel Wilen.

Q Okay. I understand you have that history there, but do you have?

THE COURT: No, he just held up the first page of the operative report in front of you.

Q Okay, my question wasn't in the doctor's report your report of December 18, 2023, when you met with Mr. Belli, had you reviewed the June 24, 2020, operative report?

THE COURT: Before or after?

MR. FRANKLIN: When he met with Mr. Belli on December 18, 2023.

THE COURT: Maybe I don't understand the question.

MR. FRANKLIN: Okay.

THE COURT: If you're asking whether he already reviewed it, I think he stipulated he didn't review any records until he met with the Plaintiff.

MR. FRANKLIN: I will clarify.

THE COURT: That would be great.

Q Doctor, when did you review the operative report of June 24, 2020?

THE COURT: There you go.

A When I saw the patient for the first time on December 18, '23, it's right there in my report, first page, second paragraph.

Q Okay. I'm sorry, I'm looking at the first, can you read it?

A Yes, I reviewed the following medical records, I reviewed the operative report of Daniel Wilen from Downstate Medical Center Brooklyn, New York, the patient's postoperative diagnoses were sinusitis (sic.) of the left knee, and that's to be synovitis, not sinusitis, synovitis of the left knee, lateral joint and intercondylar notch, and patellofemoral joint; tearing of the body and medial and lateral meniscus; plica and scar tissue development in the patellofemoral joint from trauma.

Q Okay, I've got it.

A You got it?

Q Yes.

At the time that you met with Mr. Belli, at the time that you read that report, you were aware then that Mr. Belli had age-related conditions in his left knee?

A What age-related condition, where do you get that from?

Q Well, you would agree that chondromalacia is a age-related and a precursor to arthritis?

A Read it carefully, Dr. Wilen, he says traumatic chondromalacia. Would you like me to show it to you?

THE COURT: Hold on. Don't get into an argument, let him ask questions, you answer questions. When he's done, Plaintiff's counsel ask can you more questions if he wants to.

THE WITNESS: I'm sorry.

THE COURT: No worries.

Q Doctor, I want you to assume hypothetically that the Dr. Wilen found both chondromalacia as well as what you describe as traumatic chondromalacia?

MR. DAUTI: Objection.

THE COURT: Sustained, I'm not sure there's a difference, this is the same debate as yesterday, the same semantic debate as yesterday. If someone uses a term and uses the same term with a modifier, whether the modifier modifies the earlier term, I think in the absence of testimony to the contrary, we assume that the -- that the modifier modifies the preceding term.

Q Doctor, you've previously testified that chondromalacia is an age-related precursor to arthritis, have you not?

A It can be caused by age related and trauma as well.

Q But you did testify to that?

THE COURT: In some other case you mean?

MR. FRANKLIN: Yes.

A I have, that is correct.

MR. FRANKLIN: Just give me one moment.

THE COURT: Okay.

(Pause in the proceedings.)

Q Doctor, you would agree that chondromalacia is a softening of the underside of the kneecap?

A Yes, in part, that is correct.

Q Okay, do you know if that's something that Mr. Belli exhibited to you or something that you've read -- let me rephrase that.

THE COURT: Great.

Q Do you know if that's something you reviewed?

A It is.

Q Okay. And you would agree again that the softening under the kneecap is an age-related precursor to arthritis?

A It can be age-related and traumatically induced as well, both are possible.

Q Okay, and did you perform any independent testing to determine which one it was in this case?

A Outside the scope of my evaluation, no, I did not, no need.

Q As you sit here today, you can't take say, to a reasonable degree of the medical certainty, the condition of the knee was not age-related?

MR. DAUTI: Objection.

A This was not age-related.

MR. FRANKLIN: I have nothing further.

THE COURT: Great, do you have any redirect?

MR. DAUTI: Nothing.

THE COURT: Doctor, nice to see you. Thank you for coming in, those are your models?

THE WITNESS: Yes.

COURT OFFICER: I will bring them back here.

THE COURT: What did we work out about the demonstratives?

MR. DAUTI: These are ones that were marked, but.

MR. FRANKLIN: They were just marked as demonstratives.

THE COURT: The question is do we need them, because they have been shown to the jury or be okay with the models we have.

MR. DAUTI: We are he cannot make the determination for the jury.

THE COURT: I know, but I'm not the one who chose to show them to the jury.

Q Doctor, do you have a problem leaving them here?

THE COURT: Nor forever, for like a week?

THE WITNESS: No problem.

MR. DAUTI: I will sign a paper to return them.

THE COURT: You say it, but I am proud owner besides the ones I had when I was in practice.

(Whereupon, an off the record bench discussion was held.)

THE COURT: Alright, thanks for your time, we have no other witness before lunch and we have one witness after.

MR. DAUTI: Yes.

THE COURT: Great, ladies and gentlemen you get a long lunch today, enjoy, it will rain tomorrow, get out this afternoon.

Remember don't discuss the case amongst yourselves or with anyone else, don't do any outside research and don't have any contact with witness's attorneys, the parties or their staff. Thank you very much.

COURT OFFICER: Judge, what time?

THE COURT: Back to the jury room, 2:00, and be on the bench by 2:15.

COURT OFFICER: All rise, jury exiting.

(Whereupon, the jury exited the courtroom.)

(Whereupon, a lunch break was taken.)

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

THE COURT: Are we ready to go?

MR. DAUTI: Yes.

MR. FRANKLIN: Yes.

THE COURT: Is the witness here?

MR. FRANKLIN: Yes.

(Pause in the proceedings.)

COURT OFFICER: All rise, jury entering.

(Whereupon, the jury entered the courtroom.)

THE COURT: Alright, we come back, last seen of the week.

You can all be seated, ready to call your next

witness.

MR. DAUTI: Yes, Plaintiff called Dr. Wilen.

THE COURT: Call Dr. Wilen.

(Whereupon, Dr. Wilen enter the courtroom and took the witness stand.)

THE CLERK: Raise your right hand, do you swear or affirm that the testimony you're about to give will be the truth, the whole truth and nothing but the truth?

THE WITNESS: Yes.

THE CLERK: In a loud clear voice, state your name and address for the record?

THE WITNESS: Daniel W. Wilen, 9202, for the Hamilton Parkway, Brooklyn, New York 11209.

THE COURT: Dr. W-I-L-E-N.

THE WITNESS: Yes.

THE COURT: M.D.?

THE WITNESS: Yes, M.D.

THE CLERK: Thank you. You may be seated.

DIRECT EXAMINATION BY

MR. DAUTI:

THE COURT: Your witness.

Q Good afternoon, Dr. Wilen.

A Good afternoon.

Q Doctor, are you a physician licensed to practice medicine in the State of New York?

A I am.

Q And when were you licensed?

A 1990.

Q Can you please tell the jury a little bit about your educational background?

A I went to high school in Midwood High School, and I went to college at Williams College in Massachusetts, and then went to Downstate medical I did a residency at Maimonides Medical Center, a fellowship at the Hospital For Joint Diseases, and I have been in private practice, it will be 30 years this summer.

Q And doctor, could you tell the jury what is orthopedic surgery, please?

A Excuse me?

Q Orthopedic surgery?

A It is the studies of the muscles, tendons, the bones, the ligaments.

Q Are you board certified in the field of orthopedic surgery?

A I am.

Q And what does it mean to be board certified?

A It means you successfully completed a residency, and passed a written appeared oral exam and a recertification exam over the last 25 years, I've taken recertification exams.

Q And could you please tell us about your hospital

affiliations, if you have any?

A I'm still affiliated with Downstate Medical, where I went to medical school, that's where I do my surgeries every week, and I'm also still affiliated with the Hospital For Joint Diseases in Manhattan where I did my fellowship.

Q Are you actively involved in the practice of orthopedic surgery?

A I am.

Q And do you do surgeries?

A I do.

Q And for how long have you been practicing orthopedic surgery?

A 38 years.

Q And approximately how many surgeries, do you perform in one year?

A Anywhere from between 250 to 350 depending on the year.

Q When was last time you performed a surgery?

A Last week, actually this week.

Q It's Friday?

A Right, Wednesday. I did two surgeries.

Q And when are you scheduled to perform the next surgery?

A The following week.

Q Are you actively involved in treating patients?

A I'm sorry?

Q Are you actively involved in treating patient?

THE COURT: Are you actively involved in treating patients?

A Yes, yes, I see patients five days a week including Saturdays, and then operate one day a week.

Q And in your practice, do you review imaging studies?

A On a regular basis, yes.

Q And that would be X-rays, CT scans and MRI films; correct?

A That's correct.

Q And what purpose do these studies serve?

A I'm sorry?

Q What purpose do these studies serve?

A Well, in order to evaluate a patient, I have to be able to read an X-ray and a MRI as an orthopedic, so I do that on a regular basis, I take X-rays in my office, read MRIs on a regular basis to the extremities that I'm treating.

Q And when you make recommendations to the patients, do you rely on your reading of these films or on the MRI reports?

A No, I read the films and I rely on the clinical picture of the patient also.

Q And doctor, if you were not in court today, what would you be doing?

A Well, today, I was in my Staten Island office and I saw patients and my daughter is my physician's assistant, and I said to her I'm leaving to go to court. She said to me you didn't

tell me I'm going to court. I said I'm telling you now, I didn't want to get you nervous. She's still seeing patients while I'm here now.

Q Doctor, are you being compensated for your time here today?

A I am.

Q At what rate?

A It's an hourly rate between going over the records at about $500 an hour.

Q Have you been called to testify in court before?

A Yes.

Q And have you been accepted as a medical expert by the Court in the field of orthopedic surgery before?

A I have.

Q And was that in the courts of New York State?

A Yes.

MR. DAUTI: And your Honor, at this point, Plaintiff would like to offer Dr. Wilen as an expert in the field of orthopedic surgery.

MR. FRANKLIN: No objection.

THE COURT: Without objection.

Q How many days per week do you, doctor, spend treating your patients?

THE COURT: You asked him that already.

MR. DAUTI: Oh, my apologies.

A Five days a week I see patients, Monday, Tuesday, I'm in the operating room on Wednesday, Thursday and Friday, and I have been doing Saturdays, but my family is trying to talk me out of that, I'm still right now doing Saturdays.

Q And doctor, when did you for the first time see Erion Belli?

A I believe it was in 2019.

Q Doctor, feel free to refer to the notes.

THE COURT: Yes, are you referring to your chart?

THE WITNESS: Is that okay.

THE COURT: It's in evidence.

MR. DAUTI: Yes.

THE COURT: Then that's fine.

A I believe his first exam was 10/14/19.

Q And at that appointment, did you elicit a history, did you get a history from him?

A He had a work-related accident.

Q And did you learn anything else other than the fact he had a work accident; did you learn anything else from him?

A He was a 38-year old male, he had complaints of left knee pain due to a work-related accident on 6/-- 6/29/19, patient states that while working, that he slipped on an oil spot and fell, causing injuries to his neck, back, shoulder and knee.

Q Did you perform a clinical examination?

A Yes, I did.

Q And what did the examination consist of?

A I examined the left knee joint at that time, we took an X-ray, which showed no fractures or dislocations. He did have an MRI, which showed a tear in the medial meniscus, and he had restriction in motion in the knee and weakness, and as well as swelling and inflammation in the knee joint.

Q And doctor, at this juncture, would it help to use a knee model to explain to the jury what we're talking about?

A Yes, I can.

MR. DAUTI: We have, your Honor, we have agreed to have what number is that?

MR. FRANKLIN: 30.

THE COURT: Plaintiff's Exhibit 30 for demonstrative purposes.

COURT OFFICER: (Handing.)

THE COURT: Ladies and gentlemen, I will ask the witness a question to be sure, but I assume that this is going to be, as I mentioned to you about other demonstrative exhibits, that this is a model of a generic knee, it is not intended to be an exact replica of the Plaintiff's knee and not actual --

THE WITNESS: Yes.

THE COURT: -- an actual rendition; is that correct?

THE WITNESS: Yes.

THE COURT: Great.

A This is basically a knee joint, it is a pretty good model, this is your kneecap, your patella. If you slide it over inside the knee, the blue area is the meniscus, and that's where Mr. Belli had significant injuries to both of meniscus where he had tears and he had damage to the smooth cartilage on the femur and on the back of the kneecap, which is the patella, so from the fall, he had significant traumatic damage to his knee joint.

Q Doctor, as part of the review of the medical records for Erion, did you review any MRI films?

A I did.

Q And do you have a copy of any report in your file to refer to which date was the film?

A I have a copy of the report, I have a copy of the report on my note that the MRI was from 10/14/19.

Q And doctor, we have the film, I believe over here, on the screen, is that something that you need to get close by with the permission of the court?

A Yes.

Q If you see anything --

THE COURT: That's fine, you're welcome to step up to it, just a reminder, you're still under oath when you step off the stand.

THE WITNESS: Sure.

(Whereupon, Dr. Wilen exited the witness stand.)

A There are a few different views.

Q You have a computer.

THE COURT: Can you pull over the other microphone.

A This is to give the jury an idea what the knee is about, this is the tibia, your lower leg, this is the femur, your thigh bone, and in between is the knee joint, these white areas are the meniscus, that's the cartilage that cushions the knee that I had showed you on the model. If you look on the model here that I showed you, the knee when you open it up, you have the meniscus which cushions the knee, that's the blue area here, it's like a cushiony cartilage, it's like a bumper in your knee joint so you don't slam the bone, it cushions the knee.

Erion had tears in both the medial and lateral meniscus on the MRI. If you can show a different view, keep going through the views. Okay, this is the kneecap, he had damage behind the cartilage in the kneecap that smashed up the cartilage, it was that traumatic chondromalacia that's what it's called.

When you suffer a traumatic injury to the knee, you break up the cartilage, it's no longer smooth, the cartilage is like a cue ball, it's smooth, your knee actually glides on the cartilage, it's smooth, but he has cartilage was damaged in the back of the knee joint and was also damaged on the face of the femur, keep going, this is a good view of the meniscus on each

side, the meniscus is a dark area in between the two bones, and you can see that he has highlighted areas here, that shows the meniscus is torn, a very subtle thing you see on the MRI. You only learn to read as the years go on these little white areas in the dark meniscus is tears.

THE COURT: Let me interrupt to say that's not the image that's on the large part of the screen, there you go, no?

THE WITNESS: This one here.

THE COURT: That's funny, that wasn't what everyone was looking at a minute ago, they don't seem to match up.

THE WITNESS: Bring it back a little bit.

MR. DAUTI: Back, back.

THE COURT: There you go.

A You see, this is the meniscus, cushions the knee that I showed you, the blue area in the model, he has three highlighted areas where there's tears, and the tears once the meniscus is torn, it doesn't allow the knee to flow in a fluid fashion.

So the objective of surgery is to go in and smooth out where he has tears and smooth out where he has damaged his cartilage, and like I showed you before, he damaged the cartilage behind the kneecap, here, and he damaged the cartilage on the face of the femur right here during -- after the fall.

So I smoothed out these areas with a shaver behind the kneecap in front of the femur and took the blue areas and

smoothed out the meniscus on each side, just so he can move his knee, more fluently, and not have all of the clicking and locking that occurs from an injury like that.

(Whereupon, Dr. Wilen resumed the witness stand.)

Q So, doctor, after reviewing the films, did you have a diagnosis for his knee condition?

A He basically tore the meniscus on both sides of the knee and had traumatic damage to the cartilage behind the kneecap and the face of the femur, he had -- there were a couple of areas in the knee where the cartilage what is no longer smooth, it was rigid. If you think, if you kind of look at the faces of the moon, there are craters in the cartilage and the craters occurred from trauma from the fall, and my job was to go in and smooth out the craters and smooth out the torn meniscus, the bumpers in the knee torn, smooth them out, the areas so the knee is more stable, it doesn't as swell and get as much pain but these injuries are not -- they're permanent injuries, they don't just get better, but my objective was to make his knee as functional as possible.

Q Just, so doctor so we have a clear record, what was published to the jury and we spoke about, it was dated September 6th, September 16, 2019, doctor, so we have a clear record?

A Okay.

THE COURT: What is the Exhibit Number for that?

MR. DAUTI: It's already in evidence.

THE WITNESS: Sure.

MR. DAUTI: It's number four most likely based.

THE COURT: Part of four?

MR. DAUTI: Yes, Lenox Hill Radiology.

THE COURT: It's so our transcript reflects what people are looking at?

MR. DAUTI: Absolutely.

Q After reviewing the films and examining him, doctor, did you have an opinion, and your recommendation for him, with regard to the treatment that he needed, I know that you mentioned the surgery, but --

A We try physical therapy, we tried a conservative treatments, often we try injections, but with Erion, we did put in for authorization for Worker's Comp, and we received the authorization, and then eventually we did the surgery.

Q When was surgery done?

A I believe it was done 4/15/20.

Q If I were, do you have your operative report with you, did there come a time --

A I do, I'm sorry, the surgery was done 6/24/20.

Q So it was done in June?

A June 24th of '20.

Q 2020, correct, yes.

Could you by, and you can refresh your recollection by

looking at the operative report, can you please tell the jury what did this surgery consist of?

A Basically, it's a surgery where you go in to the -- you go into the operating room, you go home the same day on a cane or crutches, and everything is done through two little incisions; one incision I put a camera in, the other incision I put a shaver in and smooth out all of the tears and remove all of the loose damaged cartilage.

Basically, you're in a bandage and a cane and crutch for a week and then after a week, I take the stitches out and then we start physical therapy.

Q And was this done at a hospital?

A Yes.

Q And which one?

A I believe he was done at Downstate Medical.

Q Was he under general anesthesia for this surgery?

A Yes.

Q And doctor, after the surgery and feel free to look at your notes, when was next time you saw Erion?

A After the surgery?

Q Correct, the surgery was on June 24, 2020, I believe?

A You're asking for the date?

Q Correct, if you have it.

A That would be after the surgery June 24th of '20.

Okay, I have a postop visit here.

Q What is the date on that; do you have a date on that postop visit?

A I have a date 6/29.

Q Okay. And what was done during that visit, doctor, do you have any notes to refresh your recollection?

A Yes, that visit we take out the stitches, we clean the wound, we cover the wound and then we start physical therapy.

Q And you gave him prescription for physical therapy; correct?

A Correct.

Q And it's your understanding that he underwent physical therapy?

A Yes, he did.

Q And doctor, I don't want to go through each visit, but could you tell us overall, how many visits, if you can approximate you had with Erion?

A He saw us then from July of '20, you know, on a monthly basis throughout '20, '21, '22, '23, and I think '23 is kind of where he fell off a little bit.

Q So, it's approximately three, four years?

A Correct.

Q At a rate of --

A Since the time, since the first visit of '19, approximately, three or four years.

Q Right, so we're talking about approximately 45 to 50

visits; is that right?

A That's correct.

Q And during this time that you saw him, all of these visits, I don't want to go through each of them, I think we will be here until next week.

Is there anything from your notes or visits that it's of particular interest to discuss regarding what you noticed during those examinations?

A Basically, just watching his progress with physical therapy, trying to get him to strengthen his knee as much as he can and give him a functioning knee and best as possible after this surgery, but this is not the knee that God gave him, because you know there's damage, permanent damage to his cartilage, permanent damage to his meniscus, and so you know, what I did was sealed everything up and created a knee that's more stable for him so he can function, but at some point in time, he will probably need an additional procedure in his life.

Q And what is the nature of that additional procedure, doctor?

A He'll probably because of the damage he suffered, he'll probably at some point need a knee replacement, he's too young for it now, we try to avoid knee replacements in the 30's and 40's, but at some point in time, due to the damage and the acceleration of the arthritis that occurs from the injury, he's going to definitely need a knee replacement somewhere down the

road.

Q And doctor, when was last time that you saw him, feel free to look at your notes, please?

A Looks like 9/19/23, 9/19/23.

Q And doctor, the total knee replacement surgery that you just mentioned, is that something that you do?

A I do, yeah.

Q What does that entail, can you explain to us briefly how does it work, what does it do?

A Basically that's a much bigger procedure you only want to do it on a patient if they're into their 50's and 60's, it's where you're actually cutting out the bone so severely damaged and putting in a steel bone, and a piece of plastic in the joint to cushion the joint, so you're replacing basically the two parts of the knee joint are being replaced, you flip up the kneecap and the femur gets replaced with steel, and the bottom tibia gets replaced with steel, and then you put a patella button plastic on the back of the kneecap, and then there's plastic that goes in between the two steel parts of the femur and the tibia.

Q And doctor, because we did not discuss your operation in anymore detail, could you please tell the jury during the surgery that you performed on his knee on June 24, 2020, what were your operative findings?

A He had quite a bit of traumatic damage to his meniscus,

on both sides, and he also had damage to behind the kneecap, like I said, the smooth cartilage that usually behind the kneecap to flow was significantly cracked and damaged. He also had cracks in the femur, the cartilage that covers the femur as well as the tibia.

Q Can you tell this jury, within a reasonable degree of medical certainty, whether the injuries that he suffered to his knee on June -- strike that.

Can you tell this jury, within a reasonable degree of medical certainty, whether knee injuries that you just described are causally related to the accident of June 29, 2019?

A They are, they definitely are.

Q Doctor, I want you to assume that Erion testified that approximately six months before this accident his left knee bothered him, he went had an X-ray taken, and he did not undergo any treatment, he did not miss any time from work, and I actually do have the X-ray report as part of the medical record in evidence?

THE COURT: It's in evidence already.

MR. DAUTI: Yes, your Honor.

THE COURT: Okay.

MR. DAUTI: With permission of the Court, we would like to show you the X-ray report.

MR. FRANKLIN: May I see it, your Honor?

THE COURT: Yes.

MR. DAUTI: (Handing.)

THE COURT: Gentlemen, do we have the film or do we just have the report?

MR. DAUTI: I think the X-ray film should be part of that too, your Honor, we will stipulate to is in evidence.

THE COURT: That's fine. It's already in evidence as counsel was saying.

MR. DAUTI: Yes.

THE COURT: As soon as it's fine, you want to show it to the witness.

MR. DAUTI: Yes.

COURT OFFICER: (Handing.)

A Basically --

Q Doctor, let me ask you a question.

A You want to talk first, go ahead.

Q You had a chance to review the document; correct?

A What's that?

Q Did you have a chance to review the document?

A I did, I did.

Q And that's the X-ray dated January 10th, I believe 2019; correct?

A Yes.

Q And so by looking at that X-ray report, what is your understanding from your professional expertise as to what are

the findings in that report?

A Well, the X-ray shows a good joint space, it doesn't mention any arthritis, he also has a benign tumor in his left tibia, which is the lower bone of the leg, below the knee, and that's called an osteochondroma.

Most of the times, we don't touch them, we leave them alone, they're noncancerous, and that was below the knee joint, this showed up on the X-ray osteochondroma; otherwise, the joint spaces are preserved; meaning, there's no degenerative changes and no arthritis.

Q And that condition, pardon me, I cannot say the name can you say it for my?

A Osteochondroma.

Q Osteochondroma, is that something he was born with?

A Yes, a lot of times you're born with, it most of the times you're born with it, yes.

Q And that did not have anything to do with the condition of his knee, it did not interfere with his daily functions with the knee; correct?

A No, most time, it goes unnoticed, the only time it does when people can kind of feel a little bump in their bone and notice it, we take an X-ray.

Q Doctor, I believe you mentioned by looking at the report, is there any evidence of any degenerative disc disease or arthritis on his knee?

A No, the report says no osteophytes or erosive changes, it says basically no arthritis.

Q And after having looked at that report and knowing that you also reviewed the MRI report following this accident, and the film that we showed to the jury here, in your intraoperative findings, is it your opinion, within a reasonable degree of medical certainty, that the injuries that he suffered to his knee on June 29, 2019, are the reason why he was in pain, and he needed to undergoing the surgery you performed on him on June 24, 2020?

A Yes, the injuries are from the trauma and the fall, osteochondroma has nothing to do with that, and this problem is below the knee joint not anywhere in the knee joint, and the fact is he has no arthritis on the X-ray, so he didn't have significant degenerative changes which is arthritis.

Q Doctor, I'm going to ask you a partially legal question. I need to ask for the record here. I will make it as brief as possible.

I would like you to answer this question, within a reasonable degree of medical certainty, and if you can't, please tell us, and so I would like you to assume that Erion testified that on June 29, 2019, he was walking at the job site when he slipped and fell on an oilily substance next to a forklift, he fell down and his left knee and left side struck the ground.

I would like you to assume that Erion was lying on the

floor as he was trying to stand up, he could not because he could not bend his knee.

I want you to assume that Erion testified that approximately one week later, as he tried to return back to work, his knee and lower back got worse, and the next time he managed to see a medical provider he complained of severe knee pain.

I would also like you to assume that other than that X-ray that you've seen, there is no other evidence of any prior conditions to Erion's knee preceding this accident, and that he had been working in plumbing for the last 20 years of his life.

Having had all of those assumptions and accepting them as true, do you have a medical opinion, within a reasonable degree of medical certainty, that the cause of the left knee injury is the accident of June 29, 2019?

A It most definitely is.

Q And could you, same hypothetical, could you please tell us, within a reasonable degree of medical certainty, whether the surgery that you performed on him was because of the injuries that he suffered on June 29, 2019?

A Yes, without the fall, he wouldn't have had the damage to the meniscus, and the cartilage behind the kneecap and in the femur and in viewing the cartilage and the meniscus tears in the operation, I could tell that they were traumatic and not degenerative, and that was when I say "degenerative," it's not

from arthritis, I put that in my operative report, because it was documented that these were traumatic injuries, that they were fresh cartilage, it was fresh cartilage damage, not wear and tear cartilage.

Q Do you have, do you have an opinion, within a reasonable degree of medical certainty, as to Erion's ability to do any kind of physical work from the date of the accident until now?

A No, his -- between his knee and his back, he had significant injuries that did not allow him to work.

Q And the same thing, do you have an opinion, within a reasonable degree of medical certainty, as to his ability to go back to the physical work in construction or in plumbing from now until whatever would be the future of Erion's work life?

A Yes, I don't think he will ever be able to do the bending, lifting and positions that you have to put yourself in as a plumber, because of the significant knee injury he has. He can't bend his knee all the way, he can't straighten it all the way, and he's at a deficit for the rest of his life.

Q And what does the future hold for him, doctor?

A He's definitely going to have to get a knee replacement somewhere down the road, because the cartilage will wear quicker, and he will get arthritis at an accelerated rate, and he will require a knee replacement somewhere down the road, there's no question about that.

MR. DAUTI: Thank you, doctor, no further questions.

THE COURT: Thank you.

Cross.

MR. FRANKLIN: Yes.

CROSS-EXAMINATION BY
MR. FRANKLIN:

Q Dr. Wilen, I think you said September 19, 2023, was the last regular visit that you had with Mr. Belli?

A I believe so, yes.

Q Okay. And based on the condition of his knee currently, do you anticipate that you will need to have further visits with him short of the knee replacement?

A He might have to come in for injections, maybe drain the knee, if he has problems with that, but eventually he'll succumb to the pain and the pain will get worse because of the wear and tear after the injury and the surgery.

So at some point he will knee a replacement, but he will need visits here and there just to check in with his orthopedist, whether that's me or someone else.

Q Is it fair to say he needs to come in on an as-needed basis?

A I think so, yes.

Q Okay. And he may not need to come in; right?

A If he he's doing okay and status quo and doesn't want

to come in just to say hello but if he's having pain he may need antiinflammatory medications, cortisone injections, possible physical therapy again to strengthen the knee, keep strength in the knee and stay away, try to ward away his pain.

Q I want to ask you about your medical records is that you have up in front of you.

A Sure.

Q In your initial office visit, can you find that?

A My initial.

Q Yeah, your initial office visit, I think it was October 14, 2019.

A Okay.

Q Do you have that in front of you?

A I think so.

Q Under sole history, did Mr. Belli indicate he was not a current smoker?

A That's what I have down here, yes Z.

Q If you can find your operative report?

A Yes.

Q Now just before you performed the operation, you, again, confirmed with him he's not a smoker; correct?

A I believe so.

Q And why is it important for someone, you know, in your position to confirm that the individual whose getting ready to undergo a knee surgery does not smoke?

A Well if he's under going general anesthesia, anesthesia wants to be aware of that, there's complications with smokers, they usually have much more fluid postoperatively when you intubate them and take the tube out, so anesthesia wants to be aware of whether he's smoking or not.

Q And if he smokes three to four packs a day could that possibly inhibit his recovery?

A His knee recovery?

Q Yes.

A Usually you're worried about the airway, I, for the most part, smokers don't recover from arthroscopy much slower than non smokers, it's more concern of the anesthesia, putting the patient to sleep, the knee recovery is usually the same whether you're a smoker or non smoker.

Q Okay. And isn't it in fact true every time you met with Mr. Belli, he denied being a smoker?

MR. DAUTI: Objection.

THE COURT:

A I guess.

THE COURT: Overruled.

A He did, I have it in the note that he's a non smoker, so, you know people sometimes they smoke two or three cigarettes a day and they claim they're not a smoker, I don't know what his story is, I don't know how much he smoked, if he did smoke at all, according to the note he's not a current smoker in my

notes.

Q Okay. Now, the damage to the knee, I'm going to make sure I get this correct, you indicated that there was damage to the femur itself?

A Damage to the cartilage behind the femur, yes.

Q Is that like a blunt trauma that induces that?

A That's correct.

Q You indicated there was damage to the patella?

A Correct.

Q And is that a blunt trauma?

A Correct.

Q Would that be consistent with someone who fell on their knee?

A That's correct, yes.

Q And now, you saw as part of your.

Let me go to your operative report, if you can refer to your operative report, I have questions about what you found?

A Sure.

Q Did you take any intraoperative photos?

A I checked, I didn't have any intraoperative photos available I checked before I came here today, there were none available, a lot of times they don't come out, and there's problems with the machine, but I didn't have any available or I would have brought them today.

Q Those create like a nice colored photo of what's going

on in the knee?

A Correct.

Q Are you able to recall other than what you've Wren in your report the details of what you found?

A It's hard to recall, that's why I document in an operative report and I dictate my surgeries right after I do them, I do not let my dictations go to the next day or the next week, so, what I put in paper here is basically what I saw ten minutes before.

Q And you would be reliant on what you included in your operative report, because you perform so many of these knee suggestion you wouldn't have an independent recollection?

A That's correct I would not.

Q So I understand there's postoperative diagnosis, but I want to turn you to the findings on page two of your report.

Now, I guess a third of the way down you said arthroscopy was begun introducing a scope?

A Yes.

Q You found what's called chondromalacia?

A Correct.

Q That was on the patellofemoral joint?

A Yes.

Q Can you tell us exactly what that is?

A Like I said, to the jury, earlier, patella femoral joint is the kneecap, behind the kneecap and the femur, patella,

femoral joint, there was damage to the cartilage on the surface of the femur and damage to the cartilage behind the kneecap and that comes from the knee crashing down, what happens is the cartilage gets crushed and it becomes piecemeal, no longer smooth like a cue ball, it becomes jagged, like I said, crater on the moon so to speak to visualize it, the cartilage is no longer smooth and healthy it's not jagged, piecemeal and my job is to go in and seal it up and make it as stable as possible.

Q Is it possible that someone could lands right on their kneecap and have that damage without, I guess, fracturing the kneecap itself?

A Yeah, well he did it, he fell on his kneecap, he damaged the cartilage but he didn't fracture the bone. If it had gone deeper it would have been into the bone it only fractured the cartilage so to speak, chondromalacia is fracturing the cartilage, so to speak, splintering the cartilage, damaging the cartilage.

Q Now, if you were to hear that Mr. Belli weighed 315 pounds on the day that he came down on his knee, did you that surprise you, that he damaged the cartilage but not the kneecap?

A He's lucky he didn't break the kneecap, he must have come down with a tremendous force, because he did damage the cartilage significantly, in both the kneecap and behind the femur.

Q Okay, ad it would take significant forces to have the level of cartilage damage that you observed when you went into the knee?

A Oh, yes.

Q Now, you also found, let me see if I got this, plica scar tissue on the medial aspect of the patellofemoral joint, I'm misreading that, can you tell me what you found next?

A You're saying it correctly, it's scar tissue.

What happens is, as you fall, and then you crush the cartilage, now the knee swells and balloons up and now scar tissue forms, because you don't move the knee, because you're hurting so badly you don't want to move it, now when you don't move it, strands of scar tissue develop.

So when I was in the operating room, I did notice the strands of cartilage and the strands of scar tissue, and I released them so to give him back as much motion as he could get.

Q Now, I don't recall the exact hypothetical, but if you heard hypothetically that Plaintiff after he fell, had to sit for a while and couldn't move his knee, would that be consistent with what you just described?

MR. DAUTI: Objection.

A Yes.

THE COURT: Overruled.

A Yes.

THE COURT: Hold on, objection to what?

MR. DAUTI: The testimony was could not bend his knee.

THE COURT: Also, he didn't get up right away.

MR. DAUTI: That part is true, correct.

THE COURT: Isn't that what he said?

MR. DAUTI: Well, that part is correct.

MR. FRANKLIN: I can't remember exactly, but I can clarify it.

THE COURT: Sure.

Q Well, would it at all be surprising to you to hear following coming down on that knee he wasn't able to bend the knee?

A Not at all, it doesn't surprise me at all, he's a big man, he came down on his knee.

Q Now, you also found synovitis down the medial gutter, what is that?

A That's inflammation, again, another common sight that you see in the operating room, after a traumatic injury, because after you fall and crush the knee, now you develop the swelling and inflammation, and synovitis develops, synovitis is inflammatory tissue, which makes the knee swollen, painful and difficult to bend.

Q You also found tearing in the body of the medial meniscus, is that as opposed to the radial tear?

A Correct, the meniscus was torn in the body and that's -- I spoke to the jury, that's the blue area, and the blue area is the cushion area, and he had a tear in the rim in the blue area on both sides of the knee.

Q Is that consistent with coming down on the knee?

A Yeah, coming down and then probably a twisting action that occurs also, on the way down, because you know, he's trying to either avoid his fall, and there's a twisting component to it that he may not even realize.

Q Okay. You weren't there?

A Excuse me?

Q You weren't there?

THE COURT: You weren't there during the accident?

A No, no, no, I wasn't there.

Q But based on the evidence that you found, the tearing of the medial meniscus is consistent with someone coming down on the knee?

A Coming down with some sort of twisting motion too, yes.

Q And then you also talked about traumatic chondromalacia, and that was to both the patella and femoral groove and the medial femoral condyle, that's both sides of the knee; correct?

A Yes.

Q Is that like a symmetrical, like you landed squarely on the --

A It's the impact when you come down and smash the knee, the cartilage gets damaged on the femur, and cartilage gets damaged on the tibia, and the cushion cartilage in the knee gets torn, because the knee, you know, subluxates, kind of come down when you hit the floor.

So that's why all of this damage occurs from a blunt trauma, but there's always a twisting component going down to the floor with the knee and that usually causes the meniscus tearing.

Q But more or less a direct hit on that knee; correct?

A Yes, correct.

Q Now, you didn't find any tearing of the ACL or PCL, can you explain the significance of that?

A The ACL and PCL ligaments are the major ligaments that hold your knee in place, they're the cross ligaments, and in your knee you have two ligaments that cross each other, the ACL in the front, the PCL is in the back, both of those ligaments were intact and not torn.

Q Now, you used a tool to go in and shave back a portion of the meniscus?

A Correct.

Q How much of the meniscus did you remove?

A Probably about 15 percent, to 20 percent.

Q Okay, you left enough of the meniscus for him to continue to have a cushion?

A That's exactly right, that's your goal in the tissue to leave back as much healthy meniscus as you can to save the knee from a knee replacement or future surgery, so you trim out the meniscus where it's torn, ripped and it's not doing him any good, and it's flapping around in the knee, that's not good for the knee, makes swelling and inflammation.

Q You tried to preserve as much of the meniscus as possible?

A Correct.

Q When you have this type of procedure, is it fair to say that you know, you're going to take the option that's going to give the patient the most stability?

A Yes.

Q In other words, you're not going to shave down the meniscus to the point where it's going to be basically useless to him?

A No, years ago, before the arthroscopic procedures, the surgeons would go in and take out the entire meniscus, when it was torn, and back in the 70's, they did that and people developed arthritis at such an accelerated rate, so you know as time went on we realized in orthopedics you want to leave back as much as of the meniscus as you can.

So your goal when you go in there is to leave as much healthy meniscus as you can and remove the damaged tissue back to healthy tissue.

Q Depending on extent of the damage, is it possible that this procedure could be successful in giving someone two, three decades before they would need a knee replacement?

A It's possible, but it's not only his torn meniscus, it's chondromalacia on top of that, that makes that timeframe shrink down.

Q Did you anywhere in your report document specifically how much of the meniscus was preserved?

A No, I didn't.

Q As you sit here, do you have an independent recollection of how much the meniscus was preserved?

A No, I don't, I don't.

Q Is it fair to say you don't know how long that meniscus is going to continue to serve Mr. Belli?

A I left him as much as I thought was good for him for a healthy recovery. I always take out the absolute minimum and for the most part, that usually is around 15 to 20 percent of the meniscus comes out, usually not more than that, unless it's severely torn, and you have to take out a bigger chunk than that.

My assumption would be, he probably had about 15 percent to 20 percent of both meniscus taken out.

THE COURT: 15 percent of each you're talking about?

THE WITNESS: Excuse me.

THE COURT: 15 percent of each one?

THE WITNESS: Yes, correct.

Q Mr. Belli hasn't required any kind of revision surgery, has he?

A No.

Q Your procedure was successful?

A I believe so.

Q When you went in there, did you notice any fraying of the meniscus?

A No, looking at my operative report, I don't see any, just tears, they were acute traumatic tears. I didn't see any fraying and any arthritis in the op, documented in my operative report.

Q You didn't document any sort of a condyle?

A Any kind of what? Excuse me?

Q I think I may be mispronouncing condryle C-H-O-N-D-R-Y-L-E?

A No, I don't believe so, no.

Q Maybe I got that wrong.

THE COURT: There is less a condyle, that's part of your knee?

THE WITNESS: The condyle is part of the knee. If you notice in my operative report I did osteochondral drilling which is to bring blood to the area and try to get the cartilage to regenerate in certain areas where the

cartilage was severely damaged. If you noticed in my operative report, I did osteochondral drilling into certain areas of the cartilage.

Q Okay. Now, a total knee replacement, is it fair to say you perform a lot of those procedures on the elderly?

A Yes, but it seems like society is moving towards doing them younger now, because there are people who need them younger, but the goal is to not do it until you're in your 60's.

Q Do you sometimes perform such or see such procedures needing to be performed on athletes?

A Athletes?

Q Yes, athletes, who've gotten a sports injury?

A For a replacement?

Q Yes, for a total knee replacement.

A Post getting out of their field, baseball, football whatever it is you don't do it and then you go out and play again, you can't, but there are plenty of Bo Jackson had his hip replaced after he had that severe hip injury, so there are plenty of athletes that end up with knee replacements after their careers.

Q Understanding that the knee will never be the same, is it still expected that someone will immediately begin rehabilitation following a total knee replacement?

A Yes, rehabilitation occurs the day after a knee replacement.

Q And for the procedure that you performed on Mr. Belli, that is something less invasive than a total knee replacement?

A Almost definitely.

Q And, in fact, meniscus tears are those, those are pretty common repair of meniscus tears are very common?

A Very common.

Q Do you see many a lot of athletes who have meniscus tears?

A That's correct.

Q Do they on and continue to play?

A Yes, some of them do. They don't have the chondromalacia that Mr. Belli has thought. Athletes who have meniscus tears, they either get the meniscus trimmed and they're back in functioning again, but chondromalacia is a whole different animal, and he has quit a bit of chondromalacia which is damage to the surface cartilage not just the meniscus.

Q Now, doctor, do you know if someone who has osteoarthritis in their back is likely to have arthritis in their knee?

MR. DAUTI: Objection.

A You can get both.

THE COURT: Sorry, are you saying if you find arthritis in the back, does that mean someone is likely also at the same time to have arthritis in the knee; is that the question?

MR. FRANKLIN: Yes, that's the question.

THE COURT: It's overruled, I don't know if he has an opinion, he's certainly qualified to offer an opinion if he has one.

A If you have osteoarthritis in one area, you tend to have it in different areas besides that, yes.

Q And you reviewed MRI images of Mr. Belli's lower back; correct?

A Yes.

Q And he does have osteoarthritis in his lower back?

THE COURT: At the time, at the time of the first consult you mean or he has it now?

MR. FRANKLIN: Let me clarify.

Q Did you review an October 14th, 2019, MRI of Mr. Belli's lower back?

A I did.

Q Did that show osteoarthritis?

A It did, there was some arthritis.

Q And that was, I guess a matter of four months after the accident?

A Yes.

Q And osteoarthritis, that's something that develops over time?

A Correct.

Q And it's something that's degenerative?

A Yes.

Q And based on that finding, would you be surprised or not surprised that if Mr. Belli had arthritis in his knee?

A Well, he had an X-ray from his -- before his accident that showed he had no arthritis in his knee, he had the -- he had the X-ray that showed he had the osteochondroma, but had no arthritis in his knee before the accident, I believe it was six months, the accident, the X-ray he took was 1/10/2019, he has no degenerative changes and just a bone actual in the tibia, so he didn't have arthritis in his knee on that X-ray.

Q Now, there is a document towards the back of the packet you have there, doctor, I believe it's right before your operative report, if you can take a look at that?

A Is it in my operative report?

Q It should be the page right before your operative report, it should be an orthopedic interpretation radiological examination?

A Is it in an office note?

Q I don't know if you changed the order of the exhibit, but it should be the page right before, for the record, I believe you're referring to what's been marked as Plaintiff's Exhibit 9, if not, can I get plaintiff's Exhibit 9?

A You can show it to me, I would be happy to help you with it.

Q Now, doctor, unfortunately, these exhibits aren't

paginated, it's towards the back your operative report, I have it as page 162 -- page 163.

MR. DAUTI: If it's an office visit, what is the date?

MR. FRANKLIN: Well --

A Do you have a date on it?

Q Yes, the date of the examination says October 12, 2019.

A If you can point it out to me, this is a big folder, I don't know where it is.

MR. FRANKLIN: May I, your Honor?

THE COURT: Yes.

(Whereupon, Mr. Franklin approached the witness.)

Q Here it is.

Doctor, you see that this says "Date of Examination October 12, 2019"?

A Correct.

Q And this is in your file?

A Correct.

Q And was this something that you would have ordered prior to that meeting with Mr. Belli?

A I'm trying to see my initial visit was, it says no arthritis in the knee, if that's what you're referring to, there was a study performed and no fractures or dislocations, and there's no documentation of any arthritis.

Q Yeah, but Number two, down there, under "Impression,"

says "other modalities are needed for clinical correlation"?

A MRI, the next step is an MRI.

Q Okay. What would an MRI provide that an X-ray may not?

A MRI, you -- you get to visualize the meniscus, as I showed you, on the screen, the meniscus is, you see more detail, you see the ligaments, you don't see any of that on X-ray, X-ray doesn't give you any ligaments, any tendons, you don't see the meniscus. The MRI gives you all of the ligaments, tendons and the meniscus.

Q Might that show something arthritic that an X-ray might miss?

A An MRI?

Q Yes.

A Well, he did have an MRI, did he not?

Q Well, I'm just asking as far as the October 12, 2019.

A Yeah, he had a -- he had -- his accident was in June, and when he came to see me, I believe he had an MRI already, and we did, we did get an MRI, yes.

Q At some point did he -- you ordered an MRI, that did show arthritis?

A Do you have that?

Q No, I'm asking.

A Not that I know of.

Q And as of the last time that you met with Mr. Belli in September of 2023, had he developed arthritis in the left knee?

A Well, after the fall you can start to develop arthritis, it can take a few months, you can develop arthritis after the fall.

Q My question is, has the arthritis shown up yet?

A He has on his MRI of his left knee he started to show some mild changes, yes.

Q When was that?

A It looked like, I don't know the exact date of the MRI, his fall was in June, I think this MRI was 10/14/19.

Q So there were arthritic changes three months after his fall?

A Correct, he stated to develop some arthritic changes, yes.

Q But you never saw an MRI that predated his fall, did you?

A No.

Q Alright.

MR. FRANKLIN: Nothing further.

THE COURT: Great, do you have any redirect?

MR. DAUTI: Yes, your Honor, briefly.

REDIRECT EXAMINATION BY
MR. DAUTI:

Q Doctor, counselor was asking you during the cross as to how big Mr. Belli is, and how come he didn't fracture the kneecap when he fell down, and I want you to assume that

Mr. Belli testified that he actually fell on the side, twisted the knee and fell on the left side to the ground, would that be the explanation why he didn't fracture the kneecap?

MR. FRANKLIN: Objection, speculation.

THE COURT: Form, it calls for speculation given that he testified about his records and injuries, but as to form, it does seem to restrict the witness to one answer.

MR. DAUTI: Okay.

Q So, doctor, you were asked as to whether, like, you expressed that you were surprised he did not fracture the kneecap; correct?

A I'm not surprised, he just got lucky enough he didn't break the kneecap and damaged all of the cartilage behind the kneecap and on the face of the femur, yes. It's fortunate he didn't break the kneecap, too.

Q And you also testified that the meniscal tear came as a result of twisting?

A There's always a twist action as you go to the floor. You may think it's a direct blow, but there's some twisting of the body that occurs that can tear the meniscus.

Q Correct. I want you to assume that he testified that as he fell down, his kneecap hit on the left side with the rest of the body; does that make sense?

A That does make sense, that's how you would tear the meniscus, by the -- by this trunk twisting, he could actually

tear the meniscus, not only damage the surface cartilage, but tear the meniscus.

MR. DAUTI: Thank you, no further questions.

THE COURT: Thank you.

MR. FRANKLIN: Nothing further.

THE WITNESS: Do I keep it?

THE COURT: His copy of his chart we have already; right?

MR. BENSON: That should be nine.

MR. DAUTI: Yes, it's already in evidence.

THE COURT: Great.

MR. FRANKLIN: Well, your Honor, that packet he has is not the same as.

THE COURT: That's what I literally just asked you.

MR. FRANKLIN: It's not the same.

THE COURT: Tell me what, is that a spare copy?

THE WITNESS: You can take it.

THE COURT: Don't forget your briefcase and your models.

Thank you very much. We will mark that in a few minutes.

(Whereupon, Dr. Wilen exited the witness stand.)

THE COURT: Take care, doctor.

THE WITNESS: Thank you.

THE COURT: That's it for witnesses today; correct?

MR. DAUTI: Yes.

THE COURT: Thank you.

Monday morning, we have two witnesses?

MR. DAUTI: Correct.

THE COURT: Lovely.

Enjoy your weekend, it's quarter to 4:00, look how efficient, honestly, I think we were concerned we would be like yesterday, be right up against closing time, so, perfect I thank counsel for getting to it.

We will see you Monday morning at 9:30, enjoy your weekend. Don't discuss the case, don't go out and get trained as an orthopedist in the meantime, don't have any contact with counsel, their clients or anyone who works with them, and we look forward to seeing you Monday morning at 9:30.

COURT OFFICER: All rise, jury exiting.

(Whereupon, the jury exited the courtroom.)

(Whereupon, the trial was adjourned to April 27, 2026 at 9:30 a.m.)

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CERTIFIED TO BE A TRUE AND ACCURATE TRANSCRIPT OF THE ORIGINAL MINUTES TAKEN OF THIS PROCEEDING.

Laura Delvac

LAURA DELVAC
Senior Court Reporter