In The Matter Of:

Wilton Villalta and Argenia Villalta Diaz v. The City of New York, The New York City Department of Education and New York City School of Construction Authority

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Dr. Ali Guy

January 21, 2026

Michelle Cox
Senior Court Reporter
Bronx Civil Supreme Court
851 Grand Concourse
Bronx, New York 10451

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX: CIVIL TERM: PART IA-5

WILTON VILLALTA AND ARGENIA VILLALTA DIAZ, Plaintiffs,	:	Index No. 22499/2019E
-against-	:	Dr. Ali Guy
THE CITY OF NEW YORK, THE NEW YORK CITY DEPARTMENT OF EDUCATION AND NEW YORK CITY SCHOOL CONSTRUCTION AUTHORITY, Defendants.	:	

851 Grand Concourse
Bronx, New York 10451
January 21, 2026

B E F O R E:

HONORABLE ALISON Y. TUITT,
Justice of the Supreme Court

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

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Michelle Cox
Official Court Reporter

(Defendants' Exhibit C, Lincoln Hospital Medical Records, was admitted into evidence.)

THE COURT: All right. I understand somebody wants to put something on the record.

MR. ROSS: Good morning.

THE COURT: Good morning.

MR. ROSS: I would like to.

Your Honor, I was going to, you know, make my request and application again to have the ability to question witnesses, including crossing the plaintiff, on the issue of the syncope episodes, dizziness, you know, those kinds of issues, based upon the fact that, again, listening to the plaintiff, the rest of his direct exam yesterday, he constantly brings up, you know, the notion that I was a very active person, okay. I was always very healthy, and keeps elaborating on that.

And I'm being disallowed of going into the fact that he has other unrelated issues.

You're already allowing me to go into the fact, obviously, he was diagnosed with diabetes and whatever those issues are. I'm not talking about that.

We still have the issue of his dizziness episodes, his, you know, having episodes after engaging in physical activity. And then I have an individual who is painting a picture to the jury, but for this accident, I

was literally a picture of health.

And that impacts things both before the accident and subsequent to the accident because they're claiming he's incapable of ever doing anything again. They're claiming he's going to need all of this incredible treatment, which is what I anticipate the next witness that comes on the stand, Dr. Guy is going to talk about.

Every time he references the fact that I was the picture of health, I could do all these things, it raises this issue.

I believe, again, it becomes a credibility issue, therefore I should be allowed to comment on that.

THE COURT: I thought I ruled on it yesterday.

MR. ROSS: Yes. Before the plaintiff testified.

What you indicated, Your Honor, is that with respect to the March 2019 episode where he had a syncope episode and fell down the stairs, if I understood you, unless I misunderstood you, you said, I am not allowed to bring up that he and a syncope episode.

You said that I can bring up the fact that plaintiff had a fall on the stairs, but I couldn't go into the reason or why, but that he did have a fall on the stairs in March of 2018.

And, in fact, when plaintiff continued his direct exam -- when counsel continued his direct exam of

Mr. Villalta yesterday, he actually asked him himself, and Mr. Villalta admitted that he had a fall in March of 2019.

THE COURT: Correct.

MR. ROSS: I believe you also said that I have the right to bring out the fact that the plaintiff referenced, remember, a few months later in June of 2019 in the hospital records, that he was afraid, essentially, to walk more than five blocks, but I couldn't say because of fainting, I could say because of the fall incident in March. He can deny it or not. But your ruling, I believe, was that I had a right to cross on that.

What I'm reapplying for, though, is Your Honor, based on -- after your ruling, the plaintiff took the stand, finished direct exam and, again, during that time, he indicated, you know, I was a very active person. I was very healthy. And he keeps reiterating those things.

And so I'm just making my application to ask Your Honor to reconsider and allow defendants to actually bring up the March 2019 incident and reference it, that he's had syncope.

And, remember, that March record indicates "episodes," meaning plural.

THE COURT: Right.

MR. ROSS: That he has had episodes in the past. We don't know if that was before, during, or after this

accident. But he had episodes in the past. I am reapplying for that reason, Your Honor, based on further testimony from the plaintiff.

THE COURT: Thank you.

MS. KALLFA: Good morning, Your Honor.

Your Honor did rule on this yesterday, so I'm not sure why we're discussing it again.

But, again, for the record, plaintiff had one date of treatment for this syncope episode. And there's nothing in that medical record that says the syncope was over multiple days. It was one day. He didn't fall down the stairs. It's not this dramatic event that defense counsel makes it out to be. He collapsed on the landing of the stairs. He went to the hospital. It was resolved. There was no dizziness or syncope prior, and there was no dizziness or syncope thereafter.

Plaintiff stating that he was afraid to walk five blocks is just plaintiff making a statement. There is no diagnosis. There was no medical relation to the syncope episode.

THE COURT: But I believe I told him he could question about that fearfulness.

MS. KALLFA: He was afraid to walk or afraid to fall. But not to relate it to the syncope episode. Your Honor has said that counsel could not mention the syncope

episode. He could ask him if he experienced dizziness at the time of the accident, or if he was afraid to walk or afraid to fall after the accident, but not relating it to the syncope treatment, which is completely unrelated to any medical treatment or any medical issues here before Your Honor.

On top of that, in review of the EMS records from the time of the accident are negative for dizziness. Dizziness was denied. So that completely takes it out of any relation to this accident or contributing to this fall.

So counsel shouldn't be even allowed to talk about the dizziness in general because the EMS records, which are contemporaneous, and the ER records, which are contemporaneous, all deny dizziness.

Just because plaintiff had one dizziness or syncope episode five or six months after the accident that could have been related to DVT or something else, it was undiagnosed, has no relation to the material facts at issue here and would just unfairly prejudice plaintiff because now counsel is allowed to include this alternate theory without any support by the medical records or defendants' own experts.

MR. ROSS: Your Honor, may I just add, again, and I'm going to comment, in fact, on something counsel indicated. And that is the fact that -- counsel is absolutely right. When the pediatrics came and spoke with

him, he specifically denied -- he did. He denies dizziness.

And I would submit to Your Honor that that actually opens the door now for additional credibility issues because he is denying dizziness, yet we also raised and confirmed with the coworker, Milton Chimborazo, the first person to get to the plaintiff right after the accident, where all that plaintiff told Milton was that he fell. He first said I'm okay, but my back hurts. I fell. Never told Milton how he fell. Never told Milton why he fell. There was absolutely no evidence that he fell from a higher level to a lower level, other than plaintiff's self-serving testimony. You got the plaintiff denying dizziness with the paramedics. And I've got a few months later, a dizziness episode.

And, by the way, the record doesn't say he was on the landing. It says that he lost consciousness and was on the stairs. And then it says, "episodes," plural, which implies more than one incident. Whether or not the plaintiff ever went to a doctor for it doesn't mean he didn't have any incidents, Your Honor.

It, again, goes back to credibility.

THE COURT: So you want to ask the plaintiff if he ever had dizziness; is that what you're saying?

MR. ROSS: I want to be able to cross-examine the

plaintiff, and quite honestly, any of their other experts on whether or not they took a look at or reviewed or considered the fact that he had had at least one recorded syncope episode where he -- and, Your Honor, it's just not dizziness.

That March 19 record indicates that he had loss of consciousness on the stairs and, basically, he collapsed. He fell. That's why he went to the emergency room that day.

THE COURT: Right.

MR. ROSS: And it was commented again, not one open episode, but episodes.

And, again, the other key issue here, Your Honor, is that medical record says that he has that kind of indication when engaging in physical -- I didn't make that up, that's in the medical record, when engaging in physical activity.

The doors keep opening.

By the way the plaintiff has pictured himself to this jury, the defendants should have the ability now to counter that with an argument.

Thank you.

MS. KALLFA: It's one medical record, and one medical event that counsel's referring to that all occurred six months after this accident that has absolutely nothing

to do with why plaintiff fell off the scaffold, his medical treatment thereafter, his loss of enjoyment of life or economic claims.

And if counsel is going to be allowed to ask questions about this, then request that we be allowed to bring in Dr. Akman, who's the cardiologist that conducted the medical treatment at Lincoln Hospital that counsel's so enamored with, who can come in. And he's going to say exactly what he said to us on the phone, that this has absolutely nothing to do with anything. It was nothing.

Any cardiac event that may or may not have occurred was appropriately age-related. It was a one-time thing. Plaintiff didn't need to go on any medication afterwards. And as of 2019, all the medical records say that there's no cardiac issue. There's no fainting. I was a one-time thing. And plaintiff's accident occurred in 2018. It's now eight years later.

So counsel would have multiple medical records if this dizziness or fainting or syncope, whatever was happening and was affecting plaintiff's quality of life or his medical treatment or his economic losses. But there's one event that counsel is grasping to. And all that event talks about is a dizziness and a syncope episode. And the dizziness is completely left out of the EMS records. It's actually negative. There's no dizziness in the EMS

records. And there's no dizziness in the ER records.

And the case law that we cited to in our motion in limine is very clear about this, that when trial courts properly exclude evidence, whose marginal relevance is outweighed by substantial prejudicial effect, which is Molina versus Goldberg, 231 A.D.3d 46. And evidence concerning medical conditions that are unrelated to the injuries at issue are properly excluded, which is the Togut, T-o-g-u-t, versus Riverbay Corp., 114 A.D.3d 525, which is a 1st Department case from 2014. The case law is very clear that counsel cannot bring this up. It's unfairly prejudicial.

And just because counsel is attempting to grasp at straws to make it relevant and related to how this accident happened. There's no evidence that supports that argument. And counsel should not be able to bring it up because it's not based off of any actual evidence, or even counsel's own expert reports.

Thank you, Your Honor.

THE COURT: Okay.

Counsel, I'm going to adhere to my prior decision.

Thank you.

And you have an exception.

MS. KALLFA: Thank you.

THE COURT: Anything further that I need to do prior to getting the doctor?

MR. ROSS: No, Your Honor.

THE COURT: Does the doctor have a file when he comes in so we can mark it?

And did you have an opportunity to look at it?

MR. ROSS: I have not, Your Honor.

Again, I'm happy to get going. And I can do it before I start my cross.

THE COURT: Good. Thank you so much.

Madam officer, can you get the jurors for us.

And you could let Dr. Guy come in so we can mark his report.

MR. ROSS: I'm sorry, Your Honor, just while we're talking, I'm just confirming again, based on your ruling yesterday, I do have the right to ask or comment, cross, whatever, that the plaintiff had a falling incident on stairs --

THE COURT: Yes.

MR. ROSS: -- in March of 2019 without referencing any dizziness or syncope episode, that was your ruling yesterday.

MS. KALLFA: I'm sorry, Your Honor. You actually instructed counsel that he could ask if plaintiff had a falling episode, not down stairs, because there's nothing

in the evidence or in the medical records that support that.

THE COURT: Well, it says on the stairs.

MR. FREDERICK: It says he was going up the stairs.

THE COURT: Well, he's on stairs.

MR. ROSS: On the stairs.

MR. FREDERICK: And then had dizziness. I don't even think it says "fall."

MR. ROSS: He just admitted to a fall on direct.

THE COURT: What did he testify to?

Didn't we have the trial transcripts?

MR. FREDERICK: He said he fell on the landing.

MR. ROSS: No. He said he had a fall in response to counsel's question yesterday.

THE COURT: I don't know. You could take a look at the transcript.

MR. FREDERICK: Let's just say what counsel just said is correct, that he had a fall.

THE COURT: Okay.

MR. FREDERICK: When he testifies, he's going to explain it; and it's not down steps. And nothing in the record says anything about down steps.

MR. ROSS: I didn't say "down." I said on the stairs. I said on the stairs. That's what I said. I said

he fell on the stairs.

MS. KALLFA: You said he fell down the stairs, Counselor.

MR. FREDERICK: Your Honor, just for clarity, can we just have counsel pull that record up so we know exactly what it says, at this point, before we get into any of this?

THE COURT: Well, that's for the cross-examination of plaintiff.

MR. FREDERICK: That's fine. We can do it later.

THE COURT: Okay. But we can look at it.

MR. ROSS: Thank you, Your Honor. I have it right here.

THE COURT: Okay. Thank you.

(Defendants' Exhibit 17, Dr. Ali Guy's Medical Records, marked for identification as of this date.)

THE COURT OFFICER: All rise. Jury entering.

(Whereupon, the jury enters the courtroom.)

THE COURT: Please be seated.

Now I'm going to get upset because, really, I don't get the memos with the black today. You know I thought I was in the loop. But everybody has on black and they didn't let me know.

THE JURY: You're halfway there.

THE COURT: Yeah, right.

Good morning, members of the jury.

THE JURY: Good morning, Judge.

THE COURT: We're going to continue on with plaintiffs' case. We're going to not have the cross-examination of plaintiff. We will do that at a later time, and plaintiff is going to call another witness, though.

Counsel.

MR. FREDERICK: Thank you, Your Honor.

Plaintiff calls Dr. Ali Guy.

And, Your Honor, would you like the expert disclosure?

THE COURT: Please. Thank you so much.

THE COURT OFFICER: Please remain standing. Raise your right hand.

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

THE COURT OFFICER: State your name and occupation.

THE WITNESS: My name is Dr. Ali Guy. A-l-i. Last name is G-u-y. Office address is 7 Gramercy Park, suite 1-8, New York, New York 10003.

And my profession is, I'm a physician.

THE COURT OFFICER: Please be seated, sir.

THE WITNESS: Thank you.

THE COURT: Now, Dr. Guy, please use the microphone for the reporter and speak slowly and loudly.

THE WITNESS: Yes, Your Honor.

THE COURT: Counsel, you may inquire.

MR. FREDERICK: Thank you, Your Honor. I'm just getting the batteries for the microphone.

THE COURT: Okay.

Good morning, Dr. Guy.

THE WITNESS: Good morning.

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

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

Q And when did you receive your licenses?

A 1985.

Q Can you briefly go over your educational background for the jury.

A Yes.

My undergraduate, I went to Queens College, Flushing, New York, Medical School. I graduated from University of Northeast Dominican Republic, June of 1981. Thereafter, I did three separate residencies. I did 18 months of internal medicine at Mount Sinai School of Medicine. Mount Sinai Medical

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

I was the chief of the Department of Rehab Medicine at Maimonides Medical Center in Brooklyn, New York, from 1997 to 2002. That would be five years.

My duties were to be in charge of all the inpatient and outpatient rehab services. Provide teaching to the house staff. That would be the internal medicine residents, the general medicine residents, the surgical residents, the orthopedic surgical residents, and supervise the work of ten other doctors under my supervision, and to do consults to other doctors in the hospital.

And from 1990 until 2006, I was the director of NYU's Hospital for Joint Diseases, Neuromuscular Equipment Clinic. My duties were to teach the residents from NYU to take care of the patients that were assigned to that clinic.

These patients were born with birth defects, had spinal cord injuries, multiple traumatic injuries.

And from 2006 until 2019, I was the director. I was a clinical instructor of physical medicine and rehabilitation to the NYU residents. My duties were to teach them to prepare them for the board parts one and two.

And from 2019 to the present, I was promoted to clinical assistant professor of physical medicine and rehab at NYU School of Medicine and NYU Medical Center currently, and the director of the department of Rehab Medicine at Med-Alliance, which is an Article 28 facility. It's like a small hospital. We have 50 doctors, four operating rooms, and I'm also in charge of morbidity and mortality conference.

That means if a patient gets injured or if a doctor makes a mistake, it's brought to my attention. I investigate and I teach to make sure nobody makes that same mistake.

I'm also the director of the pain service at the North Queens Surgery Center since the past five years. My duties are to supervise the work of 50 other doctors that do interventional pain management procedures: Epidurals, microdiscectomies of the spine, nerve ablations, so on and so forth, and also to teach them. And I'm also an official designated physician mentor for the New York State Education Department, Office of Professional Medical Conduct.

My duties are to go into doctors' offices who are considered doing some misdeeds, but not bad enough to lose their license. My job is to investigate their medical records. To teach them and bring them up to par. And I have private practice in Manhattan and Long Island.

Q Okay. We'll talk about --

MR. FREDERICK: I think it died.

THE COURT: It died again.

Mr. Toomer?

Q Doctor, are you board certified?

A Yes, sir. I'm board certified in my specialty, physical medication and rehabilitation.

Q Is that also known as physiatry?

A Yes, it is.

Q Can you give the jury an understanding as to what physiatry is.

A Yes.

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

Initially, this specialty was called orthopedic medicine and rehabilitation. But because of all the chaos and confusion between orthopedic surgery and physical medicine, the name was changed to physical medicine and rehabilitation. This specialty covers the whole body from head to toe. Traumatic injuries, spinal injuries, disc herniations, disability, impairment evaluations; deals with pain management, both pharmacological and interventional, such as epidurals, nerve blocks, selective radiofrequency ablations of the nerves of the spine. It deals with electrodiagnosis. It deals with rehabilitation. It's similar to orthopedics, except we don't do orthopedic surgeries. We get involved after the fracture has

been set and after the joint replacement has been made. We did the rehabilitation and the pain management.

It's similar to neurology, except we do a lot more than what a neurologist does. Neurologists concentrate more on central neurology. Neurology such as Lou Gehrig's Disease, Parkinson Disease, migraine headache. They do some neurology of the spine. But we do a lot more than that.

We do interventional pain management procedures where they don't. So this specialty covers the whole body, from head to toe. And we have training. And you're supposed to have training to pass your boards. You have to have training in neurology, orthopedic surgery, neurosurgery, muscle and nerve physiology, electrodiagnostics, pain management, internal medicine, cardiac and pulmonary rehabilitation, and also life care plans. Life care plan is a special report put together to explain the patient's diagnosis, prognosis, or look into the future and what the patient's future medical needs and expenses would be.

Q What does it mean to be board certified?

A To be board certified is a recognition that's given to you by other experts in your field. It's the highest recognition you can obtain.

Basically, you're considered an expert in your specialty by other experts in your specialty. In order to get that you have to pass the following: You have to complete a

three-year residency training program. You have to pass the monthly examinations given by your teachers. You have to pass the annual exams given by your teaching department.

And then once you graduate, you sit and take your boards part one, which is an eight-hour written examination. You get tested on orthopedics, neurology, interpretations of x-rays, MRIs, EMGs, and other physiatric treatments.

And then once you pass your boards, part one, you have to be in private practice at least an additional 18 months. Acquire additional knowledge and experience.

Then you fly to the Mayo Clinic in Minnesota, where all the elite doctors that do research, that do textbooks, they test you orally for half a day, again, on these similar topics: Neurology, orthopedic surgery, neurosurgery, interpretations of x-rays, MRIs, electrodiagnostics and other principles of physical medicine and rehabilitation.

And once you pass that, all your credentials from college, from medical school, residency, are sent to the American Board of Physical Medicine and Rehabilitation. And if they see everything is up to par, they pass you and give you a title of a diplomate of the American Board of Physical Medicine and Rehabilitation. That was obtained in May of 1989, and to this date, it still stands in good standing.

Q Doctor, can you describe your practice to the jury?

A My practice is very mixed. I treat patients from age

six, all the way up to 110. I have a patient who is 115. So all the way up to 115.

These are patients with complaints of pain, multiple traumatic injuries, whether it's work-related accident or a car accident or any other problems.

I take care of stenographers. I do interventional pain management procedures. I do microdiscectomies of the spine, disc herniations. I do life care reports. I do disability impairment evaluation reports.

Q You mentioned microdiscectomies.

Do you perform surgery?

A Yes, I do.

Q Can you just explain that to the jury.

A I'm licensed to practice medicine and surgery in the State of New York. And microdiscectomy of the spine is where you don't cut the spine open. You do microscopically through a small portal hole, like arthroscopy of the shoulder and knee. Similar to that.

Q You mentioned life care plan.

Do you receive training to perform life care plans?

A Yes.

Q Can you describe that to the jury.

A As a physiatrist, we're trained to know the standards of care, know the guidelines for treatments for patients with disabilities, whether it's a permanent disability or partial

disability. If it's a total or temporary disability and what the future medicals would be based on the standards of care and optimal levels of care. Optimal number means the best levels of care a patient can have.

Optimal level of are we get the optimal care in the life care reports.

Q Doctor, is the term "trauma" medically significant?

A Yes.

Q Can you explain that to the jury.

A Yes.

Trauma is defined as anything that interferes with normal body function, or anything that disrupts normal body function.

Q And what percentage of your patients have undergone or complained about a traumatic event that brought them to your office?

A I would see a good 70 percent could be more.

Q Have you testified in court?

A Many times. Approximately 300 times in my 37-year career as a physician. Could be slightly less, could be slightly more.

Q Typically, who do you testify for?

A Typically, for my patients.

Q Now, Doctor, are you being compensated for the time in which you're spending with us today?

A Yes, for canceling my patients and to be here, yes, I am.

Q At what rate?

A 5,000 for half a day.

Q Now, Doctor, I'm going to ask you if you can provide the jury with an understanding of the anatomy of the spine.

MR. FREDERICK: Your Honor, may he step down.

Q Would these models assist?

A Yes, they would.

THE COURT: You want him to step down?

MR. FREDERICK: Yes.

THE COURT: Dr. Guy, if you're going to step down, you can put on the lapel mic.

THE WITNESS: May I step down, Your Honor?

You have an objection?

MR. ROSS: I object to him testifying about the spine since he is here as a life care planner. So I'm not sure as to the relevance with this particular witness regarding that.

THE COURT: Overruled.

Go ahead.

MR. ROSS: Is it okay if I?

THE COURT: Absolutely.

MR. ROSS: Thank you.

THE COURT: And we'll deem these models marked

together as plaintiffs' -- what's the next number?

MR. FREDERICK: We're now at Plaintiffs' Number 18, Your Honor.

THE COURT: Okay. Plaintiffs' 18.

It's two models of the spine?

America, Doctor, these are models of the spine?

THE WITNESS: I'm going to use this model and these other four models.

THE COURT: Okay. So there's --

MR. FREDERICK: Collectively, five.

THE COURT: 18A through E.

(Plaintiffs' Exhibit 18-A, Model, deemed marked for identification as of this date.)

(Plaintiffs' Exhibit 18-B, Model, deemed marked for identification as of this date.)

(Plaintiffs' Exhibit 18-C, Model, deemed marked for identification as of this date.)

(Plaintiffs' Exhibit 18-D, Model, deemed marked for identification as of this date.)

(Plaintiffs' Exhibit 18-E, Model, deemed marked for identification as of this date.)

THE WITNESS: May I begin?

MR. FREDERICK: Yes.

A So in the human spine, we have three segments.

THE COURT: Wait one second.

A We have the neck.

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

A In the human spine we have three segments. The neck is referred to as the cervical spine. The midback is referred to as the thoracic spine. The lower back is referred to as the lumbar spine. Each area is labeled according to its location.

In the cervical spine we have seven vertebrae. In the thoracic spine we have 12 vertebrae. In the lumbar spine we have five vertebrae.

The lumbar spine ends with the coccyx and the sacrum. This is the sacrum. This is the coccyx. The coccyx is the tailbone all the way on the bottom.

At each level we have nerve roots which come off the spinal cord. These nerve roots, they innervate. They give you power and sensations to the different muscles in the arm. All the different nerves in the arms come from the neck. All the nerves that go down the legs, they come from the lower back.

So between each vertebra, we have a disc. The function of a disc is to serve as a shock absorber. And a disc is like a jelly doughnut. Inside there's a gelatinous material called the nucleus pulposus, n-u-c-l-e-u-s, p-u-l-p-o-s-u-s.

And the outside portion of a disc, we have approximately 100 rings of a fibrocartilage material called the annulus, a-n-n-u-l-u-s, fibrosis, f-i-b-r-o-s-u-s.

And inside we have the spinal canal where the spinal cord comes from the brain, goes all the way down to the lower back. And it ends somewhere between the first and second lumbar vertebrae. It then continues with branches of nerves that resemble a horse's tail. That's why it's called a "caudae equinae." C-a-u-d-a-e, e-q-u-i-n-a-e.

And right behind the disc comes the nerve roots from the spinal cord. Each nerve root has two branches: one for motor, for movement, the other for sensation.

This is what a normal disc looks like.

A disc bulge or a disc protrusion is a partial tear of the disc.

A disc herniation is a complete tear of a disc where the disc material passes the disc margin. Right there, that's a disc herniation.

Now, inside the disc, we have -- it's filled with gelatinous material and water. So once a disc herniates, the water content leaks out. The disc shrivels up.

Normal disc.

Disc herniation shrivels up.

The body tries to stabilize that area by forming bony projections called "osteophytes." These are osteophytes. And the nerve root exits right outside the neuroforamen, where the nerve root exits from the spinal cord.

These are the bony projections called "osteophytes."

This is the neuroforamen.

So when we have a disc herniation, the outer one third of the disc has neural fibers. They are called "nociceptors." n-o-c-i-c-e-p-t-o-r-s, and they release a lot of chemicals that irritate the surrounding structures, that would be the nerve root, the muscles, the tendons and ligaments.

Now, there is no cure for disc herniation because the disc is fibrocartilage material. Once it is torn, it does not have the ability to repair itself unless you remove the disc and you do a whole prosthetic disc replacement with fusion; that creates another problem. You stabilize the area, but you have an artificial disc, you lose range of motion.

So a disc herniation is a permanent condition and it's progressive.

This is normal. This is an end-stage disc disease from a herniated disc, okay. The space is almost completely gone.

A good example is like riding a truck in the streets of downtown Manhattan. You don't have a shock absorber. You feel every bump. And because of the space that's decreased, you lose height. You lose flexibility.

Q Doctor, are you familiar with the term "impingement"?

A Yes.

Impingement is -- here's an example of impingement from the disc herniation. The nerve root is going to be

compressed from a disc herniation. We have the nerve root on top. But an impingement, the nerve root is usually on the bottom, and the disc material falls on top.

Q Doctor, how about the term "radiculopathy"?

A "Radic" comes from the Latin root, which means nerve root. Radic is nerve root. "Opathy" means any pathological condition to a nerve root.

So if you have a cervical radiculopathy, the pain shoots down the arm with or without numbness or tingling, with or without weakness, with or without loss of a reflex. Same with the lower back.

So in order to have radiculopathy, you can have radiculopathy with direct compression of a nerve root. You can have it when the nerve root becomes swollen from a forceful rotational force or from an axial loading as a fall from a height.

If you drop someone, or if a patient falls from a significant height, or you have crushing, axial loading on the discs, they rupture. It's like a little balloon, it ruptures, and a whole bunch of chemicals are released. I'll mention just a few. We have prostaglandins, p-r-o-s-t-a-g-l-a-n-d-i-n-s. We have nitric oxide, n-i-t-r-i-c o-x-i-d-e. Leukotrienes, l-e-u-k-o-t-r-i-e-n-e-s. And it goes on and on.

If I give you all of them, I'll put everybody to sleep. I won't do that.

Okay.

Q Yes.

Doctor, you're familiar with the term, "mechanism of injury"?

You've mentioned axial loading.

A Yes. Axial loading is when you have something compressing the spine.

MR. ROSS: Objection, Your Honor. Again, this particular witness is getting into all of these items, axial loading.

Can we approach?

THE COURT: Yes.

Q So, Doctor, go on.

Axial loading mechanism of injury.

THE COURT: Objection is overruled.

A I can explain?

Q Yes.

A So we have many different mechanisms of injury that a disc can be herniated. Trauma is the most common cause of a disc herniation in a healthy adult. So trauma can come many different ways: A forceful push, a forceful accident, or even a powerful sneeze can cause a disc herniation.

But axial loading, when you fall from a height, the disc becomes compressed and squashed.

Picture a disc like a little balloon, like a little

jelly doughnut. What happens when you push on a jelly doughnut like this?

The outside of the jelly rips open. The jelly material leaks out. Same thing with a disc herniation from axial loading, from a drop from a height.

Q Doctor, when you see a patient for the first time, is it important for you to know the mechanism of injury?

A Yes.

Q Why is that?

A That's how you arrive at your causal relationship in relation to the accident and the time of the injury.

Q Do you use that for diagnosis and treatment?

A Yes, sir, I do.

MR. FREDERICK: He can retake the stand, Your Honor.

THE WITNESS: Do I need this?

THE COURT: You can leave it. You may have to step down again. You can turn it off.

Q So let's pick up there, Doctor.

Why is it important to understand how an injury was incurred for your diagnosis and treatment?

A That is how a physician arrives at his diagnosis, treatment plan, prognosis, and the causal relationship, meaning where the injuries come from.

Q Now, we're going to get into this particular case in a

moment, but let's just take a brief look.

Are you aware of how this accident occurred?

A Yes.

The patient was working on a job doing construction. He fell from a height approximately 6 to 8 feet, and he injured his neck, his back, and his right foot, right ankle.

Q And how would you categorize an injury like that?

A It's a serious injury.

Q And does it correlate with axial loading in any way?

A It does.

Q Can you explain.

A You fall from a height of 6 feet to 8 feet, that's a lot of axial loading, yes.

Q Okay. If I were to ask you to assume that the plaintiff testified that when he fell, he went down legs first. His heels hit the ground. After his heels hit the ground, then his lower back hit the ground, and his upper back hit the ground, and his neck, okay.

How would you categorize an injury like that?

A That is exactly what happens when you fall from a height of 6 feet or 8 feet. You usually land on your feet.

MR. ROSS: Objection, Your Honor. And I'm moving to strike that. That is pure speculation.

THE COURT: Sustained.

Q Doctor, I'm more asking you with regard to the effect

it may have on the discs?

A It will compress the discs and how -- that's how the discs get injured.

Q Okay. Doctor, what is -- are there certain types of testing that is used in order to diagnose conditions of the spine?

A Yes.

X-ray checks the bone. CT scan typically checks small fractures of the bone. It can detect some disc crumbs, but is not the best test. MRI is the gold standard to see if there's any disc damage or soft tissue damage. And EMG is the gold standard to check for nerves of the spine that are damaged.

Q Let's talk about these for a moment.

With regard to an x-ray, what are you actually looking for in an x-ray?

A If there's a fracture, a broken bone.

Q Okay. Does it assist in looking at a tear or a herniated disc or something of that nature?

A Absolutely not.

Q Explain why.

A Because a disc or soft tissue; it's not bone. And x-ray will not pick it up. It has its limitations.

Q How about a CAT scan?

A CAT scan is good for a small or even large breaks in the bone, but is not the best test for disc bulges or disc

herniations.

Q Why is an MRI the gold standard?

A Because MRI takes the body's protons, transforms them into real live images. You can see the discs clearly, where on a CAT scan you cannot. That's why it's the gold standard.

Q And did you look at any films in this particular case?

A I did.

Q We'll get to that in a minute.

And what is an EMG?

A EMG stands for electromyography. It is a test done typically by a physiatrist like myself or neurologist. It checks to see if there's any muscle or nerve or damage.

Q Doctor, did there come a time when you were asked to consult on this particular case?

A Yes.

Q And can you just explain to the jury what this consulting type work is that you do?

A Yes.

I was asked to evaluate the patient and do a life care plan for the patient.

Q Just with regard to this particular patient, what did that entail?

A Taking a history. Doing a physical examination. Reviewing all the pertinent medical records. And I have them all in front of me, including the operative reports that was done by

Dr. Merola to the cervical spine in February of '22. And the lumbar surgery that is done in November of '22 by Dr. Merola. Other medical records from Lincoln Hospital. Records from Dr. Weinstein. Records from Dr. Merola and many, many MRIs.

Q Did you also examine the patient?

A I did.

Q And how many times did you do that?

A Twice.

Q Did you render a diagnosis?

A I did.

Q And did you actually render a life care plan?

A I did.

Q Now, let's take a look.

Did you formulate a report?

A I did.

Q How many?

A Two.

Q Okay. Is the first report contained essentially within the second report?

A It is.

Q Then can we look at the second report?

A Yes.

Q Okay. Can you give the jury an idea and an understanding as to what medical records you looked at?

A Okay. I looked at the actual DVD films of many, many

different MRIs.

Would you like me to list all of them?

Q Please.

A There's a lot of them.

Okay. I reviewed the actual DVD MRI films of the cervical spine taken on April 26, '24; lumbar spine taken on April 26, '24. And June 9th of '22, MRI of the lumbar spine taken on December 16, 2020. MRI of the cervical spine taken on December 16, 2020. Various x-ray reports from Lenox Hill Radiology. X-rays of the cervical spine taken on 2/9/23; lumbar spine taken on 2/9/23; MRI of the right ankle taken on August 31, 23; MRI of the lumbar spine taken on April 26, '24; MRI of the lumbar spine taken on to December 16, 2020. MRI of the lumbar spine taken on June 9, '22. MRI of the cervical spine taken on December 16, 2020. MRI of the right ankle taken on August 31, '23. X-rays of the cervical spine taken on 2/9/23. X-rays of the lumbar spine taken on 2/9/23. MRI of the cervical spine taken on April 26, '24.

I reviewed defense IME report of Dr. John Bendo, dated November 17, 2020. I reviewed another report from Dr. Bendo dated March 5, '24. I reviewed the defense vocational earning capacity analysis from Apex Rehab Management date 12/15/2020. Records from Dr. Mark Ramnauth, R-a-m-n-a-u-t-h. Second report from Apex Rehab Management dated 2/29/24. Defense report from radiologist Dr. Scott Coyne, C-o-y-n-e, dated 8/24/24. Records

from Kathleen Acer. Defense expert, I reviewed appraisal of economic loss from Kenneth Betz, B-e-t-z. Records from Dr. Andrew Merola. Records from New York Orthopedic Sports Medicine and Trauma and Lincoln Hospital, and operative reports of cervical and lumbar spine.

Q Now, Doctor, just with regard to the films that you looked at --

A Yes.

Q -- did you find these films medically significant?

A Yes.

Q In what way?

A They showed multiple herniations in the cervical spine, from C3 to C7. That's four disc herniations. In the lumbar spine, three disc herniations: L3-L4, L4-L5, L5-S1. L5-S1 being the worst one. That was where the surgery was.

In the neck it was C4 to C6. That's where the surgery was.

Q And, Doctor, typically when an MRI is conducted, does a doctor prescribe that?

A Yes, you have to. You can't just go ahead and get an MRI like a bottle of orange juice. You have medical indications, and a doctor has to sign off on it.

Q And after the MRI is done, what happens?

Is a report generated?

A A report is generated, and the films are sent to the

requesting physician. He looks at the films to see if it confirms the radiologist's report. Most of the time it does; sometimes it does not.

Q Now, you mentioned -- let's talk about the cervical spine for a moment.

You mentioned that there were certain findings relative -- that you found in the cervical spine; is that correct?

A Yes, sir.

Q Let's just focus on that for a second.

What were they?

A C3 through C7 disc herniations. That's a total of four disc herniations at multiple levels.

Q And did any of those MRIs support those findings?

A Absolutely, they did.

Q And were your findings any different from the findings that were done by the initial radiologist who saw them?

A No.

Q They were the same?

A Same.

Q Okay. And how about your findings relative to the lumbar spine?

A The lumbar spine showed the L3-L4, L4-L5, L5-S1 disc herniations.

Q And were your findings any different from the original

radiologist who read them?

A No, sir.

Q Okay. Is that significant?

A It is significant.

Q And why is that?

A One herniation is bad. Two herniations are worse. Three herniations are very bad.

Q Okay. Now, you mentioned Dr. Merola; is that correct?

A Yes, sir.

Q And I think you mentioned that Dr. Merola performed surgery?

A That is correct.

Q What type of surgery did he perform on the neck?

A He did open surgery, Anterior Cervical Discectomy with Fusion, C4-C5, C5-C6.

Q We received information from the plaintiff when he testified that the insertion was through the neck --

A That's correct.

Q -- in the front.

Why is that?

A So when we do surgery to the neck, we go from the front because, if we go from the back, there's lots of dangerous structures, blood vessels, a lot of nerves, so on and so forth. From the front, it's an easy exposure to the disc and the procedure becomes easier.

However, where you have to do multiple fusion levels and you want to have a tremendous amount of stability, then you go from the back.

Q Now, regarding the fusion surgery itself, can you just describe what that is to the jury.

A If I may be allowed to step down, I could show with those models and diagrams.

MR. FREDERICK: May he step down, Your Honor?

THE COURT: Yes, he may.

MR. ROSS: Just for the record, Your Honor. I'm just noting my objection with respect to this witness testifying about this aspect, that's all.

THE COURT: Thanks.

A So the surgery that was done is called Anterior Cervical Discectomy with Fusion. This is the front. This is the back. This is the spinous process.

If you take your fingers, touch the back of your neck, you're touching the spinous process. So this is the back portion.

So anterior cervical discectomy means we cut the neck from this angle or this angle. We get exposure to spine, and we -- discectomy means we remove this portion of the disc that is ruptured or herniated. Herniation means a complete rupture of the disc; a bulge means a partial tear of the disc.

This portion of the disc is removed. Then the surgeon

cuts this portion, removes the bone from here to here, removes the bone from here to here, and they place an artificial disc.

But then you have to fuse it. If you don't fuse the artificial disc, it will pop out of place. So then they fuse it with metal plates, screws, and other hardware so the disc does not pop out of place.

Now, when you have an artificial disc, you automatically lose 10 to 15 percent range of motion for each level of fusion.

So you have stability, but you also have a stiff neck. And cold weather affects metal. Cold contracts; heat expands. Cold will make this worse. You have more pain, more stiffness during the cold weather.

Q And how about the lumbar?

A Lumbar, the patient had a L5-S1. That's the last disc in your lower back. That was removed in a similar fashion.

Q That will come right off there if you want. There you go.

A So this is L4-L5. This is L5-S1. He did surgery at L5-S1.

Again, he did posterior. He went from the back, not from the front. In the lower back, the anatomy is different. And you get a much better exposure if you go from the back than a discectomy, remove the disc. He did a laminectomy. This is the lamina.

He cut the lamina to get exposure to the disc. He did a fusion from the lower back to stabilize the area for the lower back.

Q What is involved with a fusion?

A A fusion, you take a bone from the iliac bone, usually, bone graft. And you have metal plates and hardware to stabilize the area. And the extra bone stabilizes the area even better and makes it stronger.

Q Are these permanent fixes?

A Nothing with the spine is permanent. They usually last for a few years. Every case is different. Depends on how often of the patient uses his spine.

If the patient does a lot of bending, it will last less often. The average life span of these procedures is about seven years, plus or minus two years.

And then what happens is, you have adjacent segment pathology and traumatic arthritis.

Q Explain that.

A Yes.

So adjacent segment pathology is, in this case you have three disc herniations. There is no other disc after L5-S1. So the pressure of the spine gets transferred to the discs above; they have to do more work. As a result they begin to wear and tear as you could see here.

This is a tear of the disc.

So then we have recurring disc herniations at the levels above, and the area that was operated begins to wear out.

Q So is that kind of like a domino effect?

A Yes. That's a good way to phrase it, yes.

Q Now, Doctor, in reviewing all those medical records, did you notice whether Wilton Villalta had any type of treatment to his neck or back prior to this incident occurring?

A Yes. He had physical therapy.

Q I'm saying before this accident occurred.

A Oh, before this accident, I'm sorry. He had no treatments to his neck or back because it was not medically indicated.

Q So is that medically significant?

A Yes, that's very important.

Q Please explain.

A That means he had no prior significant problems, injuries to his neck and the back, that required physical therapy, that requires MRIs, or other diagnostic studies.

Q Now, with regard to the injuries that you just talked about relative to Wilton Villalta, are they consistent with a fall from 6 to 8 feet and axial loading?

A Yes, sir.

Q Please explain.

A So as I explained earlier, this is one of the ways you get disc herniations from a big fall, from crushed injury to the

spine or axial loading, compression loading to the spine.

Q To a reasonable degree of medical certainty, did you develop a causation here?

A I did.

Q Please explain.

A Based on the history obtained, based on the physical exam findings, review of the medical records, the fact that there was no prior history of any prior problem to the neck or the back or the foot and ankle, I felt the injuries were causally related to the accident of 10/18/2018.

Q Okay. Now, Doctor, what is degeneration?

A It's wear and tear.

Q Can you just explain that to the jury.

A So our bodies start to undergo degeneration. In the male the process starts at the age of 40, plus or minus two years.

In the female -- don't get mad at me -- it starts earlier. It starts between 26 and 28 years of age. Different hormones protect different sexes from different ailments. That's why men can get heart attacks as early as 26, and ladies don't get heart attacks until way after menopause.

So the degeneration process or osteoarthritis or the normal natural aging, arthritis begins at this age. For the males, about 40, plus or minus two; ladies 26 to 28.

Q So what would you expect to see as far as degeneration

is concerned in a 52-year-old male?

MR. ROSS: Objection.

THE COURT: What's your objection, Counsel?

MR. ROSS: Again, what we would expect to see in a normal person.

THE COURT: That a little vague.

Q Doctor, you indicated that degeneration begins at 42 in males; is that correct?

A Forty, plus or minus two years, yes.

Q Okay. So what would you expect to see in a 52-year-old.

A Normal, natural degenerative conditions. Normal, natural asymptomatic, doesn't cause pain.

Q When you looked at the records in this case, and when you looked at the films in this case, did you notice whether there was any degeneration?

A Very, very, very minimal.

Q Is that medically significant?

A No, because it's very, very minimal.

Q Is it medically significant to causation?

A No.

Q Okay. How about with regard to the patient -- you looked at films, throughout, right?

A Yes.

Q Multiple years?

A Yes.

Q Did the degeneration change in any way?

A Once you have surgery, it's hard to answer that question.

Q Explain that.

A Okay. Once you have surgery at those two levels, it's very difficult to see the degeneration because the disc was removed and the surrounding structures were carved out.

So there was no significant degeneration. And if a patient has some degeneration, they're all predisposed to trauma, making that worse.

Q Why?

A Because it's a known fact that trauma makes a normal natural aging asymptomatic condition worse because it causes a whole bunch of release of inflammatory substances. It causes increased bone reaction. It causes increased stress to the discs. It causes disc space to begin to become more and more narrow, and it causes the bone projections to form and grow at a much faster rate.

Q Now, Doctor, with regard to the two times that you saw the patient, you performed physical exams?

A Yes, sir. I did.

Q Can you go over both of them with the jury.

A Yes.

So range of motion is done in two ways. Passive range

of motion is what the physician does. I'm the physician. I'm pushing the patient's neck in this direction, this direction. That's called "passive." It's much more accurate.

Active is you turn to the patient. Turn your neck to the left. This is active range of motion. It's under the control of the patient. It is not the most accurate. Passive is the most accurate.

And I used the goniometer, like a protractor to measure exactly the range of motion deficits. So that's how it was done.

And the pain level that I did on the first visit, May 8, '23 was 8 out of 10. Zero means no pain; ten means intractable pain; eight means severe pain.

Q Is that medically significant?

A Yes. Eight out of ten is very significant, yes. Especially after five years after an injury.

Q Okay.

A So the neck showed there was tenderness and spasm throughout the neck. There was a five-centimeter Anterior Cervical Discectomy Fusion scar, at about two and a half inches.

Q Before we go further, you mentioned spasm?

A Yes.

Q What is spasm?

A Spasm is defined as a prolonged involuntarily contraction of a muscle spasm. Involuntarily means it is not

under the patient's control.

I'm touching this muscle in my hand. It's not in spasm. It's soft to touch.

When it goes into spasm, it goes hard. And when you touch it, it doesn't move and the fibers shorten and you lose range of motion, and the surrounding area becomes inflamed and painful.

Q And what did you find when you looked at that?

A I found spasm.

Q And why was that medically significant?

A The accident was in 2018; this is five years later.

In the medical field, anything that has lasted more than one year is considered permanent. This is five years. It's most definitely considered permanent.

Q Okay. Continue.

A So I found spasm, moderate amount of spasm.

Q Describe what trigger points are?

A Trigger points are when you examine the neck on the physician's fingers, you touch the area, you feel a palpable knot, like a little marble inside the muscle fibers. It is defined as an area of muscle, scarring, muscle degeneration.

That area has -- the blood supply to the area has been cut off from trauma.

Q Why? Why?

A Because of the trauma. One, the disc herniation; two,

the surgery that was performed, and now he's undergoing the early signs of clinical findings of early trauma arthritis to the spine.

These are the reasons: Range of motion of lateral flexion normally is 45 degrees. In his case it was 30 degrees out of 45. Lateral rotation was 50 degrees out of 80. This is lateral rotation. And forward flexion and extension was 40 degrees out of 60. And the Spurling sign was position, that indicates nerve root compression.

Spurling's maneuver is when you push down on a patient's neck in different directions, and a patient has shooting pain down the arm; that means there's nerve root compression still present, which is still here. And the MRIs still confirm that.

Then I examined the back again. Tenderness against spasm. Again, multiple trigger points. Backward extension was 15 degrees out of 30. Bending forward was 60 degrees out of 90. Bending sideways and rotating sideways was one half normal. It was 15 degrees out of 30. Straight-leg raising was 60 degrees out of 90. Straight-leg raising is a test that is done to see if there's nerve root compression or any disc -- residual disc problems.

The patient lies flat on examination table. The physician with his right hand, takes the right foot, places his left hand underneath so the leg is straight. You bring it all

the way up. Normally, it should go to 90 degrees. If it does not go to 90 degrees without shooting pain, that's abnormal. It's called a positive straight-leg raising test, indicative of a disc problem or a nerve root problem or both, which is the case here.

I also found an 8-centimeter surgical scar in his lower back. Eight centimeters is almost 4 inches.

And the range of motion, the PILE testing was normal, all four extremities as expected. Sensation to the biceps, which is the C5-C6 distribution was abnormal, was decreased. And the right calf, which is the S1, nerve distribution was also decreased. That's where the surgeries were. And his gait was normal. The rest of the exam was normal.

Q Did you also examine his ankle?

A I did. The ankle was diffusely tender with crepitation. Crepitation is a grinding sensation indicative of either arthritis or a torn structure. A torn ligament or a torn tendon.

Q Did you also examine films relative to the right ankle?

A Yes. The MRI of the right ankle showed I partially torn talo- --

MR. ROSS: Objection.

What MRI is he talking about, Your Honor?

THE COURT: Yes.

Sustained as to form.

A I'll tell you what --

Q Doctor, can you verify, or just let us know which MRI you're referring to.

A August 31, '23.

THE COURT: Do you have that, August 31, '23?

Q And what were your findings?

A That there was a partial tear of the talofibular ligament.

Let's say this is the foot. And this is the fibula, the little, small bone on the outside of your foot. The ligament that attaches from this bone to this bone was partially torn.

Q Is that medically significant?

A Yes.

Q Why?

A Because the foot and the ankle are your foundation. That holds your whole body. If your foundation is strong and stable, as you go higher and higher in the building, the building becomes stable.

But if your foundation is cracked or partially damaged, you're going to have instability going all the way up the spine. You already have instability in the lumbar spine and the cervical spine. We don't need any more instability, but unfortunately, we do have it in the right ankle.

Q With regard to the MRI of the right ankle, did you also review the original radiologist report relative to that?

A I did, similar.

Q Were your findings any different?

A Similar. The radiologist reported joint --

MR. ROSS: Objection.

THE COURT: Yes.

Do we have the film here?

MR. FREDERICK: We do.

THE COURT: Is it in his report?

MR. FREDERICK: It is.

THE COURT: What's your objection?

MR. ROSS: My objection is him testifying about what some other radiologist said or did or commented on.

MR. FREDERICK: It's on the record. The reports are all on the record. They're all in evidence.

THE COURT: Overruled.

A There's also surrounding fluid inside the ankle. It's called "effusion," e-f-f-u-s-i-o-n; that is indicative of a trauma.

Q And how are -- how is an injury like that treated?

A If the pain goes away, you observe it. Initially, if it's very painful, you give anti-inflammatory medications, pain medications.

If the pain persists and it becomes very painful, you

do surgery.

Q Is such an injury of that sort consistent with the type of mechanism of injury that we have in this case?

A Yes, sir.

Q Why?

A Axial loading, when you land, what do you land on? You don't land on your head; you land on your feet. A force from a height of 6 feet or more was the one that caused that tear of the ligament.

Q To a reasonable degree of medical certainty, did you develop an opinion with regard to causation of the right ankle injury?

A Yes. It was due to the accident of 10/18/18.

Q And prior to 10/18/18, did you see any records anywhere that indicated that Wilton Villalta had sustained an injury or a tear to his right ankle?

A No, sir, I did not.

Q Okay. Is there more to your first examination?

A No. That concludes my examination.

Q Can we go to the second examination.

THE COURT: You want to take a break?

THE COURT REPORTER: Yes, I do.

Thank you, Judge.

THE COURT: We're going to take a ten-minute break.

THE COURT OFFICER: All rise. Jury exiting.

(Whereupon, the jury exits the courtroom.)

(Whereupon, a recess was taken.)

THE COURT OFFICER: All rise. Jury entering.

(Whereupon, the jury enters the courtroom.)

THE COURT: Please be seated.

You may inquire, Counsel.

MR. FREDERICK: Thank you, Your Honor.

Q Dr. Guy, we'll get back to your second examination in just a moment.

When you reviewed the medical records, did you also review the ambulance records?

A I did.

Q And was the mechanism of injury described in the ambulance record?

A It was.

Q And what was the mechanism of injury in the ambulance record?

MR. ROSS: Objection, Your Honor.

THE COURT: Sustained.

MR. FREDERICK: Your Honor, may we approach?

THE COURT: Yes.

(Whereupon, a discussion was held outside of the hearing and presence of the witness and the jury.)

(Whereupon the following discussion was held in

open court.)

THE COURT: Okay. It's overruled, subject to connection.

MR. FREDERICK: Thank you.

I'm sorry, may I have that last question read back.

THE COURT: Madam reporter.

(Whereupon, the record was read.)

A Yes, may answer?

Q Yes.

A From a height of several feet.

Q And is that consistent with the other records that you reviewed?

A Yes.

MR. ROSS: Objection, Your Honor.

THE COURT: Sustained.

Q Now, let's go to your second examination.

A Okay.

Q Can you go over that with the jury.

A Yes.

That was done on June 23, '25, approximately six weeks -- almost two years after the first exam.

Again, the pain level was 8 out of 10. Again, I used the goniometer to measure the angles and the passive range of motion, lateral flexion, bending from side to side was 35

degrees out of 45. Lateral rotation, looking behind your shoulders was 60 degrees out of 80. Forward flexion and extension, bending forwards, backwards, was 40 degrees out of 60.

Q Before we go further, are those numbers medically significant in any way?

A Yes. They show significant reduction of range of motion. Now, we are approximately seven years after the time of the accident.

Remember what I said earlier, whatever has lasted more than one year is considered permanent. Seven years is most definitely permanent.

Q Go ahead.

A The back showed tenderness, showed spasm, showed again, multiple trigger points present. Bending backwards was 20 degrees out of 30. Bending forward was 70 degrees out of 90. Rotating from side to side was 20 degrees out of 30. Straight-leg raising was 70 degrees out of 90. Range of motion was normal. Muscle power was normal, except for the right ankle, which is 4 out of 5. That's two grades weaker than normal.

The right ankle was still diffused the tendon with crepitations. Range of motion is two thirds normal. Gait was slow and antalgic. Antalgic means the patient walked with a limp.

Q Now, Doctor is the antalgic gait medically

significant, especially in conjunction with neck and back injury?

A Yes.

Q Please explain.

A Antalgic gait usually goes to a disc problem in the lower back, a disc problem or a pinched nerve in the lower back. So that is what correlates the injury.

Q How about the ankle injury?

A The fact that the patient has pain and two thirds normal range of motion and muscle power is two grades weaker than normal, that is significant.

Q Okay. How did the examination from one to the other change in any way?

A Some areas got slightly better; some areas got slightly worse.

For example, before the muscle power testing was normal, all four extremities. On June 23, '25, muscle power testing for the right ankle was abnormal, two grades weaker. Initially, the gait was normal; now, on June 23, '25, the gait is slow and antalgic?

Q And, in your opinion, Doctor, when examinations are conducted for patients over a period of time, are they always the same, or do they fluctuate?

A They can fluctuate. Usually they can worsen, especially if you examine them in the wintertime. If you examine

them in the summertime, it can be slightly better. It depends.

Q Okay. Now, Doctor, what is a life care plan?

A A life care plan is a special report that is generated by a physiatrist like myself, or a life care planner.

A life care planner has 100-hour training, less than a month training. They're not doctors. They're not allowed to order any diagnostic testing. They're not allowed to order any prescription or medication. They usually follow the recommendations of a doctor.

And a physiatrist like myself, we are trained in doing these life care plans. Our training is more than ten years doing these reports, and we are physicians. We have a license to do surgeries, do injections, to order MRIs, to order x-rays, everything from A to Z.

It usually depicts the patient's overall diagnosis and the prognosis, a look into the future. And we use the standards of care, SOC, to know what the patient needs for a particular condition.

For example, if the patient has pain, spasm, decreased range of motion, a muscle weakness, they need physical therapy to strengthen those areas and to address those areas.

If a patient has high blood pressure, you want to treat the high blood pressure, so they don't go have a heart attack or a stroke.

So these are some of the indications for life care

plan. They call for the indications and the frequency and the fee schedule in the New York prevailing areas.

Q We're going to get to the life care plan in one second.

But with regard to this particular patient, when you reviewed his records, did you see whether he undertook courses of physical therapy, injections, and medication?

A In the past, he did. But from the time I saw him recently, he has not. So he has not had optimal level of care; he's had suboptimal level of care.

Q What does that mean?

A Optimal level of care is the best care you can give to a patient. If you want a patient to do well and to live a normal life span, you want to have the best treatment available. You don't want to have a suboptimal treatment.

Can I give two examples?

Q Yes.

A If a person has high blood pressure. They're taking their medication sporadically. One day they take it; one day that don't.

And what's going to happen to the blood pressure?

It's going to keep going up. Go up until you get a heart attack, a stroke or even death.

Second example, a diabetic. Patient needs insulin for their diabetes. They need 25 units in the morning; 25 in the

afternoon. They don't have the money or the means to buy the insulin.

MR. ROSS: Objection, Your Honor. And I move to strike that. No comparison here. I would like all that testimony stricken.

THE COURT: It's stricken.

Q Doctor, without the -- without the example, can you explain what the optimal care means?

A Yes.

Optimal care is to keep the patient functional with the least amount of pain as possible, so he can have a good quality of life.

Q Okay. And does your life care plan represent optimal care?

A Yes.

Q Why?

A Because as a life care planner, you want to give the best optimal care. And people, the jury, will decide if the patient deserves optimal or suboptimal.

MR. ROSS: Objection, Your Honor. And I move to strike that again. He knows better.

THE COURT: Sir, Counsel, that remark is stricken, as well as the last remark by the doctor.

Q What if a patient was not receiving optimal care up to this point, what effect, if any, does that have upon the

patient?

MR. ROSS: Objecting, Your Honor. Again, I object to this line of questioning.

THE COURT: This is -- why don't you approach.

(Whereupon, a discussion was held outside of the hearing and presence of the witness and the jury.)

(Whereupon the following discussion was held in open court.)

Q Doctor, I want to go through your life care.

THE COURT: Objection is sustained.

Q I want to go through your life care plan.

Would you be able to use the whiteboard and the markers in front of you as we detail each element of your plan.

A Yes.

MR. FREDERICK: Your Honor, may I set up the easel?

THE COURT: You have any objection to that?

MR. ROSS: No, Your Honor.

THE COURT: Okay, yes.

MR. ROSS: I'm just going to go over there so I can see.

THE COURT: You have to use the lapel mic, Doctor.

THE WITNESS: Yes, Your Honor.

Q Doctor, I want to ask you one other thing before we

get to that, but we'll set that up.

THE COURT: You'd like to have him step down?

MR. FREDERICK: Not yet, Your Honor. I want to ask a couple more questions and then we're going to go to that.

Q Doctor, as a result of reviewing all the records, examining the patient, looking at all the films, reading all the radiological reports, did you develop a diagnosis?

A I did.

Q What was the diagnosis?

A Multiple cervical disc herniations from C3 to C7. L4 through S1 disc herniations with impingement. L3-L4 disc herniation. Status post: Decompressive lumbar laminectomy, medial facetectomy and depression of the neurological elements at L5-S1. Status post: C4 to C6, anterior cervical discectomy with partial corpectomy and fusion and placement of mechanical devices. Permanent scarring to the cervical, lumbar spine. Persistent clinical, cervical, and lumbar radiculopathy. Right ankle partial tear of the anterior talofibular ligament.

Q Okay. And, Doctor, to a reasonable degree of medical certainty, is it your opinion that those injuries were caused as a result of the accident of 10/18/18?

A Yes, sir.

Q Doctor, I'm going to ask you to assume for a moment that there's been testimony that the patient had another fall in

March of 2019.

Ask you to assume he climbed some steps, he was on a landing and he collapsed, at that point.

Did you see any records relative to that?

A I did not.

Q With regard to that, would that -- understanding that fact, would that affect any of your opinions in any way?

A No.

Q Why?

A Because the injuries have already been -- have already occurred as a result of the 10/18/2018 accident, and that happened after all these diagnostic studies were performed.

Q And in your review of all those records, did anything change after March of 2019?

A No.

Q Okay. Now, if we can go to the life care plan.

A Okay.

MR. FREDERICK: May he step down?

THE COURT: Yes.

A So tell me again how you want these colors to be coded.

Q It's up to you. You can do it all in one color if you want or whatever you want to do.

A Okay.

Q So we'll take your life care plan piece by piece.

What is the first element of your life care plan?

A Can I give the reasons and the medical indications also.

Q Absolutely, yes. That's part of it.

A Number one, is the patient should be seen by a spinal surgeon at least four times a year to monitor the patient's spinal injuries, to look for traumatic arthritis, to look for adjacent segmental pathology, to look for any possible hardware failure, okay.

And, of course, for each visit it's $300 to $400 depending on the amount of time spent with their patient.

So number one would be spinal surgeon.

THE COURT: Can everyone see?

THE WITNESS: I think it's running out of ink.

A So what I'm writing is spinal surgeon, four times per year, at a cost of $300 to $400 per visit depending on the amount of time spent, the doctor and the patient.

Q What is your second element?

A The patient should be seen by an orthopedic surgeon at least six times per year to monitor the orthopedic injuries, especially to the right ankle.

Q Are orthopedic doctors different than spinal surgeons?

A Yes, they are.

Q And how is that?

A Orthopedic surgeon does not do spinal surgery.

Q Okay?

A Spinal surgery concentrates on spinal surgical problems. Does not concentrate on the shoulder, the foot, the ankle, et cetera.

So that's the orthopedist.

Third, a physiatrist like myself, at least 12 times per year to monitor the patient's overall musculoskeletal injuries.

The physiatrist would be the primary gatekeeper to see if the patient needs physical therapy, to see if the patient needs medications. To see if the patient needs diagnostic studies, such as MRIs, EMGs. To see if the patient needs any referrals to any other medical experts, and other physiatric treatments. The cost is $200 per visit.

I'm going to abbreviate physiatrist as PMR, physical medicine and rehabilitation. And the cost is the same, $200 per visit.

Next is, the patient should be seen by a neurologist six times per year to monitor the patient's neurological injuries, and the cost is the same. It's $200 per visit.

Number five will be, the patient will need periodic MRIs of cervical spine, lumbar spine, at least once per year to monitor the patient's overall spinal injuries to look for adjacent segment pathology, damaged discs, traumatic arthritis, or any other abnormalities above or below the herniated discs.

Number six, the patient should have EMGs of the neck,

arms, back and the legs, every one to two years to see if there's any nerve damage, and the extent of nerve damage. If there's severe nerve damage, the patient will need surgical intervention immediately; otherwise the patient will not improve. If it's a mild nerve damage, you can continue to observe.

Number seven, the patient will need medications for pain, spasm, and neuropathic pain. Neuropathic is the shooting pain down your arms and legs. I'm recommending Celebrex, C-e-l-e-b-r-e-x, 200 milligrams, one to two times per day; and Lyrica, L-y-r-i-c-a, 100 milligrams twice per day. The cost for each medication is about $2 per pill. And when you multiply it for the two pills, that's $4 a day, multiplied by 365 days.

Number eight, the patient should have blood work. Complete blood count, basic chemistry profile, liver function test because these medications have side effects on the kidneys and the liver. You want to make sure no side effect occurs. And this should be done in a urine analysis. This should be done every four months. And the cost is $400 for the complete set. And the annual cost is about $1,200.

Number nine, the patient should have physical therapy sessions at least 40 times per year to diminish pain, diminish spasm, improve muscle power, and to prevent the condition from getting progressively worse, and the cost is $150 per session.

Number ten, the patient will need interventional pain

management for pain management. For the next five years, the patient should have three surgical epidural injections per year, three lumbar injections per year, and three surgical facet or medial branch block injections per year and three for the lower back and two radiofrequency ablation procedures to burn the sensory nerves behind the disc. That gives the patient improved pain for about six months.

Nothing is permanent.

Q Why isn't it permanent?

A Because this condition is permanent and progressive. It doesn't stop. You cannot cure this condition. It goes from one injury into another level of injury, as these diagrams have been demonstrated, okay.

Once you do disc replacement, you get rid of one problem, you cause another problem. You lose range of motion, you cause pain and stiffness, and the nerve root is already damaged. Even though you removed the disc and replaced it, the nerve root is already damaged.

The cost for each cervical epidural is $2,000. For each surgical facility is $3,000 for each. And the facets are $3,000 each. The surgical facility is the same.

And then we have two sets of cervical radiofrequency ablations, RFA, and two lumbar RFAs. Each one is $5,000. And the outpatient surgical facility for each is $4,000; therefore, it would be nine times two, $18,000. And this is also $18,000

multiplied by five years.

Q By the way, do you perform all these --

A I do. I perform them. I also teach them.

Number 11 -- I have that on number 11.

And the patient will need future cervical and lumbar surgeries. And the cost for each is $100,000. One to two days' hospital stay is 100,000. Anesthesia fee is 3,000. Intraoperative eval potential studies to monitor the spine during surgery is another $3,000. Post-surgical basing will be 1,000, and the cost for neck total would be 207,000. The cost for the lumbar spine would be also 207,000.

And taking into account the patient is currently 56 years of age. And with excellent medical care, patient longevity should be 82 years of age. That's an additional 26 years. And the total would be $1,712,000.

Okay. That's it.

Q Thank you.

A You're welcome.

Q Now, in your report that you provided, do you define the care that you provided here as optimal care?

A This is optimal, yes.

Q And is it in your report?

A It is, yes.

MR. FREDERICK: Your Honor, I have nothing further.

THE COURT: Thank you so much.

Any cross-examination?

MR. ROSS: Yes, Your Honor.

I just need two minutes. I already started looking at his file.

THE COURT: Okay.

MR. ROSS: I need two minutes to take a quick look.

THE COURT: Okay, great.

MR. ROSS: If it's okay.

THE COURT: Absolutely.

Doctor, if you could just give your file to Mr. Ross.

CROSS-EXAMINATION

BY MR. ROSS:

Q Good afternoon, Dr. Guy.

A Good afternoon, sir.

Q I'm going to be asking you a series of questions. I'd just ask that, if you don't understand one of my questions, please let me know so I can rephrase it or clarify the question for you.

Is that fair?

A Yes.

Q If I ask you for a yes-or-no answer, please, answer that question yes or no, or if you can't, just say so.

Is that fair?

A That's fair enough, yes, sir.

Q And certainly you're kind of used to those types of instructions because, as you told the jury, originally, you have testified in courts such as this around 300 times; is that correct?

A Yes, sir. That is correct.

Q In those approximate 300 times that you've testified, that has been on behalf of plaintiffs who are suing for money damages, correct?

A I've testified for defense a couple of times as well.

Q So out of the approximate 300 times that you've testified, a handful of times on behalf of the defense?

A Yes.

Q 95 percent or more has been on behalf of plaintiffs who are suing for money damages, correct?

A For patients, plaintiffs, that's correct.

Q I understand.

In response to questions from Mr. Frederick and what you told this jury was, I testify on behalf of my patients.

That's what you said, right?

A That's correct.

Q Okay. But those patients were plaintiffs suing for money damages?

A That is correct, yes.

Q Those plaintiffs were patients who were suing to try and get as much money as they could from juries, correct?

MR. FREDERICK: Objection.

THE COURT: Sustained as to form.

Q Certainly, you're aware of the fact that your patients and plaintiffs were suing for money damages, fair?

A Yes.

Q By the way, you are not a treating physician in this particular case, correct?

A Correct.

Q You never actually treated Mr. Villalta for the injuries that he claims he sustained on October 18, 2018, fair?

A That is correct. Yes, sir.

Q He's had physicians who have treated him since this accident; is that correct?

A Yes, sir. That is correct.

Q In fact, you mentioned some of those to this jury a little while ago, correct?

A That is correct. Yes, sir.

Q You mentioned Dr. Andrew Merola who performed the neck and back surgery, fair?

A Yes.

Q You never spoke to Dr. Merola or consulted with him before coming in to testify?

A That is correct.

Q Never spoke to him once about the surgeries he performed or whatever care would be necessary, if anything, from a spinal surgeon post-surgery, correct?

A That is correct.

Q And, also, you're familiar with Dr. Grimm; is that right?

A Dr. Grimm, yes, I am.

Q And Dr. Grimm is, essentially, a pain management specialist?

A He's a physiatrist.

Q Right.

A Pain management like myself.

Q Like yourself.

And, to your knowledge, he's not coming in to testify before this jury?

A I have no knowledge.

How do I know that?

Q But he was the one who was treating the plaintiff since this accident; is that correct?

A He was one of the treating physicians, yes, sir, that is correct.

Q To your knowledge, Dr. Grimm is in the same office with Dr. Jeffrey Kaplan; is that right?

A That is correct. Yes, sir.

Q Now, you told the jury -- just getting a few

background stuff out of the way, all right. So just bear with me.

You told the jury you're being paid $5,000 for coming in to testify today for half a day --

A Compensated. Big difference between the two. I'm compensated for loss of not being in my office.

Q $5,000?

A Yes, sir. For half a day.

Q In addition, when you examined the plaintiff on those two occasions, you also charged a fee for that as well?

A Yes, sir.

Q What was that fee?

A The first one, the life care report, was 4500. The second one was 1500.

Q And then also what about the -- did this include your review of the records, things of that nature?

A Yes.

Q And you do agree that it's important to have medical records to be able to review before you come in and testify before this jury and give them your opinion; is that fair?

A To the extent that it's what is pertinent, yes, sir, that is correct.

Q You would agree with me that having the most information that you could have would be beneficial to you before you're going to come in and testify before a jury as to

your opinions?

A As to what is pertinent, yes, sir, that is correct.

Q So you -- so, Doctor, you started off this testimony by explaining -- and, actually, I'm going to remove those for a second.

MR. ROSS: Judge, I'm just taking those things away. The demonstratives --

THE COURT: Sure.

MR. ROSS: -- they were left there.

Q Now, Doctor, you don't -- you mentioned you do perform certain types of procedures, like a discectomy; is that correct?

A Yes, a microdiscectomy.

Q You don't perform obviously fusion surgeries or anything of that sort?

A No, sir.

Q By the way, you never spoke to Dr. Kaplan either?

A I did not. There was no need.

Q And you never spoke to any of the radiologists that did any of the films; is that right?

A No, sir. No need.

Q And, Doctor, we can agree that you -- you gave some different terms you used. You used a disc bulge. You used a disc herniation.

Do you remember that?

A Yes, sir, I do.

Q And for starters, we can agree that disc bulging and bulging of the discs can occur over time, degenerative wear and tear, not necessarily have to be the result of some kind of an acute trauma?

A It can be caused by any one of the above.

Q We could agree, sir, too, that the same would also hold true for a disc herniation?

A Is it possible, yes. It is possible.

Q Yes.

In other words, in fact, you actually gave a good example on direct, when you came out and you were standing in front of this jury, you said someone could actually sneeze?

A Forceful sneeze.

Q Forceful sneeze and herniate their disc --

A Yes, sir.

Q -- fair?

A That's correct.

Q And we can also agree, sir, that not every herniated disc requires a surgical intervention; fair?

A Yes, sir, that is correct.

Q Because it depends.

A Yes, sir.

Q Some people could be fine and walk around with one herniated disc and never have to get surgeries; fair?

A That is fair, yes, sir.

Q And then there are other times when someone might require a surgery; fair?

A Yes, sir.

Q Now, degenerative wear and tear, okay, or what I'll call "wearing out of the disc," that occurs over a long period of time; is that fair?

A Yes, sir. It varies from patient to patient. But, yes, it does.

Q We can agree that it doesn't just start when a male is 40 or 42 years old; they can have wear and tear even in their 20s and going on up over time?

A That is very unusual for the age of 20.

Q But we can agree, sir, that depending upon the type of activity you were involved in, that wear and tear could easily advance itself more quickly?

A Is it possible, yes; but that's not likely in this case.

Q Okay. And you are aware of the fact that Mr. Villalta is a construction worker; is that right?

A Yes, sir.

Q Do you know what kind of construction work he did?

A General construction, working on scaffoldings.

Q Doing what?

A Whatever's required to work on scaffoldings.

Q When you examined and you saw Mr. Villalta on the

first -- I'm sorry.

The first time you saw Mr. Villalta was in 2023; is that right?

A That's correct.

Q You never saw him before that, from the date of his claimed accident on October 18, 2018, though, I believe it was -- what was the date you saw him the first time?

A First was May 8, 2023; last was June 23, '25.

Q So you obviously never saw Mr. Villalta between 10/18/18 and May 8, 2023; fair?

A That is fair.

Q And did you indicate anywhere in your report that Mr. Villalta was an individual who came to this country in 1995 and started doing construction work since 1995?

Did you note that?

A Outside the scope of my evaluation.

Q So you didn't note it?

A No. Outside the scope of my evaluation.

Q Because your evaluation was solely to put together a life care plan so you can get up in front of this jury and put a $1.7 million claim that he needs future life care?

MR. FREDERICK: Objection.

Q Yes or no.

THE COURT: Sustained as to form.

Q As a life care plan, it is you who comes up and

testifies before this jury and says, it is my opinion that the individual needs this treatment, and this is how much the current cost is and this is how long he needs the treatment for; fair?

A In part, based on the explanations I have given, yes. That's the most important part.

Q And what you wrote down a little while ago on the board over there concerning what he needs and the cost; fair?

A Yes, sir.

Q But you didn't indicate anywhere in your report the fact that he had been doing construction work, going up and down scaffolds, ladders, caulking, brickwork, manual labor, from 1995 up through the time of this claimed accident in 2018, 23 years, you didn't make any note in there as to the impact that that would have on one's back and/or neck, did you?

Yes or no.

A No. For the reason I just gave you.

Q Did you review -- correct me if I'm wrong. I took a look, obviously briefly, at what you brought with you.

But did you review or see any indication that Mr. Villalta had treated specifically with a neurologist at any time after the date of this accident?

A I did not see any record, no.

Q He did not treat with a neurologist, at all, for any of his claimed injuries from this accident of October 18, 2018,

correct?

A Not that I know of, correct.

Q Nothing in your records?

A No. I said no.

Q And, by the way, when you did your -- when you had your -- you examined him in May of 2023 and you generated a report, in that report, you list all the records that you reviewed; is that correct?

A Yes.

Q You have that in front of you --

A I do.

Q -- am I correct?

Is there any indication in that report that you reviewed the FDNY ambulance report?

A Let me see.

No.

Q No.

So the ambulance record or report that's in your file there, was that something that you got later on after you generated your first report on May 8, 2023?

A I'm not sure. I must have overlooked it.

Q You made no reference to it in your report; is that correct?

A You asked me that. I said, no, I did not.

Q No. What I asked you was, did you look at it, and you

said no.

And my next question was did you reference it, and you said no.

MR. FREDERICK: Objection.

THE COURT: It's overruled.

MR. ROSS: I'll rephrase it.

Q You neither looked at the ambulance report before you reported your May 2023 report, and you didn't list it as a record that you looked at it; fair?

A I'm not sure if I looked at it or I didn't mention it. But it's not mentioned in my report. It doesn't change anything.

Q Would you think it would be important to look at the ambulance report, the actual first responders that were there on the scene, don't you think that would be helpful to you in assessing issues concerning his injuries, what he complained about, or anything of that sort?

A That question I cannot answer with a yes or no. I can answer it with an explanation if you'd like.

Q So -- I'll get to that.

Because in the first report of May 8, 2023, there's no reference that you reviewed or looked at the Lincoln Hospital records; is that correct?

A That is correct.

Q And there's nothing to indicate when you generated a second report and examined him again this year before trial a

few months ago -- I mean, a few months before this trial started, to indicate that you reviewed any of the Lincoln Hospital records; is that correct?

A Let me see.

No, it's not in my report.

Q Okay. So before generating your report in May of 2023 that included your exam of the plaintiff four and a half years after the accident, your review of certain records that you did describe to the jury, you didn't even look at the hospital that he literally went to and was treated with on the day of the accident?

Yes or no.

A It's not in my report, but I do have the records from Lincoln Medical Center. They're right here. And I did review it. It's got those red tags on them. That means I did review it.

When I reviewed it, I'm not sure. And why it's not in my report, I may have overlooked it. But it doesn't change my diagnosis and the opinions I have given because I've looked at it.

Q There's nothing in your first report and there's nothing in your second report to indicate that you ever reviewed and looked at the Lincoln Hospital records in conjunction with your opinions?

Yes or no.

A I just said that is correct.

MR. ROSS: So, Your Honor, may I approach the witness for a second?

THE COURT: You may.

Q This is the record of the ambulance call report; is that correct?

A That is correct.

Q Now, you were asked on direct exam, Dr. Guy, if the information in the ambulance call report was consistent with the manner in which you were told the plaintiff's accident occurred, you know that fall and this, what you've referred to as some kind of axial impact injury, you said it was; is that correct?

A Yes, sir, that's correct.

Q Now, we can agree, sir, that there's nothing in that ambulance call report that indicates that the plaintiff fell from a height and landed on his feet or his heels, correct?

A That is correct.

Q Yes or no?

A That is correct. That's correct.

Q So when the ambulance folks got there, they indicated -- because it says, "patient states, he claims he fell from a height, and he claims he fell onto his lower back"; isn't that what that record says?

Yes or no.

A Give me a second.

THE COURT: Counsel, this is going to be the last question.

MR. ROSS: Before lunch, you mean?

Because I'm not done, obviously.

THE COURT: Yes.

A Ask the question again.

Q I said, is there any indication in the records that he actually came down on his feet?

A No. There is no such indication.

Q No such indication?

A No, sir.

Q And in that ambulance call report, the only complaint of pain that the plaintiff mentioned was pain to his low back, correct?

A That's correct.

Q Absolutely no evidence or indication that he had neck pain, correct?

A That's correct.

Q No indication that he had any pain to his heels or his feet; is that correct?

A Yes, that is correct.

Q There was no loss of consciousness, correct?

A That is correct.

Q No head injury; is that correct?

A None claimed.

Q And all of his extremities he was able to move.

There was no indication of any numbness or tingling or anything else, correct?

A That is correct.

MR. FREDERICK: Your Honor, this would be a good time to stop.

THE COURT: Okay. Members of the jury. We're going to recess for lunch at this time.

Please remember my admonitions about speaking among yourselves and with others. Please have a light lunch because we're going to continue on with our testimony this afternoon.

See you back at 2:15.

THE COURT OFFICER: All rise. Jury exiting.

(Whereupon, the jury exits the courtroom.)

THE COURT: Thank you, Doctor. You may step down.

Of course, Doctor knows not to speak with counsel about the case during lunch.

MR. ROSS: Thank you, Your Honor.

(Whereupon, a luncheon recess was taken at 1:00 p.m.)

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

(Whereupon, the proceedings resumed at 2:46 p.m.)

COURT OFFICER: Jury entering.

(Whereupon, the jury enters the courtroom.)

THE COURT: Please be seated.

Okay. Members of the jury, good afternoon.

We're going to continue on with our cross-examination of our doctor.

Mr. Ross?

MR. ROSS: Thank you, Your Honor.

CONTINUED CROSS-EXAMINATION

BY MR. ROSS:

Q. Dr. Guy, before we broke for lunch we had just completed a couple of questions concerning essentially the FDNY or the ambulance call report; correct? Do you remember that?

A. Yes, that's correct.

Q. Now, just to confirm -- and then we had also indicated that there was nothing in either one of your two reports to indicate that you ever reviewed the Lincoln Hospital records, where the plaintiff was taken to on the day of this incident; correct?

A. That's correct; yes.

Q. And Doctor, you are aware of the fact that when he was at -- when the plaintiff was at Lincoln Hospital records -- when the plaintiff was at Lincoln Hospital, as the records indicate,

he did have certain diagnostic testing that was done; is that correct?

A. Yes, sir. That is correct.

Q. And you would agree, Doctor, that if somebody comes to the emergency room and the assertion or the claim is that the person fell from some kind of a height, whatever that was, certainly the emergency room in the hospital is going to want to check the various body parts to make sure that there's no fractures, no damage; fair?

A. That's correct.

Q. And in this case, they did do CAT scans of different parts of the body; is that right?

A. That is correct.

Q. They did the CAT scan of the cervical spine; is that correct?

A. That is correct.

Q. And it was normal; is that correct?

A. That's correct. No fractures.

Q. And the cervical spine, according to the hospital records, was normal? There's nothing else they observed in the cervical spine CAT scan that was done?

A. CAT scan's for bone. There was no bony problems.

Q. And just so we're clear, in other words, the plaintiff in this case did not fracture any part of his body at all? He didn't fracture a single bone in his body; is that correct?

A. That is correct; yes.

Q. He did not sustain any fractures to any part of the spine; correct? Cervical; thoracic; and lumbar? Nothing; correct?

A. No fractures anywhere.

Q. No fractures whatsoever.

Didn't fracture his -- he didn't fracture his feet, he didn't fracture his heel, he didn't fracture his legs, back, arms, or anything else; fair?

A. That is correct; yes.

Q. And again, to confirm, they also did various x-rays? They did a chest x-ray, they did a pelvic x-ray; is that correct?

A. That's correct; yes.

Q. And you would also agree with me, Doctor, that when he was in Lincoln Hospital for a number of hours, there is no indication that he had any swelling to any part of the body; isn't that correct?

A. The answer is yes, with an explanation.

Q. So there were no noted deformities to any part of the body when he was seen in the emergency room; is that right?

A. The answer is yes, with an explanation.

Q. And there was no bleeding, there was no bruising, nothing of that sort; is that fair?

A. That is fair.

Q. And it is also a fact that the plaintiff himself actually denied having any neck pain when he was in the hospital; is that correct?

A. I saw that. That is correct.

Q. And in fact, he denied having any pain to any part of his body other than the low back; fair?

A. That is correct.

Q. By the way, do you know when the plaintiff was discharged from Lincoln Hospital?

A. Exact time I do not know.

Q. Can we agree though that it was a number of hours after he was brought in?

A. It had to be because of all the x-rays and the CAT scans he had, yes.

Q. And at no time during any of that period that he was in the hospital did it ever appear that he had any kind of a deformity; that there was any swelling that developed around his neck, or his back -- low back, mid back, upper back -- no swelling to any leg parts, no ankle swelling, no feet swelling, no heel swelling; correct? At any time was that observed in the hospital --

A. That is correct.

Q. Now, on direct exam, Doctor, you commented about --

MR. ROSS: Withdrawn. I'm going to back up for a second.

Q. You had been asked on direct exam about the fact that in March of 2019, so about five months after this incident --

A. Right.

Q. -- the plaintiff had some sort an unrelated -- had a fall; do you recall being asked that?

A. I do; yes.

Q. By the way, there's nothing in your records to indicate that the plaintiff ever told you that he had fallen in March of 2019; right? There's nothing in either one of your reports?

A. That is correct. Yes, sir.

Q. And you did take a history from the plaintiff; correct?

A. I did.

Q. Now, in response to questions from plaintiff's counsel to this jury, you said that that fall in March of 2019 is of no concern because all of the diagnostic testing was done before that; is that correct?

A. That is correct; yes.

Q. But we can agree, sir, that there is a number of MRIs that you indicated in your report that were done and you were commenting upon after March of 2019; isn't that correct?

A. Yes, but they essentially confirmed the prior MRIs.

Q. And we can agree, sir, that, you know, interpretation of MRIs can be different depending upon the radiologist who does

the observation and how they may even comment in their radiology reports; fair?

A. Yes.

Q. Right. Because sometimes, for example, one person might say a disc herniation, the other one might refer to that as a disc protrusion, for example?

A. I agree with that; yes.

Q. There was never any indications of any kind of a negative EMG or nerve conduction study results that were done; correct?

A. I did not see any EMGs performed.

Q. And what -- if you've seen the phrase or a term like step offs in the medical world, what does that mean?

A. Depends on the full sentence. Step off what? Step off on x-rays? Step off on MRI? Step off on what?

Q. Let me see if I can find it.

A. I need to hear the whole sentence and the context that it's being used.

Q. Just give me one second. I'm trying to locate it. I have it and then all of a sudden I don't, so. I got to find it, so I'm going to keep moving. I have it here somewhere and I'll show it to you in a minute. So I'm going to come back to that. Here we go. I found it. Okay.

When we have AOX3, that stands for alert and oriented times three; correct?

A. Correct.
Q. In other words --
A. Yes.
Q. -- he understands everything that's being asked of him, he's able to explain things, staff at the hospital can talk to him, he can talk to them; fair?
A. That's correct.
Q. It says neck and --
MR. ROSS: And by the way, for the record, Your Honor, I'm referring to Defendant's Exhibit C which is in evidence. These are the Lincoln Hospital records.
THE COURT: Yes. Do you have a page number, counsel?
MR. ROSS: Right now from Defendant's Exhibit C the bottom has a Bate stamp of 317.
THE COURT: Thank you.
MR. ROSS: The date is October 18, 2018.
Q. Moving all four -- for starters, moving all four extremities. So he's having no problems moving his hands, limbs, legs, et cetera; is that fair?
A. That is correct; yes.
Q. Okay. And it says neck and back, no obvious deformities or step offs. So what does that mean?
A. The way it is described means no -- nothing protruding, nothing sticking out.

Q. Now, you referred to the term when you were describing your exam yourself that you did in 2023 and again in 2025, you used the phrase tenderness; is that correct?

A. Yes.

Q. And just so we're clear and the jury understands, when you say something is either tender or non-tender, you're talking about if you were examining somebody and you touched them on their neck or you pushed on it a little bit and if the person says ouch, you would identify and say that they were tender in that area; is that fair?

A. That is correct; yes.

Q. So when we talk about the tenderness, that is a subjective complaint; correct?

A. Yes.

Q. And in the hospital records on the day that he supposedly fell X number of feet and landed so hard, he had absolutely no tenderness that was indicated at the neck or in the midline; is that correct? Or do you recall either seeing or not seeing that in the records?

A. The neck; that is correct. When you say midline, midline --

Q. I'll read it to you exactly.

"No cervical or thoracic midline tenderness."

A. Okay. Midline that is where the spinous process is. That's correct.

Q. And so that indicates that when he was being examined in the emergency room of the hospital, okay, before an attorney was retained, okay, there's no cervical tenderness? So that meant when they examined him and they touched him on his neck and in the thoracic area, he didn't indicate to them that he was in pain or that something was bothering him; correct?

A. That's what it says; yes.

Q. And just in -- and part of this, and I appreciate it, Doctor, for the term so the jury will understand, if it says "neuro", N-E-U-R-O, that means neurological exam; correct?

A. That is correct.

Q. And that indicates -- it states that it was normal as tested?

A. As expected; yes.

Q. It says he reports LBP. So what is that your understanding?

A. Low back pain.

Q. So in the hospital he was claiming that he had some low back pain; fair?

A. Yes.

Q. And the hospital put that in and noted that; is that correct?

A. That is correct.

Q. It indicates no weakness and no numbness of the extremities; were you aware of that?

A. That's correct.

Q. And explain what they're looking for? If they're talking about a weakness or numbness, what would be -- why would you be talking about that?

A. Would you allow me to give a full explanation or are you going to cut me off?

Q. We'll see how you respond.

A. So, the incubation period of trauma is minimum three to six weeks. You don't see the full-blown symptoms or the clinical picture of a trauma because everything has an incubation period. So when he was examined on day one, there was no deformity, there was no neurological abnormalities because that takes time to manifest. But it did. On all the other records it began to manifest itself. That's why he had to have surgery because the condition went into having neurological deficits.

Q. So, in other words, you're telling me that -- just so I'm clear, it's your testimony, Doctor, that this impact was so bad that it required a two-level cervical fusion and so bad that it required a lumbar fusion, but yet he had absolutely no complaints of neck pain? Somebody claims that he fell six to eight feet onto his heels and then his back and neck, and it's your testimony before the jury that he had absolutely no neck pain whatsoever on the day of the hospital because it manifested and all of a sudden appeared weeks or months later, I just want

it to make sense, that's what you just told them?

A. That is correct.

Q. Fine. That's it.

A. In the medical field we have incubation periods.

Q. Incubation period, fine.

And is the incubation period for some ankle tear that appears years later, is that the incubation period? So when he injured himself supposedly on October 18, 2018, and there's absolutely no evidence of a trauma to his ankle on that day that materialized and took years to develop, that's what your testimony is?

A. The way you phrased the question is a mischaracterization of the patient's medical condition. A tear can happen right away if it's a partial tear. He may not feel it because the body picks up the other body parts that hurts the most. The thalamus portion of the brain picks up the area that hurts the most. So this is why the other areas come into clinical presentation later on.

Q. And when was the ankle -- when was this ankle tear MRI that you referred to -- you can refer to your notes if you want to. When was that MRI done? How many years after the accident?

A. November 2, 2018. Not years just a couple of months.

Q. But November 2, 2018 what was there?

A. It showed a moderate sized amount of joint effusion with tenosynovitis and a partial tear of the anterior

talofibular ligament and that's the findings.

Q. And that finding could have happened after this accident or it could have preexisted without hesitation; correct?

A. It -- this MRI was taken November 2nd. It happened on 10/18. November 2nd is less than two weeks after this accident.

Q. And my question to you, sir, is, that is a condition that could have materialized subsequent to this accident or could have preexisted; isn't that correct? Yes or no.

A. The way you phrase the question, anything is possible. But based on the MRI findings, it happened after the accident because there's an amount of effusion, fluid collection, around the joint. That is indicative of a recent trauma.

Q. And except we can agree, sir, again, there's absolutely nothing in the emergency room or the ambulance call report to indicate that he sustained any injury to his feet, his heels or his ankles other than the plaintiff's self-serving testimony that, according to him, when he fell around 6 feet, which is this right here, just in that split whatever second, whatever it would have been, a millisecond, that he landed on his heels, crashed down on his heels first, then did he fall over gently onto his back and then hit his neck all within that 6 feet time?

MR. FREDERICK: Objection.

THE COURT: Sustained to form.

Q. Are you aware of the fact that the plaintiff had been diagnosed with diabetes and had to undergo diabetic foot care before this accident occurred; did you know that?

A. Prediabetic, yes. And then later on it became full diabetes and he was placed on Metformin 500 milligrams per day. That's a very low dose.

Q. You didn't reference anything about him having diabetes, having had diabetic foot care or any of that sort; is that correct?

A. No, unrelated to this accident.

Q. Now, I think you told us, Doctor, that when you saw him -- when you saw the plaintiff in 2023, okay, when you saw plaintiff in 2023, at that point in time he was no longer going to physical therapy; is that correct?

A. That's correct.

Q. And by the way, had he ever had any injections?

A. Knee injections?

Q. No. No. Did he ever have any injections like spinal injections?

A. Yeah, he told me he had one cervical epidural, one lumbar epidural, that's also in Dr. Weinstein's records.

Q. And that was the only time he had those injections; is that correct?

A. Yes, they didn't work. That's why he had to have the

surgery.

Q. And he's never had those injections again; isn't that correct?

A. To my knowledge, and to his recollection, no.

Q. And he's -- how long ago did he stop going to physical therapy?

A. I cannot answer that question. I don't know.

Q. Well, you're not aware of any physical therapy recently, are you?

A. I am not.

Q. And he had stopped for a period of time when you examined him back in 2023; is that correct?

A. That is correct.

Q. And Doctor, you're not -- is it your testimony or you're suggesting that if someone -- anyone who has a two-level cervical fusion needs to go to physical therapy 40 times a year for the rest of their life after they have that surgery? Yes or no, is that your testimony?

A. No, sir. My answer is no with an explanation. I'm talking about this patient.

Q. And don't you always recommend physical therapy in all of your patients, plaintiffs, when you testify? Isn't it a fact that in all your life care plans you always recommend physical therapy for the rest of their lives?

A. If the condition is permanent, if they have spasm,

they have reduction of range of motion or any motor deficits or any gait disturbance, yes, those are the universal criteria for physical therapy.

Q. And you also recommend that he get these -- you would agree with me that everyone who has a fusion surgery, whether it's to the back or the neck, it doesn't have epidural injections X number of times a year sticking a needle in them for the rest of their life; is that correct?

A. I never said for the rest of life. Read my report carefully. I said for the next five years. I never said for the rest of their lives.

Q. So you're saying then that he needs it for the next five years every year?

A. That's correct.

Q. And he hasn't had injections for the past few years and he only had one round of injections since the accident?

A. He hasn't had many of the treatments that I recommended. He's had suboptimal treatments as I indicated.

MR. ROSS: I just move to strike that last response, suboptimal.

MR. FREDERICK: I object to that. Objection.

THE COURT: I'm sorry, can you read back the question, please?

(Whereupon, the requested portion of the record was read by the reporter.)

THE COURT: And you're objecting to that?

MR. ROSS: I objected to his response on the issue of suboptimal. That's just -- I'm objecting because it's a guess.

THE COURT: He can answer. Next question.

MR. ROSS: Okay. That's fine.

Q. So, in other words, what you're saying is that Dr. Merola provided suboptimal care? That's what you're saying; correct?

A. No, sir. I'm not saying that at all.

Q. And you're saying that Dr. Kaplan and Dr. Weinstein and Dr. Grimm, all of the treating physicians provided suboptimal care to this plaintiff, that's what you're saying; isn't that correct?

A. That is not correct. That's a mischaracterization of what I'm saying.

Q. Okay. And plaintiff was discharged from the hospital. I mean, again, we talked about that, a number of hours later, like in the morning hours of October 19, 2018; correct?

A. Yes.

Q. In other words, he didn't have to be admitted and stay in the hospital overnight; is that fair?

A. That's correct.

Q. Do you know if Mr. Villalta has had or has a primary care physician?

A. I believe he does for his diabetes.

Q. And primary care physician is able to prescribe medication if and when it's necessary; is that correct?

A. Depends on the primary care physician. But generally speaking, yes.

Q. And if somebody is going for a regular checkup with their primary care physician, and they indicated, you know what? My neck is hurting, or my back is hurting, then the primary care physician could at that point in time refer him and say, okay, I'm going to send you to a specialist; fair? Isn't that what primary care physicians do?

A. The answer is a yes with an explanation.

Q. But according to you, this individual for the rest of their life needs to go see an orthopedic X number of times per year; is that correct?

A. That's correct, for the reasons I've given.

Q. And then separate from an orthopedic, they should go to a pain management specialist?

A. That is correct.

Q. And separate from that, they should go to a neurologist even though he has never treated with a neurologist to date; correct?

A. For the neurological injuries; that is correct.

Q. And he should go to a surgeon, the spinal surgeon, for the rest of his life as well?

A. For the reasons I've given, the answer is a yes.

Q. And, again, when this plaintiff had -- whatever this incident was on October 18, 2018, whatever impact he had, whatever his incident had, there was no swelling; correct?

A. You asked me that about 15 times.

Q. Just --

A. There was no swelling; yes.

Q. No loss of consciousness?

A. No loss of consciousness, no.

Q. No fractures?

A. No fractures.

Q. And would it be your opinion, Doctor, that everyone who has a two-level cervical fusion is going to go see their surgeon for the rest of their life?

A. Every case is different. I'm only talking about this patient. I'm not talking about every single patient. No, I am not saying every single patient needs to see their spinal surgeon. It's on a case-by-case basis. If they have deficits, the answer is yes.

Q. Well, isn't it a fact that in every case that you've testified for on behalf of a plaintiff/patient, they all have deficits and they all need to see surgeons for the rest of their lives and they need to see the orthopedic specialist for the rest of their lives and they need to have physical therapy for the rest of their lives; isn't that true?

A. Again, a mischaracterization. The patients that I've testified for are the patients that have serious injuries. If they don't have serious injuries, I will not testify for them because they don't need my testimony.

Q. But in this case, Doctor, you were not even the treating physician; correct?

A. I'm not a treating physician as explained several times already.

Q. Right. So you've testified very experienced because you've told us that you've testified like 300 times, and you acknowledge or admitted that the actual treating physician in this case, Dr. Matthew Grimm, does what you do but he's not here testifying; why is that?

A. Why you asking me?

MR. FREDERICK: Objection.

A. Am I Dr. Grimm?

THE COURT: Sustained.

Q. Are you aware of the fact that the plaintiff has indicated that as a result of this fall in March 2019, he indicated this a couple of months later, that he's basically afraid to walk like five blocks for fear that he might fall again; did you know that?

MR. FREDERICK: Objection.

THE COURT: It's overruled.

A. I'm not aware of any such thing.

Q. Because the plaintiff never mentioned that to you on the two occasions when you saw him; is that correct?

A. That is correct. Nor did I see it in any of the other medical records that I reviewed.

MR. ROSS: Your Honor, may we approach?

THE COURT: Sure.

(Whereupon, a discussion was held off the record.)

THE COURT: Okay. Counsel, you want to ask your next question, please.

MR. ROSS: Just give me a moment, Your Honor.

Q. Dr. Guy, just so we're clear, you did not review all of the medical records; isn't that correct? The Lincoln Hospital records.

A. I reviewed what I have. I don't know if that's all of the records.

Q. You reviewed what you have that's in front of you --

A. That's correct.

Q. -- are those are -- are those like diagnostic like radiology type testing, the CT scans, the x-rays that were done? Take a look please.

A. These are the records I have. There's x-rays there. There's notations there.

THE COURT: What do you want him to look for, counsel?

MR. ROSS: I want him to look to see if he has in their records --

Q. Do you have anything from June of 2019 in there that you looked at?

A. No, I do not.

Q. Okay. So then you wouldn't have seen any records indicating the plaintiff being fearful of walking five blocks because of the falling incident in March of 2019 because you never saw that; correct?

MR. FREDERICK: Objection.

THE COURT: It's sustained.

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

THE COURT: Thank you.

Counsel? Mr. Frederick?

MR. FREDERICK: Thank you, Your Honor.

THE COURT: Redirect?

MR. FREDERICK: Yes.

REDIRECT-EXAMINATION

BY MR. FREDERICK:

Q. Good afternoon, Dr. Guy.

A. Good afternoon, sir.

Q. Remember when you were on cross examination, counsel was asking you about testing when Mr. Villalta first went to Lincoln Hospital?

A. Yes.

Q. And you indicated that there were a variety of tests?
A. Yes, sir.
Q. Okay. Is that medically significant?
A. Yes.
Q. Please explain.
A. They check the areas that they thought that was trauma could be involved with, that would be a CT scan of the head, the neck, x-rays of the lower back, x-rays of the hip and pelvis. These are the things you check for when a person falls from a height of 6 feet or more. And they checked all those things looking to see if there's any fracture, fracture is a break, and none was found.
Q. Also in cross examination you indicated that it wasn't likely that his injuries were caused by degeneration; do you recall that?
A. I do.
Q. Can you explain that?
A. Yes.
MR. ROSS: Objection, Your Honor. This is beyond the scope of my cross.
MR. FREDERICK: This is exactly -- I wrote it down.
THE COURT: It's overruled.
A. First of all, normal degeneration does not cause pain. It does not cause shooting pain down the arms, does not cause

numbness or tingling. He had radiating pain down the arms from his neck. He did have radiating pain down his legs from his back. He did have some abnormal physical exam and neurological findings. That's why he had the MRIs ordered. That's why he had the epidurals done to his neck and his back. And that's why when it failed, and the symptoms persisted and they worsened, that's why he had to have the surgery. And the surgeon's report indicates exactly what was found. What was found was nerve root compression and other involvements of the spinal areas.

Q. Doctor, you recall during cross-examination counsel was asking you questions if you knew what kind of work he does.

A. Yes.

Q. Okay. Is the work history relevant with regard to the injuries sustained?

A. No, because he fell from a height of 6 feet or maybe more, so.

Q. But counsel was trying to indicate that it was his work that caused the degeneration which caused the injury, do you agree with that?

A. Absolutely not.

Q. Explain.

A. If you are doing construction and you're flexible enough to go up and down ladders, you're strong enough to lift, pull or push different things, you don't have any problems. If you did, you would not be able to do those things. And if you

had problems, you would have had MRIs, x-rays or have the physical therapy or some treatments for this condition.

So the answer is no, that is not significant. And the MRIs that were done shortly after the accident did not show any significant degeneration nor did the x-rays, nor did the CT scans.

Q. And does it matter whether the x-rays and CT scans were negative?

A. That means they were looking for fractures or any significant arthritic conditions. None was found.

Q. And would injuries in a CAT scan or an x-ray show up like they would in an MRI?

A. No.

Q. Explain.

A. Again, x-rays shows --

MR. ROSS: Objection, Your Honor. Again, this is beyond the scope of what I asked him. I didn't go into that.

THE COURT: Yes, I believe that he didn't go into this.

Q. Okay. Doctor, when trauma occurs, are all the injuries from that trauma do they come out immediately?

A. They do not.

Q. Explain.

A. May I get a quick example?

Q. Sure.

A. Boxers when they fight, they you don't see the full swelling of the eyes, their face, whatever. It starts to happen several days later. And trauma has an incubation period. A common cold has an incubation period of 24 to 72 hours. So does trauma. Several weeks nerve injuries after trauma must wait minimum, minimum three to four weeks before you can do a test to see if there's any nerve damage.

Q. Counsel also indicated to you that there was no swelling mentioned in the Lincoln records; do you recall that?

A. I do.

Q. Is there any significance to that?

A. No, just because there was no swelling doesn't mean there was no injuries.

Q. He also asked about deformities.

A. None -- nobody's saying there was any deformities.

Q. Is there any significance to the fact that there's no complaint registered in the Lincoln Hospital record relative to neck pain at that time?

A. No, because again, again, the incubation period takes several weeks to begin to manifest itself. And the brain only picks up the one or two body parts that hurts the most. This is why when people have multiple body injuries, they don't have pain in all those sites. It begins several weeks after. They have maybe the one or two that hurts the most.

Q. Now, remember when you were being asked questions on cross with regard to this fall in March of 2019?

A. Yes.

Q. And you indicated on cross that the MRIs that came after confirmed the ones that came before; was that your testimony?

A. Yes, sir. Essentially the same; yes.

Q. Please explain that.

A. There was no significant change from the alleged fall of March of 2019.

Q. Also counsel asked you with regard to tenderness in the Lincoln Hospital record; do you recall that?

A. I do.

Q. And he said that -- is there any significance to the fact that there was no tenderness noted in the Lincoln Hospital record?

A. To the neck there was no tenderness in the Lincoln records. Because, again, the incubation period. That begins to manifest itself several days to several weeks later.

Q. But at the risk of sounding redundant, counsel also asked with regard to neuro testing was normal in the hospital; correct?

A. Initially, yes. Again, neuro testing is nerve injury. Nerve injury takes three to four weeks to begin to manifest itself and sometimes much longer.

Q. Now, you also were asked some questions with regard to the ankle; correct? The right ankle.

A. Yes.

Q. And you indicated that there was an MRI that came shortly thereafter?

A. About two-and-a-half weeks later; yes.

Q. And I think you indicated on cross that there was a fluid collection?

A. That's correct. That indicates recent trauma.

Q. And why?

A. Because the body tries to protect itself from a recurrent injury. When you have a blow to a joint, it swells up. It may swell up internally, it may swell up externally or both. Effusion is internal swelling.

Q. And counsel suggested that that may have happened before, he might have been working with that injury; do you recall that?

A. I don't think so. I don't believe that was the case, no.

Q. Please explain.

A. If you have a tear of the anterior talofibular ligament, ligamentous injuries are painful. They're painful. And sometimes it's camouflaged by other areas that are more painful, namely, the back in this case. But if he had a tear, he would not be able to walk up and down ladders, scaffoldings,

et cetera.

Q. Now, Doctor, you indicated when you were being crossed, that the plaintiff had some injections in the past; correct?

A. Yes.

Q. And I believe you indicated that they didn't really work for him; correct?

A. Correct.

Q. So why would he need more in the future if those did not work?

A. Because he had surgery now. Because he had surgery now, they decompressed the compression on the nerves and the cord, now it's a different picture. So we are going to -- the injections will give him some relief temporarily. It is not permanent. So some relief is better than no relief.

Q. Why is physical therapy recommended into the future?

A. Physical therapy -- the universal criteria for physical therapy is to decrease pain instead of taking a lot of medications which will destroy your kidney and your liver. It's to improve range of motion. If you have range of motion deficits, it is done to improve range of motion. It is done to improve overall function. It is done to improve muscle power. He has all these deficits, therefore, physical therapy is needed.

Q. You used that term universal criteria. What do you

mean by that?

A. Means that this is what is --

MR. ROSS: Objection, Your Honor, beyond the scope of my cross.

THE COURT: Overruled.

A. Universal criteria means no matter which doctor you see as an expert in this field, they would agree that this is the indication for physical therapy.

MR. ROSS: Objection, Your Honor, again, to what somebody else may agree to.

THE COURT: Sustained.

Q. What if they don't agree to that?

A. Get a second opinion.

Q. When you were testifying on cross, counsel asked you if Dr. Grimm and Dr. Kaplan and Dr. Merola provided Mr. Villalta with suboptimal care; do you recall that?

A. I do.

Q. And you said they did not. Can you explain?

A. Yes, Dr. Merola's job is to do the surgery and then send the patient to the rehab doctor or a pain management doctor. Now, if the patient has -- I don't know if I'm allowed to say this in the courtroom but if they have the financial means --

MR. ROSS: Objection, Your Honor.

THE COURT: Sustained.

THE WITNESS: I cannot say it.

Q. Well, don't use that word.

MR. ROSS: I object then to this line of questioning whatsoever. It is improper.

THE COURT: That's --

MR. ROSS: And pure guesswork by this witness.

THE COURT: Let's try to stay away from that.

Can you ask him another question, counsel?

Q. Doctor, you indicated that this patient will need to see doctors for the rest of his life on cross; correct?

A. Yes, sir. I do.

Q. Why is that?

A. Because to address his deficits, to address his overall condition, and most importantly, to prevent this condition from getting progressively worse so that he will have a better lifespan during this period of impairment.

MR. FREDERICK: Doctor, I have nothing further.

THE COURT: Okay.

Anything further?

MR. ROSS: I have nothing further, Your Honor.

THE COURT: Okay. Thank you so much, Doctor. You can step down.

THE WITNESS: You're welcome.

(Whereupon, the witness exits the courtroom.)

THE COURT: Counsel, you want to step up?

(Whereupon, a discussion was held off the record.)

THE COURT: Members of the jury, you want to stretch a little bit before we get our next witness? We're going try to finish up one of the witnesses that we had before. We have Dr. Acer. I don't know. You probably don't remember but when you see her, it will ring a bell I'm sure.

But right now you might as well stretch a little bit.

THE COURT: Come on up, Doctor.

(Whereupon, the witness enters the courtroom.)

Officer

MR. ROSS: Sorry, Your Honor, I just need one moment while I get my stuff here.

THE COURT: Okay. We have everybody. Okay.

Counsel, you may inquire.

MR. ROSS: Thank you, Your Honor.

CONTINUED CROSS-EXAMINATION

BY MR. ROSS:

Q. Good afternoon, Dr. Acer.

A. Good afternoon.

Q. Just a reminder, again, because I know we started questioning the other day. If you don't understand one of my questions, please let me know so I can rephrase or clarify the

question for you. And if you don't understand the question of mine -- I mean, if you do answer my questions, then we're going to assume that you understood them. Is that okay?

A. Fine.

Q. Now, Doctor, when we left off we were talking about various records that we -- that you had reviewed in conjunction with your vocational rehabilitation assessment; do you recall that?

A. Yes.

Q. Just in general. Okay. Good.

And one of the records that you reviewed and commented upon, for example, in your report were the Lincoln Hospital records; is that correct?

A. That's correct.

Q. And you're aware of the fact that that's the hospital where the plaintiff went to after he was picked up by ambulance; correct?

A. That's my understanding.

Q. And it's your understanding that when he went to Lincoln Hospital, that was not a place that he was referred to by any attorney that he retained; correct?

A. That's my understanding.

Q. Are you aware of the fact that Mr. Villalta, the plaintiff, retained counsel literally less than 24 hours after his alleged accident occurred?

A. I don't have any information regarding that.

Q. Are you aware of the fact that his attorney referred him and was able to get him in to see a specialist within seven days of the accident; were you aware of that?

A. I don't have that specific information.

Q. Did you review records from Dr. Kaplan who was the first doctor he saw that he was sent to from his attorney?

A. I believe so. I don't have my report with me.

Q. You didn't bring it with you?

A. Well, I have another copy but you have it here. It was handed in. So if I could have that back, that would be great.

THE COURT: Do you remember what number it was? It's plaintiff's?

MR. FREDERICK: There it is. It's right there.

MS. KALLFA: It's plaintiff number 16.

THE COURT: Do you remember what exhibit it is?

MS. KALLFA: It's 16 maybe.

THE COURT: Do you have Plaintiff's 16? Do you have it over there?

THE WITNESS: I'm sorry to delay this. I do have another copy.

THE COURT: She does have another copy.

MR. ROSS: Oh, good.

THE COURT: Oh, the clerk has it.

(Handed to the witness.)

Q. You have the report?

A. Could you ask that question again?

Q. I'll ask it again.

Again, just to confirm, based on your report, you did review the Lincoln Hospital records; correct?

A. Yes.

Q. And you referenced that he was able to move all of his extremities without difficulty; is that correct?

A. That's what was in the record --

Q. That's what I'm asking you. You referenced that; is that fair?

A. Yes.

Q. Okay. And you reference the fact that, you know, other than, again, him complaining of just low back pain -- by the way, you're aware of the fact that the only complaint that the plaintiff had when he was taken by ambulance to Lincoln Hospital was low back pain; is that correct?

A. That's my understanding.

Q. And in your review of the Lincoln Hospital records, as part of your overall vocational assessment, it was indicated, too, that there was no indication of extreme pain or debilitating pain in the back or anything of that sort that was noted in the hospital records by the plaintiff; correct?

A. He complained of lower back pain.

Q. And that's it; correct?
A. That's what he complained of in the record; right.
Q. And after a few hours, he was able to move about with no apparent injuries; isn't that what you indicated on page two of your report?
A. I don't think I specifically said no apparent injuries. He was there, he was evaluated, they did a slew of testing including brain, CT scans and --
Q. And they were all normal?
A. They were all negative.
Q. And according to what you're indicating here, he was moving all extremities without difficulty with no apparent injuries; isn't that what you said?
A. That was in the medical record.
Q. Correct.
A. I didn't say that. That is from what the doctor said there --
Q. That's my point.
A. -- to be clear.
Q. That is what was in the doctors' records from Lincoln Hospital, the only place that the plaintiff went to where he wasn't sent and referred by starting with an attorney; correct?
A. I don't have any information about where he was referred other places.
Q. Now, Dr. Acer, we could agree that individuals who

have -- who claim or assert a back injury, are able to find employment; fair?

A. I think it would depend on the back injury.

Q. Well, you're aware of the fact that the plaintiff had not undergone or stopped going to physical therapy for a number of years; were you aware of that?

A. He had --

MR. ROSS: I'll withdraw.

Q. Are you aware of the fact that for a period of time the plaintiff had done some physical therapy, for example, after he had each of his surgeries, et cetera?

A. Correct.

Q. And to your knowledge, the plaintiff is not undergoing any physical therapy and hasn't undergone physical therapy for quite some time now, probably a number of years; is that fair?

A. He was in physical therapy when I saw him in 2023.

Q. Okay. And do you have any indication for how many times he had gone in 2023?

A. I don't know that.

Q. Did you ever see any indication that at any time in any year between the time of the accident and today where he went to physical therapy 40 times in a year?

A. I don't know.

Q. You didn't make mention of that anywhere in your report; is that right?

A. I don't know. It's not there.

Q. Just so we're clear, Doctor, you were retained to provide to plaintiff's counsel a vocational assessment; correct?

A. Yes.

Q. Right? In other words, you weren't retained to try and find Mr. Villalta a job; is that correct?

A. That's correct.

Q. Like folks at Access VR would do if Mr. Villalta had gone there; fair?

A. Yes.

Q. You never -- by the way, Mr. Villalta does drive; correct?

A. Yes.

Q. And are you aware of the fact that literally like two months after this accident Mr. Villalta took a trip down south with his family where he was able to get on a plane and he flew down to the Atlanta area and then drove to Alabama, did he tell you that he had done those things?

A. No.

Q. Okay. And no indication, again, that he had to be carried on a stretcher or wasn't able to get on an airplane and buckle in on the plane and fly, and that he wasn't able to drive along with his daughter, you know, when they went down to Atlanta and Alabama; did he tell you any of that at all?

A. No.

Q. And he didn't tell you that that was literally about seven or eight weeks -- within seven or eight weeks of this accident; did he tell you that?

A. No.

Q. Is that something you would have wanted to know to see what kind of abilities he has literally within two months of the accident?

A. Well, my evaluation was in the present tense. So I was looking at what he was doing currently.

Q. And we could agree, Dr. Acer, that you have to rely quite a bit on what Mr. Villalta is telling you; is that fair?

A. To a degree, sure.

Q. And just so we're clear, Mr. Villalta, to your knowledge, he certainly didn't tell you, he has not attempted to seek any employment whatsoever; is that correct?

A. That's my understanding.

Q. Didn't go out and say, you know what? I'll be an Uber driver, I can set my own hours, I can do those things. He didn't do anything like that; right?

A. Not to my knowledge.

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

THE COURT: Thank you so much.

Anything redirect?

MR. FREDERICK: No, Your Honor.

THE COURT: Thank you so much, Doctor. You can

step down.

THE WITNESS: Thank you.

(Whereupon, the witness exits the courtroom.)

THE COURT: Counsel, you want to step up, please?

(Whereupon, a discussion was held off the record.)

THE COURT: Okay. Members of the jury, that's it for today. We're going to conclude our testimony.

Please remember what I always say, remember my admonitions about speaking among yourselves or with others about the case. And since you are going home this evening, please do not walk to or past the incident site. Have a great home, safe home, and I'll see you in the morning 9:30. We'll have a witness.

COURT OFFICER: All rise, jury exiting.

(Whereupon, the jury exits the courtroom.)

THE COURT: We're down till tomorrow.

(Time noted: 3:52 p.m.)

(Whereupon, Court is recessed and the case adjourned to Thursday, January 22, 2026.)

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