SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX: CIVIL TERM: PART 1A-21

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JOSE LUIS URQUIA,

Plaintiff,

-against- Index No: 22340/2019E

DEEGAN 135 REALTY LLC, CHESS PROPERTIES LLC, CGS BUILDERS, INC., and CHESS BUILDERS LLC, TRIAL

Defendants.

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DEEGAN 135 REALTY LLC and CHESS BUILDERS LLC,

Third-Party Plaintiffs,

-against-

CAPITAL CONCRETE NY INC.,

Third-Party Defendant.

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CAPITAL CONCRETE NY INC.,

Second Third-Party Plaintiff,

-against-

DUNN CO. SAFETY,

Second Third-Party Defendant.

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Bronx Supreme Court
851 Grand Concourse
Bronx, New York 10451
May 15, 2025

B E F O R E:

HONORABLE MATTHEW PARKER-RASO,
Justice of the Supreme Court

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AMANDA ALVAREZ
Senior Court Reporter

THE WITNESS: Thank you.

Good morning, Your Honor.

THE COURT: Good morning, sir. Just speak towards the mic.

Counsel, you may inquire.

MR. BRENNAN: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. BRENNAN:

Q Good morning, Doctor.

A Good morning.

Q Can you please introduce yourself to the jury?

A My name is Dr. Ashley Simela.

Q Can you give us a sense of your educational background?

A Certainly. I'm an orthopedic spine surgeon. My education became actually here in the Bronx. I am a native son of the Bronx, where I attended elementary school and high school.

Following high school, I attended Pace University where I did my undergraduate degree in biology.

Subsequent to that, I went to Cornell University finishing in a graduate level of degree in physician assistant studies.

Following my undergrade and graduate training, I then went to medical school at NYCOM, which is also in New York on Long Island.

Q What degree did you earn at NYCOM?
A I graduated with a medical degree, a doctor of osteopathic medicine.
Q After you earned that degree, can you tell us about the professional work you've done since you became a -- well, are you a licensed physician?
A Yes, I am.
Q What's some of your professional background since you became a licensed medical doctor?
A Certainly. In terms of my training, I completed an internship at Northwell Health. Following an internship, I then went on to do an orthopedic surgery residency, and then a spine surgery fellowship.
Q How long was the spine surgery fellowship?
A Just about two years.
Q How long have you had your medical license?
A Wow. I obtained my license in 2009.
Q What does it mean to be an orthopedic surgeon?
A Orthopedic surgeon is a physician that specializes in diseases that treat the bone and joints.
Q I think you told us when you were sworn in, but do you maintain an office in New York?
A Yes.
Q Where is that?
A I maintain an office on Madison Avenue, New York but

also, my primary location is Canarsie, Brooklyn.

Q Do you have any hospital privileges in the tri-state area?

A I do.

Q Where?

A I am credentialed at Harlem Hospital, level-one trauma center. Also CareWell Health Medical Center, Hoboken University Hospital, Hudson Regional Medical Center, and most recently, Bayonne Medical Center.

Q What dos it mean to affiliated or have those privileges at those hospitals?

A As an attending physicians, that means I am able to admit patients to a hospital. I'm credentialed to treat patients in a hospital. As a surgeon, I'm credentialed to do surgeries on patients in a hospital.

Q You talked about orthopedics in general. Do you have a particular concentration or area of expertise in that field?

A I do.

Q What is that?

A Orthopedic spine surgeon.

Q Are you board certified?

A Yes. I am a diplomat of the board of certification in orthopedics. I'm also a fellow of the American Academy of the Orthopedic Surgeons.

Q What does it mean to be board certified?

A Certainly. Throughout our training, we take annual exams. There is a culminating or final exam at the very end which encompasses all of your training, test, your skill.

That is usually comprised of three parts, a written part; the second part is actually a verbal part, where you defend your surgeries; and the last part is presentation of your surgeries. I completed all three of those stages.

Q When did you become board certified?

A In 2017.

Q When was the last time you performed a spine surgery?

A Yesterday.

Q Okay. When's the next time you are scheduled to perform a spinal surgery?

A Tomorrow morning.

Q Did you take any time away from your practice to be here in Court today?

A Yes.

Q And to talk on behalf of Mr. Urquia?

A Yes, my patient.

Q Are you being compensated from your time away from your practice?

A Yes.

Q What are you being compensated?

A I do believe my office sent an invoice for just about $9,000 to review the records to and to appear today.

Q Dr. Simela, as a spine surgeon, an orthopedic spine surgeon, board certified, do you regularly come across patients who have been injured in incidents or accidents?

A Yes.

Q Have those patients ever been involved in lawsuits pertaining to those incidents or accidents?

A Yes.

Q Had you ever had to come to Court before to testify on behalf of your patients?

A Yes.

Q About how many times have you had to do that?

A I would say on average, twice per year over the past six years.

Q Okay. Are you familiar with a patient by the name of Jose Luis Urquia?

A Yes.

Q When did you initially meet Mr. Urquia?

A I think in 2019, I initially met him.

Q Do you know how he initially came into your care?

A During that time, I was affiliated with a practice in Lower Manhattan, and he was referred by one of the pain management physicians there.

Q Who were pain management physicians at that practice at the time?

A Dr. Edwin Perez and Dr. Jose Colon.

Q Okay. Would it aid in your testimony to have your medical chart?

A Yes.

Q I am going to hand you what's been entered into evidence as Plaintiff's Exhibit 11 -- or the court officer will do the handing.

And I think your particular notes have been turned -- you see it's turned sideways? So, hopefully, that will be able to aid you more readily.

COURT OFFICER: (Handing).

THE WITNESS: Thank you.

Q So, Dr. Simela, you have in evidence -- before you rather, what's in evidence as Plaintiff's Exhibit 11, the Rehabilitation Medicine Center of New York records.

Is that the practice you were affiliated with back in 2019?

A Yes.

Q Have you had an opportunity just to identify your particular office note for when you first encountered Mr. Urquia?

A Yes.

Q All right. So, if you need to reference your note, just let us know that you're doing that, okay?

What was date that you first met Mr. Urquia?

A In reviewing my note dated September 17th of 2019, that

appears to my initial evaluation.

Q Okay. Can you tell us what you did at the initial evaluation with Mr. Urquia?

A As I do with most of my initial evaluations, I start with taking a history of the actual injury.

Q Can you tell us what a history is?

A Certainly. A history is actually the basic tenant of an orthopedic physical exam. It starts by asking the question, how, what, why, when, and where, typically.

Q Okay. Why is that as you put it, a tenant of orthopedic surgery?

A Because for the most part, the patients that I care for have been injured and understand the timing, mechanism of that injury is wildly important to determine whether or not surgery is appropriate.

Q What was the history you took from Mr. Urquia that day?

A He gave me a history that he was working in construction, when metal beams toppled upon him.

Q Did he give you an indication as to when that had occurred?

A That did occur while he was at work.

Q The particular timing of it, the date?

A Per my note that I am referencing, December 27, 2018.

Q Following the taking of the history of Mr. Urquia, what was the next step you took in that initial evaluation?

A Once I have what we call the present history, I then look at the past history to determine if there were any other previous injuries to the particular body part or region.

In this case, that's called a past medical history and a past surgical history.

Q Well, what body parts were you addressing in that initial evaluation with Mr. Urquia?

A He was referred to me specifically for consultation of the cervical spine, the neck.

Q Okay. Were you aware, just generally speaking, if there were other body parts that he had injured in that accident?

A Typically, I will reference any other notes that I reviewed, whether physical therapy notes or other clinicians. So, there my be actual other sites of injury, but my focus that day was the neck.

Q Okay. You had told us that you specialized in spinal surgery.

Do you regularly treat patients for other type of orthopedic injuries or do you leave that to other specialists?

A I still do a fair amount of sports medicine and arthroscopy.

Q What was the past history that you had obtained from Mr. Urquia?

A Based on the records that I am referencing in front of

me, there was no significant past medical history.

Q What is the significance of that finding or indication?

A Meaning that he did not sustain a previous injury to the body part that I was seeing him for.

Q Why does that matter to you as a spinal surgery?

A Well, as a surgeon, if a patient had a previous injury to, for example in this case, the neck, I would need to know, did he have previous surgery. It could certainly alter my decisionmaking process.

Q What was the next step you took in your initial evaluation?

A Following just the overview of the history and medications, I then conducted a physical exam.

Q Okay. What did that entail?

A Physical exam primarily focused on the cervical spine included palpation, which is actually touching the patient; range of motion testing, which involves moving the associated limb through its normal position to determine if there's any restrictions; and lastly, a neurologic exam.

Q So, when you say palpation, you touch the patient, what are you looking for when you do that?

A Specifically when you're feeling for the cervical spine, you are looking for any signs of tension. That would be muscle spasm, any focal areas of pain, specific, or any open injuries, for that matter.

Q What's an open injury?
A I treat a patient that has a huge laceration or sort of a defect in the muscle.
Q Okay. When you palpated Mr. Urquia that day, what did you find, if anything?
A Based on my physical exam findings of that day, he did have a muscle spasms, which was noted on the right side with tenderness.
Q What does tenderness mean?
A When I pushed, he had pain.
Q What other testing did you perform at that point in time?
A Range of motion of testing was performed.
Q What did -- you mentioned earlier associated limbs. What does that mean?
A Meaning if you touch or move a certain part of the body, if the patient expresses concern that the pain is traveling, for example, down the arm, that is indicative of neurologic findings.
Q And what was the result of the range of motion testing for Mr. Urquia that September day?
A Based on the records that I have in front of me, he had reduces range of motion, particularly in cervical flexion, which is bending the neck forward.
Q Can you demonstrate -- you talked about cervical

flexion. When we are using the word cervical, what part of the body are we talking about?

A So again, we are referencing the neck primarily. Flexion would be bending the neck forward. Extension would be pulling your head up above your eye limit.

Q I believe your record indicates a particular measurement of that range of motion?

A Yes.

Q First of all, how do you measure range of motion?

A There's a special device called a goniometer and unfortunately I don't have one with me today. But if you could imagine a protractor or something that you would use in elementary school to determine the degrees of flexion or degrees of freedom, that's a similar device that we use.

Q And you had said there was reduced range of motion for Mr. Urquia in his cervical spine?

A Yes.

Q Did that -- was that of any significance to you?

A It does. Typically if someone has reduced range of motion in a setting of trauma, there means that there is something that's either irritating the spine or restricting the spine.

Q After performing the range of motion testing, did you do anything else in terms of evaluation?

A Yes, I did.

Q What was that?
A A neurologic exam.
Q Okay. Now, we've heard a little bit about -- well, very little rather, about the field of neurology.
Can you tell us what that is?
A Certainly. The nervous system, which is the function of your brain, gives off your spinal cord, which then branches into various nerves. Those nerves have a corresponding function. For example, if something is warm or cold, you sense that because your nervous systems detects sensation.
If you are able to move your arm, your hands, you are doing that because your brain is using a nerve specifically motor nerve to actuate that function.
So, the nervous system essentially allows you to walk, eat, speak, drink, the large majority of your bodily functions.
Q In what way does neurology and the nervous system come into play within the field of orthopedic spine surgery?
A In this case, as a spine surgeon, if there is something that's causing an impediment or a block to the nervous system, it's typically going to be either a soft tissue compression or, in fact, a fracture, something causing a physical block.
My job as an orthopedic spine surgeon is to basically be the construction worker of the spine to remove or repair it.
Q What were the results -- withdrawn.
When you performed a neurological exam, what did that

involve?

A In this case, a sensory exam. So, essentially, I touched all of the parts of the body that offer complaints. I try to narrow down if there's a specific nerve that's causing these issues. We call that a dermatome.

So, for example, anything that is in the hand, forearm, and upper arm are controlled by the cervical nerves.

So cervical nerves two through seven control the functions of the upper arm.

So, if I touch on the side of arm, specifically over the biceps tendon, I know that's the C5-6 dermatomal region.

Q Doctor, you see -- I got a little bit of model here on the counsel table.

Would the use of that model aid you in your testimony with the jury here today?

A Yes.

Q Okay.

THE COURT: Mr. Brennan, before you use the model, I want to instruct the juror on use of what we call demonstrative aids during a trial.

It is not evidence, okay? It's just to help a witness explain what it is they are testifying about.

This is not a -- this model is plaster or plastic, okay?

And again, this is not something that is submitted

into evidence.

This is not a model of the plaintiff's spine himself, okay?

Again, it's what we call a demonstrative aid. It is not evidence. So, I just want you to keep that in mind during the testimony, okay?

Go ahead, Mr. Brennan.

MR. BRENNAN: Thank you, Your Honor.

Can we have it marked for ID purposes? I think we are up to 21.

THE COURT: Okay.

MR. BRENNAN: And once that is done, if the officer wouldn't mind just handing the model up to the witness.

THE COURT: Sure.

(Whereupon, demonstrative aid was marked as Plaintiff's Exhibit 21 for Identification.)

COURT OFFICER: (Handing).

Q Dr. Simela, you were mentioning some anatomical terms a moment ago, dermatomes and corresponding nerves. Does that model contain any reference to what you were discussing a moment ago?

A Yes.

Q So, can you -- you talked about putting Mr. Urquia through a neurological examination. Maybe utilizing that model can help illustrate what you did that day.

A Certainly. As I mentioned, each nerve has a corresponding function throughout the body. The first seven vertebral body bones, essentially, of the cervical spine all have a small hole on the side, one on the left, one on the right. Through that hole, which we call the foramen, are the exiting nerve roots.

If there's compression against one of these nerve roots, it will manifest in terms dermatome.

So, for example, just picking between numbers four and five --

Q I apologize for interrupting you. I should have asked a broader foundational question. I told you that it's a demonstrative aid, but maybe it would be helpful if you just tell us what we are looking at broadly?

A This is a plastic model of the entire spinal column.

First seven to eight vertebra are the cervical, the middle 12 are the thoracic, and the lower five are the lumbar vertebral bodies.

Q Thank you. So, you were talk about the foramen and the exiting nerve roots.

A Of the cervical spine. I just picked the random numbers four and five. The plastic piece that you see here, that represents the exiting nerve root.

Q What were the results of your neurological examination of Mr. Urquia on September 17th of 2019?

A Based on referencing the records I have before me, his neurologic exam did reveal that his strength was intact and that he was -- let's see. Overall, neurovascular intact.

Q What does that mean to be neurovascularly intact?

A Meaning that while has pain, there's not an overt block of the nerve resulting in paralysis or floored weakness of that muscle group.

Q Did you -- by the way, did Mr. Urquia have any vocalized complaints during that visit?

A Yes.

Q What are those?

A He offered complaints of right sided discomfort.

Q Okay. Did you review anything else during that initial examination?

A I did.

Q What was that?

A I reviewed an MRI.

Q Okay. From where?

A An MRI from Lenox Hill Radiology.

Q What was that MRI taken in relation to your visit with Mr. Urquia?

A Referring to my note, it appears as though that MRI was dated February the 12th of 2019.

Q And what was the purpose of reviewing the MRI?

A Similar to a physical exam, reviewing the records or

images or diagnostic studies can help formulate a diagnosis.

Q We have that MRI here in evidence. We are going to talk about it in a second.

But just from your records and your notes, can you just tell us what your review of that MRI revealed?

A Certainly. Based on the records that I have before me, I reviewed the MRI and it showed -- or revealed cervical disc herniation.

Q Okay. Can you tell us -- first of all, what a disc herniation is?

A Sure. What I'll do is just explain exactly what a disc is and where it's located in the body.

In between the bones of any portion of the spine, there's a cushion. That cushion is called a disc. I like to describe the cushion as a small jelly donut because it's soft but on the inside, there is a substance and it's consistent with jelly.

When that substance makes it's way out of the donut, typically in a young person via traumatic method, an older person for different reasons, that's what we'd describe as a disc herniation.

Q How does a disc herniate.

A Essentially, a small hole that occurs somewhere throughout the disc and the material inside leaks out.

Q And in your experience as an orthopedic spine surgeon,

just generally speaking, what could be the various causes of a herniation?

A Certainly. Typically in a young person, if you do detect a disc herniation, it's from traumatic injury.

Q When you say a young person, does that have a medical definition?

A Not really, but there is sort of a line. If someone is less than middle-aged, I describe that as a young person.

Q Okay. Do you recall what Mr. Urquia's age was at the time you met with him?

A He was mid thirties -- early thirties.

Q So, where would he have qualified in terms of young or middle-aged?

A He qualified as a young person at that time.

Q Okay. Why do you say typically a young -- if you determine or see a herniation in a person of that age, it's -- what was the phrase you used a moment ago, what causes a herniation in a young person?

A Typically a traumatic injury.

Q So, why do you say that it's -- herniations in young people are typically traumatic in nature?

A Because over time, through wear and tear, you can develop disc herniations, but they're usually associated with osteophytes or bony formation. That's typically in someone that's a little but more mature. Let's say someone in their

sixties, seventies, eighties.

Typically people that are less than middle-aged, you won't find osteophyte formation, and the disc is usually intact.

Q Are you familiar with the phrase, degenerative disc disease, or disc degeneration?

A Yes.

Q What does that mean?

A That's a phrase that we typically use to describe arthritis of the spine.

Q How about degeneration in general? Does that term work its way into the medical field?

A It does.

Q Where would it apply in the field of orthopedic spine surgery?

A Typically once a joint is worn out over time, we typically use that term as a catchall phrase to describe when two bones are impacting against one another.

Q Now, you had used a phrase or a term a moment ago of osteophytes. What's that?

A Osteophytes is what we call a bridging bone. So essentially, when two bones come into contact with each other, they tend to come and connect via another bridging bone.

Q And where do you typically see something like that?

A Typically, you see that in someone above seventy in the cervical spine or lower lumbar spine.

Q How about somebody who works in the field of construction, a pretty heavy physical field?

A It would take several cycles and several years for that to happen. So, typically, somewhere at the end of their career, you would see that.

Q In addition to the -- well, what was the significance of observing herniation at the C5-6 level on that cervical spine MRI?

A Well, most of his symptoms did occur in the upper extremity. As I mentioned, anything that's above the C-7 vertebral body corresponds directly with again the upper arm, forearm, hand.

Q Did you review any other records or materials at that initial visit?

A Yes.

Q What was that?

A A diagnostic EMG.

Q Can you tell us what a diagnostic EMG is?

A Going back to the description of the nervous system and dermatomes, a diagnostic EMG is a nerve needle that's placed into the muscle belly to determine if there's any alteration in the nerve itself.

Q And I want you to assume that there was testimony yesterday from Mr. Urquia that he had undergone some needle testing with a Dr. Hausknecht.

A Okay.
Q Would that be what an EMG would involve?
A Yes.
Q What did you learn from reviewing that diagnostic EMG study?
A From my standpoint, the diagnostic EMG was positive, meaning there was irritation of the spinal cord at a particular dermatomal level.
Q And what does the term cervical radiculopathy mean?
A That's the clinical diagnosis of that nerve irritation that we just described.
Q And at what cervical level was there positive finding?
A At the C5-6 vertebral level.
Q So, did the confirmation on that diagnostic EMG have any significance to you in conjunction with your physical examination of Mr. Urquia, as well as your review of the MRI?
A Yes.
Q What was that?
A The findings were concordant. The radiculopathy was occurring at the same level of the disc injury and the disc herniation.
Q Based on everything you've reviewed, your examination of Mr. Urquia, and your own expertise, did you form any opinion at that initial visit with Mr. Urquia about course of treatment?
A I did.

Q What was that?
A Mr. Urquia, based on my impression, had symptomatic cervical radiculopathy. He was seeing me for cervical consultation having failed conservative care. My decision at that point was that he would benefit from surgery.
Q You mentioned in that answer that he had failed conservative care. What does mean?
A Typically patients are not referred to me outside of the hospital setting unless they have completed a course of physical therapy. Typically they've undergone some form of pain management. In this case, he had done both.
Q Okay. And the form of pain management he had undergone, what did that involve?
A Epidural injection.
Q What is an epidural injection?
A An epidural injection is quite frankly putting the medication or an anti-inflammatory steroid right against the nerve to try to shrink that herniation, to try to reduce the compression against the nerve.
Q How is that actually performed?
A It's a procedure typically done under some form of anaesthesia by a pain management specialist, where they actually localize or find that area of the spine and place a needle right against that area of the spine itself and inject the medication.
Q When you say that Mr. Urquia had failed that course of

treatment, what does that mean?

A It mean that he had multiple injections and had not had complete relief in his symptoms.

MR. BRENNAN: Okay. I think we're okay with the model for now. Thank you.

THE COURT: Are you going to be using it again during the Doctor's testimony?

MR. BRENNAN: No, I don't believe so.

THE COURT: Kyle, do you mind grabbing it?

We'll put it on the floor behind the table, please.

MR. BRENNAN: Thank you, Your Honor.

THE COURT: Okay, Counsel, you may continue.

Q Dr. Simela, when was the next time that you saw Mr. Urquia?

Before we even get to that question, did you have a discussion with Mr. Urquia at that initial visit about your recommendation?

A Yes.

Q Tell us what that conversation entailed.

A My recommendation is that he undergo cervical spine surgery.

Q What kind of surgery?

A Specifically, a cervical fusion.

Q What does a fusion mean?

A Fusion is a procedure by which we remove the disc in

its entirety, that is the injured and damaged disc and replace with prosthesis.

Q And when you had the conversation with Mr. Urquia aside from the describing the surgery itself, do you have any other discussions with him about the surgery?

A Yes. A lengthy discussion about the risk and benefits of surgery.

Q Tell us what that conversation involved.

A That's typically a very serious conversation. When you offer someone a surgical solution, it is within mind the risks that can occur. There are large vessels, both blood vessels and nervous vessels, that traverse the neck. At any point, those could be injured. There's a risk of paralysis if the spinal cord gets injured. There's a huge risk of infection.

All these things have to be discussed with the patient in great detail before proceeding with surgery.

Q Did Mr. Urquia ultimately elect to undergo surgery?

A Yes.

Q Now, just to make this timeline make sense. When was it that you performed this surgery?

A Let me look up the exact date.

Referring to the records in front of me, the date of surgery was January 16, 2020.

Q Between that initial visit of September 2019 and the ultimate surgery on January 16th of 2020, did you visit with Mr.

Urquia on any other occasions?

A Yes.

Q What was the purpose of those additional office visits?

A Mr. Urquia did return to see me one month approximately after our initial meeting. We had a further discussion about surgical treatment.

Q And in each of those subsequent visits with Mr. Urquia, what else would occur during the time spent in the office?

A A physical exam.

Q Okay. And just generally speaking, what were the results of those additional physical exams?

A Referencing the records in front me, his physical exam findings were essentially the same throughout.

Q Okay. What were those general findings have been?

A Pain with range of motion, reduced range of motion.

Q I see reference to a couple of tests in here, one is Spurling and is Hoffmann.

A Both of those tests are physical exam tests used to determine where the symptoms are coming from. Spurling is a test specifically where you compress the head and neck, and you rotate the spine. If the patient complains of pain, that is a positive result. So essentially, loading the spine and seeing if that nerve is affected.

Q And what was the result of the Spurling's tests on these various office visits with Mr. Urquia?

A Always positive.

Q Tell us what a Hoffmann's test involved.

A Hoffmann is actually Hoffmann Sign. The pure definition is Hoffmann Sign.

It involves essentially tricking the fingers by forcibly putting them to a flexion moment.

If the nerve is traumatically injured or essentially not going to recover, your reflexes will cause your index finger, your thumb to move abnormally. That would be positive test. We call that myelomalacia or cervical myelopathy.

Q Did Mr. Urquia demonstrate any positive Hoffmann Signs?

A No.

Q You are talked about testing for the nerve and whether it would be a permanent injury. What is the significance of looking for that?

A Well, essentially, the goal of surgery is to try to prevent permanent injury. We want to take the pressure off the nerve because catastrophic injury can occur when the nerve is compressed for far too long, essentially.

So Hoffmann Sign is typically positive when the nerves are being compressed for a very long time and the patient is myopathic.

There are other signs that go along with that, an altered gate, ataxia, a number of different things.

He did not exhibit those signs at that time.

Q When you spoke with Mr. Urquia about the positives of the surgery what did you discuss?

A I discussed that we want to preserve neurologic function. We don't want him to become myopathic.

Q And did your opinion and recommendation for that cervical fusion surgery persist throughout those additional office visits before the surgery?

A Yes.

Q Where was it that you performed the operation of January 16, 2020?

A It was at Hudson Regional Medical Center.

Q Okay.

MR. BRENNAN: Let's do this. Can we mark for identification as Plaintiff's Exhibit 22?

Q Doctor, have you had an opportunity to review a medical illustration prior to today's testimony?

A Yes.

Q An illustration generally depicting a what a cervical fusion surgery entails?

A Yes.

Q Would utilizing that illustration -- again -- not again.

Is it an actual illustration of -- like a contemporaneous illustration of the surgery you performed on Mr. Urquia?

A No.
Q No, was it created then --
A No.
Q -- or was it created for the purposes of this case?
A It was created for the purposes of this case.
Q Would utilizing though that illustration help you explain what the procedure involved to this jury?
A Yes.
MR. BRENNAN: So, Your Honor, with permission and just with that expressed understanding it is being used for demonstrative purposes only, permission to have the illustration marked for identification?
THE COURT: Can we show your opposing counsel?
MR. BRENNAN: Sure. I mean, it's been previously exchanged but I'll show it again.
THE COURT: Okay. Mr. Gilroy and Mr. Showers, are you okay with demonstrative purposes only?
MR. SHOWERS: Yes.
MR. GILROY: Yes.
THE COURT: We will have that marked as Plaintiff's Exhibit 22 for identification only.
Members of the jury, I will just instruct you again. This is for demonstrative purposes only and this not a piece of evidence to be considered during deliberations.
(Whereupon, demonstrative aid was marked as

Plaintiff's Exhibit 22 for Identification.)

MR. BRENNAN: Judge, I'm going to first note for the record that through the use of my laptop and some incredible fancy technology, I am projecting on to the screen images from what's been entered in evidence, Plaintiff's Exhibit 17 Lenox Hill Radiology records.

And with the Court's permission, I would ask the witness to step down and utilize the laptop, which is being mirrored on to the television here in the courtroom to explain and to elicit further testimony.

THE COURT: Okay. Any objection, Counselors, for the using of the laptop by the witness down in the well there?

MR. SHOWERS: No, Your Honor.

MR. GILROY: No.

THE COURT: Okay. I'll confirm too. That was Lenox Hill Radiology reports and films were entered as number 17. That's what's on the screen.

Doctor, it's a very tight well so please be careful when you are navigating, okay?

MR. BRENNAN: What I am go to do, if that's okay, is essentially switch positions so I can maintain at a microphone and have the doctor sit here.

THE COURT: That's fine.

Q Dr. Simela, on direct examination a few minutes ago,

you talked about reviewing a cervical MRI taken of Mr. Urquia during your initial consultation with him.

Do you recall that testimony?

A Yes.

Q Can you tell us what we looking at the screen here?

A Sure. Without boring you with all the huge details, this is an MRI scan of the cervical spine.

An MRI, just to give you context, is -- it stands for magnetic residence imaging. It's an essentially a large-board magnet that causes the cells in your body to spin in a certain direction.

Abnormal findings show up in a reverse spin. Essentially, they show up on a digitized image.

Q And is this a particular MRI study we are looking at?

A Yes, this is of Mr. Urquia and this is a sagittal image and axial image of the cervical spine.

Q I see a date there reflected on a couple occasions of February 12, 2019.

A Yes. This was the date the image was obtained.

Q So, just referencing your own records, this is the same MRI you were looking at during the initial consultation with Mr. Urquia?

A Yes.

Q Okay. Walk us through what you were reviewing and what, if any, significant findings you observed in those MRI

film studies.

A Certainly. Looking at the sagittal image. Just to reference, this is the brain up top. This gray matter line coming down is the your cervical spine. The bones of the spine are represented by this other darker gray material. The intervertebral disc is represented by the sort of odd shaped circular structure in between.

The specific herniation I reviewed or noted was between C5-6. So we'll count down the bones. One, two, three, four, five, six.

And if you take a look right here, you can see this little point, maybe difficult from there. That's the actual rupture of the herniation of the disc.

So, on the sagittal image, you could see the disc is herniated; but the confirmation is now on the axial image.

So on this sagittal we are looking at his face and across. On the axial images, we're actually looking through the spinal cord. So here is the same herniation just a different point of view. (Indicating).

Q You used the term, rupture, a moment ago.

A Yes.

Q Why do you use that particular word?

A Because there's a hole in the disc and the material, that jelly substance is now extruding or coming out of the disc.

Q So, did you observe that extrusion on these particular

images?

A Yes.

Q Why did you -- what's the significance of the multiple views when you're forming an opinion and a diagnosis?

A They're confirmatory because you can see it on one view but perhaps, it may be biased left or right on another view.

Here, it's essentially central, maybe what we call paracentral, where it's sightly off to the left. But it's essentially a central herniation.

Q What's the significance of that finding?

A You can have bilateral arm symptoms.

Q What -- I don't want to take anything for granted. Doctor, bilateral meaning what?

A Oh. Both arms can be become symptomatic.

Q Were there symptoms that you had observed during your examination of Mr. Urquia?

A Yes.

Q When you looked at the film that day, what significance did that hold for you?

A Essentially he was a good candidate for a fusion, because all the other vertebral discs were in good shape and intact, essentially, except for this C5-6 disc.

Q What I am going to do now is just very briefly switch over to a projection of what's been marked for identification as Plaintiff's Exhibit 22. And then I'll ask some questions.

MR. BRENNAN: Just a brief moment, Your Honor.

THE COURT: Sure.

Q Dr. Simela, we are looking at a full screen image of what's been marked for identification as Plaintiff's Exhibit 22.

You told us a few moments ago that the use of this illustration would help you in your testimony about the surgery you performed on Mr. Urquia in January of 2020.

Was that right?

A Yes.

Q Okay. I think it might be best if you tell us what we're looking at and kind of guide us through what procedure you performed on that particular day.

A Certainly. The top left-hand image marked A is showing the actual exposure to the spine. So, in order to expose the spine, we have to make an incision, which is a formal cut, along the neck to remove the skin so we can gain access to the muscles.

After the muscles, we go through the different plane of the spine and essentially, we get to this point where we are looking at the actual bones of the spine.

What you're seeing in this image is me using a tool called a bur, essentially. And that bur is used to remove all of the herniated discs.

Q Not to ask an obvious question but during this procedure, is Mr. Urquia awake or sedated?

A He's asleep under general anaesthesia, yes.
Q So, that seems to -- you've walked us through what's labeled as portion A. I guess B would be next.
A B is going to be the axial version. Sort of this -- looking through the spine. It depicts how we actually get all the way down. So, we are drilling out all of this material so we can gain access to the spinal cord itself.
Q When you say drilling, is it what we all think of that word?
A I'm a construction worker of the spine, yes, it's a drill.
Q Why do you need to drill into any bone?
A That's how we remove it. So, once the bone of the spine is removed, we gain access to the posterior longitudinal ligament, which is where that herniation was located.
The herniation was right on top of the spine, pushing down on the spine causing compression.
Q Okay. Now, when you walked us through the model earlier, you talked about the nerve-root endings passing through an opening in the bone?
A Yes.
Q Was there any nerve relationship to the herniation in this particular patient?
A Yes.
Q What was that?

A The nerves are not well represented on this diagram but they exit left and right. So, you could tell the herniation was sort of in the middle but biased towards the left side more so.

Q Now, when you are performing this examination, you described opening up the front of the neck. Are you visualizing this with your own two eyes?

A Yes. We use a microscope to see the finite details within the spine.

Q So, when you opened Mr. Urquia on the date of his surgery, did you make any personal observations about that herniation you had observed on the MRI film study?

A Yes.

Q What'd you see?

A We saw a herniation beyond the posterior longitudinal ligament pushing on the spine.

Q What would be the next portion of the procedure?

A Following through -- from B to C, we're now just clearing all the cartilages material or the remnant disc, because we have to remove it in its entirety. So, that's C.

Coming to D, we are now actually putting in that prosthesis that I mentioned to you earlier.

This is the prosthesis or artificial disc, for lack of a better word.

Q Why do you need to replace the removed disc with a prosthesis?

A If not, the spine would collapse on itself.
Q If the spine were to collapse on itself, what's the significance or risks thereof?
A Catastrophic failure. He would be paralyzed.
Q Okay. It looks like there's imaging above the prosthesis. What's going on there?
A We put screws in to distract -- or open that space so we can get to the actual spinal cord.
Q Okay, thank you. Maybe tell us what the last portion of the illustration is.
A The last portion is, in order to actually fix the prosthesis in the disc space, we actually have to anchor it in with screws.
Q So like you told us about a drill before. When you say screws, what kind of screws are we talking about?
A There are 14 millimeter and 12 millimeter medical-grade screws.
Q What does it mean to be medical grade?
A They're made out of titanium.
Q Were there any come applications or issues with the procedure of Mr. Urquia that day?
A No, that day things went straightforward.
Q Anything else about this illustration that would help you with your testimony, or do you think we're done?
A I think we're done.

MR. BRENNAN: I'll take that down in a moment.
THE COURT: You want the witness back on the stand?
MR. BRENNAN: Yes.
THE COURT: Okay. Doctor, step up.
Counsel, will you be using this during any --
MR. BRENNAN: One more, but not at this moment.
THE COURT: Okay, so why don't we take the demonstrative aid down until you use it again.
MR. BRENNAN: Yes, Your Honor.
THE COURT: Then Counselors, if you want to move back over to the defense table.
And Kyle, can I have you slide this back a little bit so that way Mr. Gilroy and Mr. Showers can see?
Is that better, Counselors?
MR. GILROY: Much better.
MR. SHOWERS: Yup.
THE COURT: Thank you very much.

Q Doctor, the particular type of surgery you performed on Mr. Urquia that day, does that involve any sort of admission to a hospital?

A Yes.

Q Is that what occurred in this case?

A Yes.

Q What's the purpose of admission to the hospital as opposed to what we commonly understand to be an out-patient

procedure?

A Because he underwent general anaesthesia and needs to be monitored for at least a 23-hour period, we have to admit him to the hospital formally. We cannot send him home.

Q Okay. And I think you told us before, no particular issues or complications with the surgery?

A Correct.

Q All right. So, what did you do with your patient following the successful completion of that cervical fusion surgery?

A He stays in the hospital overnight. If he's able to eat, drink, and swallow appropriately the following morning, we send him for discharge.

He was discharged home and I do believe he followed up with me typically within 10 to 14 days post-operatively.

Q Did I happen to take away the exhibit or is it still up there?

A Yes.

Q So, when was the next time you saw Mr. Urquia?

A His initial post-op visit was on February 4th of 2020.

Q Okay. What did you do with -- where was that visit held?

A In the office.

Q And what happened at that visit?

A Typically, we check the wound, make sure that there's

no sign of infection. We check the neurologic system to make sure that there's no failure or problem with his neurological system as well.

Q Any issues with the surgical wound?

A Referencing my notes, no.

Q This would be the wound on his neck?

A Yes.

Q Tell us what other examination and information you took from Mr. Urquia at that first visit -- that first post-op visit.

A The key with the first post-op visit for anyone after neck surgery is, are they able to speak.

One of the anatomic key points that was not shown in the illustration are the vocal cords. There's an uptick or a chance of paralysis of the vocal cords. So in my notes, I always -- if appropriate mentioned, that he's able to eat, drink, and speak well.

Q That would have been a risk of the procedure?

A Yes.

Q At that first post-operative visit, anything else that you are particularly focused on?

A Pain control, typically, as well.

Q And had Mr. Urquia been provided with any medication following that surgery?

A Yes.

Q What was the medication?

A Typically percocet.
Q Okay. I think we have a lay persons understanding of percocet, but where would it come into play in the context of postoperative pain manage?
A Postoperatively after you have surgery, it can be very painful. Opiates are probably the most common post-operative medications that patients require.
Q What's a typical length of course your patients take postoperatively?
A A week or two.
Q Okay. Any issues -- any particular issues with any post-operative pain of Mr. Urquia complained at the first visit?
A No, standard.
Q Okay. What was your recommendation at the end of that visit?
A That he was going to follow up with me in about two weeks, and at that point we would determine if he was going to start post-operative rehab.
I also put all the patients after cervical spine surgery in a collar. So, he was going to see me back in two weeks for removal of that collar.
Q When did you -- first of all, was Mr. Urquia placed in that collar?
A Yes.
Q What kind of device are we talking about? Not what I'm

wearing on my shirt collar, right?

A It's a rigid collar to avoid, while the spine is healing, to stabilize the spine.

Q What's going on, anatomically and biologically, after those screws are placed and this artificial spacer is placed, what's the body going through?

A The first stage of healing is inflammation, so there's always swelling. The second phase is reparative. Essentially, the cells are now going to integrate with that prosthesis.

Q Did you perform any neurological testing on Mr. Urquia at the first post-op visit?

A Yes.

Q What were the results of those tests?

A His nervous system was functioning. We do a brief nervous system exam. Because he's in the collar, we don't check range of motion. We just simply assess if he's able to move the limbs and if he feel sensations.

Q When you are prescribing that kind of collar to a patient, what are the instructions you give to them? Like, how often are they supposed to remove it, if at all, in those first few weeks?

A They keep it on all the time, 24 hours a day.

Q Okay. When was the next time you saw Mr. Urquia?

A Two weeks later.

Q Do you have that note in front of you?

A I do.
Q Anything significant about that visit?
A His incision was healing appropriately. He was still taking pain medication. And we started him in physical therapy.
Q So, this would be a visit from February 18th of 2020?
A Yes.
Q A little over a month or so after the surgery?
A Yes.
Q What was the significance of him still being on pain medication at that -- that far removed from the procedure?
A He was having post-operative pain. It's not atypical to have post-operative pain.
Q Were you make anything recommendations at that point in time to resume any conservative treatment?
A Post-operative therapy.
Q Can you tell us, generally what's the significance of and importance of post-operative physical therapy following a cervical fusion?
A Essentially when we place you in a collar for upwards of four weeks, all the muscles weakness, potentially stiffen. One of the initial post-operative complaints I would say most patients have is they feel extremely tight and stiff in the cervical spine.
Q Did Mr. Urquia vocalize any such complaints?
A Yes.

Q Did you have any other complaints as you continued to follow with him postoperatively?

A On the 2/18/2020 visit, no.

Q Okay. When was the next time you saw Mr. Urquia?

A The next visit was actually via Telehealth. By then the pandemic was in full effect.

Q So, you weren't able to see patients in person around that time?

A Correct.

Q How were you even conducting Telehealth medicine visits at -- in the first few weeks of the pandemic?

A Yeah, it seems like a blur. But essentially, it was very difficult but he was a post-operative patient and we needed to monitor him. So a lot of this was done by FaceTime, phone calls, sending images of what the wound looked like.

Q In those Telehealth medicine visits with Mr. Urquia, were you able to -- how would you monitor progress or any issues or complaints he might have?

A It was a challenge.

Q Okay. In that first Telehealth visit from March 31, 2020, what, if anything, of significance occurred there?

A He reported pain. I was unable to do a neurologic exam. Just essentially an observational exam.

Q I note that towards the bottom of that particular office entry, there's the review of symptoms section, and then

below that, what appears to be portions of a report that would occur on every single visit.

So, particularly, in neurological, can you tell us -- when you say you couldn't really do neurological examinations, how do you put neurological findings in the Telehealth medicine report?

A As I mentioned, observational. So, raise your hand. He's motor functioning intact. I can't determine sensation or palpate for muscle spasm, but essentially if he could use his arms, his fingers, open and close his eyes, his motor system is intact.

Q Okay. What advice -- or rather, what recommendation did you make at the end of that visit?

A Home exercise program for physical therapy.

Q Why were you recommending home exercises at that time?

A Essentially, patients were not going in for physical therapy so the therapist would do a Telehealth visit as well to go over range of motion exercises.

Q Why would it be important to continue exercises at home when he didn't have access to the physical therapy facility?

A Range of motion is important.

Q What could happen if you don't do those things?

A Stiffness -- profound stiffness.

Q Okay. When was the next time you saw Mr. Urquia?

A Approximately one month later, April 28th of 2020.

Q So, it seems you were seeing him on approximate monthly basis, initially, postoperatively?

A Yes.

Q Why was that?

A Post-operative cervical spine patients require monitoring.

Q For how long would you see a typical patient on a postoperative?

A Four to six months after surgery.

Q As you continued that April visit with Mr. Urquia. was that also a Telehealth medicine visit?

A Yes.

Q Did you ever get to see him in person again?

A Yes.

Q When was that?

A It looks like, based on the records I'm referencing in front of me, June 24th of 2020.

Q Okay. Anything of significance of that visit? Was he still progressing on his post-operative path?

A Yes.

Q When you got to see him in person again, were you performing any additional range of motion examinations?

A Yes.

Q Did you record that examination?

A Yes.

Q Anything of significance from that exam?
A Yes.
Q What was that?
A He did have reduced extension of the cervical spine.
Q Remind us again what extension -- which direction we're moving our head in when we're doing extension?
A We are bringing our head backwards with the gaze above normal plane.
Q Is it common or is it unusual for a patient with a cervical fusion to have reduction in range of motion?
A Unfortunately it's common.
Q Why is that?
A Because you're fusing -- we are connecting those two bones and the result in connection of those bones can result in reduced motion.
Q Is the expectation for those screws and that implantation to remain for the rest of his life?
A Yes.
Q Okay. Why is that?
A Removing them would be very risky and unwarranted.
Q Okay. When was the next time you saw Mr. Urquia?
A Our next visit occurred on August the 12th of 2020.
Q What occurred at that visit?
A A clinical exam. He continued to have reduced range of motion. He was neurovascular intact.

Q Any recommendations for treatment at that point?
A Physical therapy.
Q Did you continue to see him on an almost monthly basis?
A Yes.
Q Moving forward in 2020?
A Yes.
Q I would like to direct your attention to the record from February 24th of 2021. Have you located that particular record?
A Yes.
Q Okay. Did you see Mr. Urquia on that particular date?
A I did.
Q What was purpose of that visit?
A Referencing my notes, dated February 24th of '21, he was now seeing me for low back pain.
Q What you say now seeing you for low back pain, what do you mean by that?
A Essentially he was treating for low back complaints with the pain management team.
Q So, why was he coming to you at that point to discuss anything related to his lower back?
A He had failed conservative treatment for the low back.
Q Was this more of an evaluation-type scenario, like the first time you saw him in September of 2019?
A Yes.

Q Okay. Walk us through what you did at that visit in February of 2021.

A So, in that visit, I was focused primarily on his low back complaints, as well as following up the cervical spine.

Q Any significant examination findings at that visit?

A During that visit, I did not examine his lumbar spine.

Q What was the plan of action following that February visit?

A I was referring him for a trigger point injection.

Q What's a trigger point injection?

A When there's spasm in the muscle, quite often times you can inject the muscle in a particular location and reduce that spasm.

Q How does the trigger point injection differ from the epidural type of injection you spoke about earlier?

A Trigger point injections are specifically for the muscle, unlike an epidural injection, which is more for the spine itself.

Q Okay. Did you follow up with him about his lower back --

A Yes.

Q -- after that February visit?

When was that?

A April 21st of '21.

Q Anything of significance that occurred that visit?

A On the clinical exam of the lumbar spine, he did have reduced range of motion and muscle spasm.

Q Again, this spasming, is that something he reports to you or can you observe it on your own?

A You can feel muscle spasm.

Q So, you would have been putting your hands on that portion of his body at that point in time?

A Yes.

Q How was he dealing with recovery from his cervical spine fusion at that point in time?

A His range of motion was somewhat increased from the previous visit.

Q Was it still reduced overall?

A Yes.

Q Is that something at that point in time -- over a year after the operation, what would be an expectation be about his ability to regain range of motion in the future?

A Well, following the fusion, you ultimately never regain full range of motion. You can have incremental gains, but you certainly will never get back to full range.

Q What are things that you can do to help potentially get incremental gains?

A Physical therapy.

Q I want to direct your attention now to the September 8, 2021, visit. We're skipping a head a little bit.

What occurred at that visit?

A During that visit, he described complaints of low back pain. There was an also an MRI of the cervical spine ordered.

Q And did you have an opportunity to review the cervical spine MRI?

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

Q Just at that visit, did you --

A It looks like it was pending.

Q I'm talking about the September 8th of 2021.

Are we on the same page here?

A Oh, the lumbar spine MRI was present. You're referring to the lumbar or the cervical?

Q My apologies, Doctor.

What were you able to review in the office that day?

A MRI of the -- my apologies. I think it's an MRI of the cervical spine with hardware in place, and then the lumbar spine MRI as well.

Q Now, directing your attention down to the planned portion of that office visit in September '21, what was the plan at that point?

A I made a recommendation for endoscopic discectomy me with Dr. Perez.

Q Tell us what an endoscopic discectomy is.

A An endoscopic discectomy is largely a pain management procedure where if the herniation is small enough, they're able

to remove it via a needle.

Q Why would that be something you'd refer to someone like Dr. Perez, as opposed to performing yourself?

A It's a less invasive procedure.

Q Were you making that recommendation for a particular level of the spine?

A Based on the records in front of me, he had multi-level herniations in the lumbar spine, L4-5, L5-S1.

Q Okay. You said something interesting a moment ago, that that kind of procedure, the less invasive procedure would be recommended when there's a smaller herniation?

A Yes.

Q So reflecting back on the C5-6 herniation that you had observed on those MRI studies for Mr. Urquia, can you compare the two?

A The cervical spine, the disc is actually much smaller. So, even if you compromise 15 to 20% of it by way of herniation, the disc is not functional.

The lumbar spine disc is a lot bigger and more robust, so a 10% herniation is going to be a lot easier to take out without ruining the entire disc.

Q Do you know if he ever underwent that particular procedure?

A I do not.

Q Okay. Did you see Mr. Urquia any further at that

particular practice?

A I do not believe so.

Q Okay. Have you seen Mr. Urquia since 2021?

A Yes.

Q When was that?

A I did have a chance to see him on, I think March the 6th -- excuse me, March the 8th.

Q Of what year?

A Of 2025.

Q Okay. Was that in part because we had this event coming up?

A Yes.

Q Tell us about what occurred in the visit with him in March 2025.

A During that visit, I did take an updated history to determine if he had any intervening accidents or traumas. He did not.

I did ask him about his pain and he was experiencing pain in the neck.

Q Did you also perform a physical examination?

A Yes.

Q What did that physical examination reveal?

A It revealed he had restrictions of flexion in the cervical spine, as well as extension. So again, bending forward and bending backward.

Q When you say restrictions, we talked about loss of movement. Is it compared to anything as a general standard?

A Yes. There's a customary norm for range of motion. So, when I say a restriction, he deviates from that customary norm.

Q Okay. Dr. Simela, do you have an opinion within a reasonable degree of medical certainty as to what caused the herniation and radicular symptoms and other neurological symptoms to Mr. Urquia's cervical spine that you operated on in January of 2020?

A Yes, I do.

Q In your opinion to a reasonable degree of orthopedic spine surgery, what is it?

A In my medical opinion, based on the history given, the MRI findings, the EMG findings, and my intra-operative visualization of the herniation, I believe in my medical opinion that it was causally related to the traumatic incident that he underwent.

Q At work on December 27, 2018?

A Correct, at work.

Q Okay. Why do you think that's the inciting incident?

A Because he was asymptomatic prior to the injury, and his symptoms did correlate with the physical exam findings and the MRI findings, as well as the diagnostic EMG.

Q Doctor, I want you to assume that on the day of the

accident, Mr. Urquia -- well, we also have them in evidence.

But are you aware that he went to the emergency department on the day of the accident?

A Yes.

Q Just for the purposes of this question. I want you to assume that at that emergency room visit, Mr. Urquia only made complaints of an injury to his right hand. Okay?

A Okay.

Q I want you to assume it's the defendants position -- someone is going to come in here and testify that because Mr. Urquia only complained about an injury to his hand at that emergency room visit, that he didn't injure any other part of his body in his workplace accident of December 27, 2018.

A Okay.

Q Does that opinion change your opinion in any way?

A No.

Q Why not?

A Quite often times the emergency room is exactly it stands for, emergency. And we see patients with distracting injuries all the time.

If there's a laceration, if there's bleeding, that takes precedence.

But quite often when the patient is out that acute traumatic environment, they often start to recall where they're having pain. It's very common.

Q You had used a term a moment ago, distracting injury. What do you mean by that?

A Distraction injury is a medical term that we use to describe what everyone focuses on. When you go to the emergency room, if you have bleeding, that's the focus. If have you some sort of penetrating wound, that's the focus. Then we have secondary injuries. Those are the injuries that typically get recognized afterwards.

Q By the way, did you ever treat Mr. Urquia for his hand injury?

A Never.

Q Okay. Have you had an opportunity to see any photographs related to his injury?

A No actually.

MR. BRENNAN: I'd ask that the witness be handed what's in evidence as Plaintiff's Exhibit 3.

THE COURT: Okay.

COURT OFFICER: (Handing).

THE COURT: Thank you, Kyle.

THE WITNESS: Thank you.

Q So, Doctor, there's been testimony about those photographs about Mr. Urquia, and that they reflect the injury to his hand either immediately thereafter or within the first week or so following the accident.

A Okay.

Q By the way, have you ever treated a patient who's had what you referred to as a distracting injury, and later complains about other orthopedic injuries?

A Yes.

MR. SHOWERS: Note my objection, Your Honor.

THE COURT: What's the objection?

MR. SHOWERS: This is speculative and outside of his direct testimony. Another patient.

MR. BRENNAN: So, Judge, it's defendants' position that because -- they've already argued it. That because he didn't complain in the emergency room, that he didn't have any other injuries.

So, Dr. Simela's experience with what he's already described as distracting injuries and later treating later other injuries is relevant for the purposes of the jury understanding the context of the situation.

THE COURT: I'm going to overrule the objection.

Go ahead.

MR. BRENNAN: Okay.

Q Doctor, if someone comes in here and says, well, because he didn't complain about pain to the neck on the day of or complain about pain to his lower back or right shoulder, does that impact your opinion in any way?

A No.

Q Why not?

A As I mentioned, often times when you're in the emergency room, you are treated for the thing that appears the most urgent.

Q And does looking at those photographs impact your opinion in any way?

A No.

Q Okay. I want you to assume that someone's going to come in here and say that if Mr. Urquia sustained orthopedic injuries to his spine, neck, and back, to the extent that they required surgery, he would have needed emergent medical attention to those body parts on the day of accident. Okay? What is your opinion about such a thought?

A Barring a fracture typically there's no need for an urgent surgical spine surgery.

Q Well, you had talked about the way patients typically come to your practice following what kind of treatment?

A Conservative.

Q Why is it that that's the typical way patients come to you under those circumstances?

A Because the majority of patients get better or improve with conservative treatment.

Very few percentage wise, anyway, patients actually progress to surgical treatment.

Q I want you to assume that multiple people are going to say that the MRI film studies showed no signs of any traumatic

injury. What do you say to that?

A Barring an obvious fracture, whether something is acute or subacute, difficult to say on an MRI.

Q Well, do you have been opinion as to whether the herniation you observed on the MRI is traumatically induced?

A In my opinion, I believe it was traumatic because he did not have symptoms before.

Q Okay. And those symptoms -- what symptoms are you considering when you make that assessment?

A Radiating arm pain, the persistent muscle spasm, and neck pain with reduced range of motion.

Q Now, Doctor, do you have -- in your experience, rather, do you have an opinion about what kind of care Mr. Urquia would need moving forward with respect to his spinal injuries?

A Certainly. I think going forward, he definitely will need to be monitored, annual X-rays possibly, even CT scans will need to be obtained.

Q And why is monitoring important for a patient like Mr. Urquia?

A Similar to the reason he underwent his index procedure, we want to make sure there's no neurologic progression. Early intervention is always the best option.

Q How often would you say those kind of intermittent film studies would be beneficial?

A I think annual X-rays certainly, and possibly if he has

symptoms, possibly bi-annual CT scan.

Q A question I forgot to ask earlier, but I want you to assume someone is going to come in here and say that Mr. Urquia's anatomical complaints, some of the right-sided numbness and sensation he had does not correlate to the cervical spine MRI that you showed us earlier, particularly with the left sided nature of that herniation. Okay?

Do you have any thoughts about that kind of statement?

A I do.

Q Okay, what are those thoughts?

A Yeah, the herniation is what we call paracentral. It was a midline herniation, just slightly biased to the left side, which means it can give you bilateral symptoms.

Q How can you a left-sided herniation give you bilateral symptoms?

A Because it's not purely left sided. It's paracentral, meaning it's in the middle, just slightly skewed to left side and it's positional. It's an MRI.

Q Right. I think that's important to know.

When a patient like Mr. Urquia is undergoing an MRI, how is that test conducted?

A So, when you're going for an MRI, you're supine, so you're laying on your back. So, there's no gravity.

You can't see where something's going to layout because you are flat on your back, so everything falls posterior.

When you're upright and walking and standing, gravity settles and the disc often splays. So, essentially, it's going to touch both sides of the nerve. It's not going to be isolated to one side versus the other, when you are upright and walking.

Q I want you to assume that Mr. Urquia has undergone a shoulder right shoulder surgery by Dr. Capiola.

Have you had patients have overlapping injuries, neck complaints and shoulder complaints?

A Yes.

Q Do you draw any significance from that kind of situation, like Mr. Urquia has?

A It's common if patients have a traumatic injury, to have cervical radiculopathy and some sort of extremity issue as well. We actually call it a double-crush syndrome, is how we describe it.

Q I want you to assume that Mr. Urquia testified yesterday that in addition to the beams coming down on him, about three or four weighing 20 to 30 pounds each, as a result of that incident, he also fell towards his right-hand side contacting a concrete column on his right hand side.

Does that influence your opinion in any way?

A In terms of the cervical spine?

Q Either the cervical spine or just the mechanism of injury here.

A The mechanism of injury is one that would cause

potentially a forced flexion moment or extension moment.

Q Can you tell us what that means, a forced flexion or forced extension moment?

A Essentially if you are avoiding something, you will certainly jerk your neck backwards or forwards, depending on where that object is coming from. That typically is what we call a forceful moment on the disc. So, essentially it squeezes the disc or compresses the disc, resulting in a herniation.

Q In addition to the monitoring of Mr. Urquia moving forward, do you have any recommendation about how often he should see somebody like yourself, an orthopedic spine surgeon?

A Annually.

Q Why so often?

A Because he's at risk. Since he has a prosthesis in place, he's at risk of this prosthesis either dislodging or settling. And he's also at risk of the level above the fusion or below the fusion deteriorating.

Q And why is he at risk for those adjacent levels deteriorating?

A Because the prosthesis doesn't have the same elasticity of modules as the bone. Essentially, the prosthesis is harder than the bone. So it then displays it's force to the next softest object, which would the disc above or the disc below.

Q And considering a man of Mr. Urquia's age, now 41, what kind of concerns do you have with those adjacent levels for the

remainder of his life?

A Well, the literature tells us that adjacent segment disease will occur in 10 to 15% of patients within a 10 year mark. So the older he gets, essentially he's at an increased risk for those levels to go bad.

Q And utilizing your phrasing there, if those levels go bad, what kind of intervention would be necessary at that point?

A Likely -- we can try to control it with injections and physical therapy but ultimately, a significant portion of those patients go onto a revision surgery.

Q What is a revision surgery?

A A second surgery to remove the prosthesis and extend the fusion.

Q So, that would involve more drilling into his bone?

A Yes.

Q What else would that revision surgery involve?

A Multiple levels we may have to go with a plate instead of a standalone prosthesis, which would further reduce his range of motion going forward.

Q What do you mean by a plate? Where would that come into the place?

A Essentially, we're able to replace just one disc with a prosthesis. But as you have to fix multiple discs, you cannot fix it with just individual prosthesis. You have to connect all of those levels, so that's where we start to get into using

plates, which are also titanium and multiple screws.

Q And do you have any thoughts or recommendations about any future pain management? You mentioned some injections as potentially controlling issues in the future.

A Yes.

Q What would that recommendation be?

A I would say if he's symptomatic, it's better to have early intervention. Get into physical therapy and control the pain and the muscle spasm.

Q Okay. If he were to have any sort of surgical intervention in the future, would you also recommend some post-operative physical therapy?

A Yes.

MR. BRENNAN: I have no further questions for the witness at this time.

THE COURT: Okay. Let's take a quick five-minute break to use the restroom.

We will be back and then we'll start cross-examination of the doctor.

Jury is excused.

COURT OFFICER: All rise. Jury is exiting.

(Whereupon, the sworn jurors exit the courtroom.)

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

COURT OFFICER: All rise. Jury entering.

(Whereupon, the sworn jurors enter the courtroom

and take their respective seat.)

THE COURT: Welcome back. You can be seated.

Mr. Showers, we'll start with your cross-examination of the witness.

You may inquire.

MR. SHOWERS: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. SHOWERS

Q Good afternoon, Doctor.

A Afternoon.

Q My name is Andrew Showers. I represent the defendants in this case. I just have some questions for you as well.

A Certainly.

Q Thank you.

How many times have you testified on behalf of Mr. Brennan's firm, Wingate, Russotti, Shapiro, Moses, and Halpern?

A I don't recall if I have actually. If so, maybe once perhaps.

Q One other time?

A Yes. I don't know all the firms but I think that name sounds familiar with one of my other patients.

Q Okay. How many reports have you done for Mr. Brennan's firm, Wingate?

A Probably just one. It would be that patient, if I testified.

Q This is the only report you've ever done?
A No. You're asking for previous patients?
Q How many reports have you done for their office, written reports?
A I haven't done any for their office on this patient, other than my medical reports.
Q Overrule, have you seen other clients of the Wingate Firm?
A I don't think I've seen many other clients. I don't recall many patients of their firm.
Q So, you can't recall one way or the other?
A I don't know anyone specific.
Q Okay. Do you know how many surgeries you've done on clients of the Wingate Firm?
A No. That, I wouldn't know.
Q What percentage of the time you testify on behalf of plaintiffs?
A On behalf of my patients, I'm assuming if they're plaintiffs or defendants, I don't know, but just on behalf of my patients.
Q Okay. You don't have any breakdown as to whether you've testified on behalf of plaintiff's counsels or defense counsels?
A I don't keep records of whose defense or plaintiff. If it's my patient, I'll testify if requested.

Q Okay. As we discussed, you're being compensated for your time today, correct?

A Yes.

Q Okay. And you don't know how many times you've testified in court on behalf of a plaintiff; is that correct, Doctor?

A I don't know -- recall how many patients are plaintiffs versus defendants. If it's a patient of my mine, I'll make myself available.

Q How many times have you testified on behalf of a defendant in court?

A Again, plaintiff or defendant, if it's a patient of mine, I'll make myself available.

Q Okay. Would it be fair to say that testifying on behalf of plaintiffs in courthouses, you've done that numerous times?

A On behalf of my patients, yes.

Q Okay. Would it be dozens of times?

A No.

Q How many times would you estimate?

A I would say over the course of my career that spans 14 years, probably less than 15.

Q And those less than 15 times, they would all be on the side of the person bringing the case, is that right, the plaintiff?

A I don't recall if it's all, but again like I said, if it's a patient of mine, I'm happy to show up and speak on their behalf.

Q Would you say it's majority of time that you testify on behalf of plaintiffs?

A Yes.

Q Okay. Have you ever testified on behalf of a defendant in a personal injury case?

A I don't know if it's a personal injury case, but I've testified on times that I think the person may have been a defendant, but I can't recall specifically.

Q Okay. Would you agree that when you're retained by plaintiff's attorney, part of your role is to support their position as to the injury?

A I disagree with that actually.

Q And part of your role is to support their position as to the need for treatment?

A I disagree with that.

Q Doctor, most of your patients are referred to you by either other doctors or attorneys; is that correct?

A No.

Q Not correct?

MR. SHOWERS: Your Honor, may we discuss the affirmation that we --

THE COURT: Sidebar?

MR. SHOWERS: Yes.

THE COURT: Come on.

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

THE COURT: Back on.

You want to mark something for identification, Counsel?

MR. SHOWERS: Yes, Your Honor.

THE COURT: The document we were just discussing sidebar, I'll have my court reporter mark it as Direct Defendant's Exhibit A for identification.

(Whereupon, 26 page affirmation of Dr. Simela was marked as Direct Defendant's Exhibit A for Identification.)

Q Doctor, is that an affirmation signed by you?

A Yes.

Q I believe it's the first sentence of paragraph six.

Do you see that sentence, Doctor?

A I do.

Q Okay. Does that refresh your recollection that most of your patients are referred to you by various doctors and attorneys?

A Yes.

Q That was affirmed or sworn to by you under the penalty of perjury, correct?

A Correct.

MR. BRENNAN: Objection.

THE COURT: Overruled.

Q And after you're referred a patient --

THE COURT: Mr. Showers, I'm going to stop you right there. Are you done with there piece of identification?

It was a very limited --

MR. SHOWERS: Yes, one more limited question, Judge, and then I will be done with it.

MR. BRENNAN: I understand it's a little improper and requesting a sidebar.

THE COURT: Come on up.

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

THE COURT: Okay, we are back on.

Thank you for your patience, everybody.

Mr. Showers?

MR. SHOWERS: Yes, Your Honor.

Q Hello, again, Dr. Simela.

A Hello.

Q After the referral of this patient, did you have any contact with the Wingate Firm to determine what was needed on this patient?

A No.

THE COURT: Mr. Showers, are you done with this

identification document?

MR. SHOWERS: Yes, Your Honor.

THE COURT: I will have you pass that back to Mr. Showers, please.

THE WITNESS: (Handing).

MR. SHOWERS: Thank you.

Q Your first examination of Mr. Urquia was September 17, 2019, correct?

A Give me one moment to get that. Yes.

Q And on that day, you determined that he needed surgery, correct?

A Yes.

Q And you never looked at the Lincoln Hospital records, correct?

A I don't recall if I looked at them at that time.

Q Well, you never looked at them prior to the surgery, correct?

A I don't recall if I looked at them at that time.

Q Do you see them referenced in any of your records prior to surgery?

A No.

Q Is it safe to assume that you never looked at the Lincoln Hospital records before the surgery?

A Not at all safe to assume.

Q Well, Doctor, you always take a history, correct?

A Yes.
Q Okay. As part of that history, you would review possibly medical records?
A As part of orthopedic spine surgeon history, yes, the relevant records, you are correct, yes.
Q Okay. And you would note that in your records, correct?
A Possible.
Q Well, in order to keep accurate records, you would have to notate what you referred to, correct?
A Accurate records for relevant items, yes.
Q Well, wouldn't a ER record on the date of the accident with respect to the complaints that the plaintiff made, that's a relevant record, isn't it?
A Not necessarily.
Q You wouldn't want to see that record before you operated on somebody?
A I think the context and during when I would like to see that record are different. If it's patient that I'm treating in a hospital that's been admitted, that's one context.
If it's a patient being referred after months and months of conservative treatment, it's a different context.
Q Doctor, there's nothing in your record that says you saw the Lincoln Hospital records before you operated on Mr. Urquia, correct?

A Correct.
Q And in fact, when you saw him, he was taking ibuprofen on the first visit, correct?
A Going through my records, it says, the patient has taken ibuprofen.
Q Right. He was taking ibuprofen when he had pain correct?
A It said the patient had taken ibuprofen. You asked me if he was taking ibuprofen.
Q He wasn't even taking medication when he saw you, correct?
A Again, I don't know what he had taken that day. It just says the patient had taken ibuprofen. I don't know if that's the day or the day before.
Q That's Advil, correct?
A Yes.
Q His pain was being controlled by over-the-counter Advil, correct?
A I don't know if it was being controlled, but he was taking ibuprofen at some point.
Q He wasn't taking any prescription pain medication?
A None that I prescribed to him.
Q That's not reflected in your records, correct?
A Correct.
Q Okay. What is paraesthesia?

A Altered sensation.
Q Where?
A Depends on the context of the body part.
Q Well, in your record of September 17, 2019, you say he denied paraesthesia. Do you see that, page two at the top?
A Yes.
Q Where was that denial of paraesthesia?
A It means he denied it throughout.
Q So, he had no altered sensations in his body; is that correct?
A Correct.
Q And he showed no evidence of acute distress on your first visit, correct?
A Correct.
Q Neurologically, he had no focal defects, correct?
A Correct.
Q And you found him to be, upon examining him, in no apparent distress, correct?
A Yes, correct.
Q He walked normally and unassisted, correct?
A Yes.
Q He had no signs of acute trauma, correct?
A Correct.
Q He was intact to light touch?
A Correct.

Q He had full strength?
A Correct.
Q You rated him as neurovascularly intact, correct?
A Correct.
Q And what's the Spurling maneuver again?
A Spurling maneuver is a form of compression testing.
Q So, you pushdown on someone's head?
A Correct.
Q And if they say pain, then you note it as positive, correct?
A Somewhat, yes, correct.
Q So, that's not an objective test, correct?
A Correct.
Q And can you just tell the jury what's the difference between an objective test and a subjective test?
A Certainly. A subjective test is one in which the patient reports symptoms, but you cannot exactly determine whether those symptoms are positive or not. It's just a report of symptoms.

An objective test is similarly to the MRI, you can determine whether or not there's a herniation, because you can see it.

Q So, the test is positive if the patient tells you its positive, correct?
A Yes.

Q Patient says, I feel pain, then you rate it as positive?

A Yes.

Q That's the same as the range of motion test, correct?

A No. There's actually a measurement with range of motion.

Q Well, the range of motion is, I feel pain, and you tell them to stop when they feel pain, correct?

A Depending if you're taking passive or active range of motion. There's a difference.

Q Well, if it's passive, they're doing it themselves; is that correct?

A That's active, if they would be doing it themselves.

Q And you tell them, don't strain yourself. When you have pain, stop, right?

A Yes.

Q So, they're telling you essentially what the range of motion is, based upon their subjective feeling of pain, correct?

A There's a subjective component.

Q Okay. When you evaluated Mr. Urquia on the first occasion, did you find out what his hobbies were? What his interests were? What sort of sports he engaged in?

A No.

Q Okay. Did you know he played soccer for money?

A No.

Q Did you see the films -- you say imaging available for my review today.

Did you see the film of the February 12, 2019, MRI? Or were you relying on a paper -- just a paper report?

A I'm a spinal surgeon. I have to look at the films. I did see the films.

Q You saw the films?

A Always.

Q I'm just asking because it's not clear.

You say available for my review today is an MRI.

A The review part is me looking at them.

Q So, it wasn't a written report that you were looking at?

A Again, I'm a spine surgeon.

Q You just have to say yes or no, Doctor.

A Okay.

Q So, you looked at the films?

A Yes, I looked at the films.

Q And that film, it showed at C5-6 osteoarthritis, correct?

A No.

Q It also showed disc desiccation in that area?

A Yes.

Q Okay. What is disc desiccation?

A Similar to what I described earlier. If the disc has a

hole in it, and the contents come out, it starts to loss its height. Essentially, it starts to lose its water content. That's the desiccation part.

Q And that's a degenerative finding, correct?

A No.

Q Do doctors differ on that, Dr. Simela, as to whether disc desiccation is a degenerative finding? Does the literature differ on that?

A I think you have to put it in context. If it's a degenerative condition and you see disc desiccation, you can say yes, it's degenerative -- if it's an acute event and age-appropriate patient, then it's likely that the disc desiccation can lead to degeneration, but that's not the inciting event.

The generation is not the inciting event of the desiccation, if that makes sense to you.

Q Doctor, people in their thirties, about 52% have disc degeneration, correct?

A I would need to see the study you're referencing.

Q Okay. I can put it in the record but I don't have the actual study for you. It's AJNR.

Are you familiar with that publication?

A No.

Q April of 2015?

A No.

Q Okay. So, you don't accept that, that 52% of people in their thirties have disc generation in their spine?

A I accept that there's a range, but that's a single value. I would need to weigh the evidence. There's a whole slew of things you would have to do just before one study.

Q So, medical literature doesn't say that; is that correct?

A The medical literature supports a range.

Q What sort of range?

A I would vary to say that patients in middle aged, which I --

Q I'm talking about thirties, that's this study.

A Again, the range is going to be much lower than 52% across the board in terms of degenerative conditions.

Q Okay. So, the one, two, three, four, five, six, seven, eight, nine -- it looks like ten doctors who offered this report --

MR. BRENNAN: Objection, Judge. Improper foundation.

THE COURT: Yeah. There's no foundation laid for this. Thank you.

Q I just want to clear up a few things that are obvious but I just want to ask them. You didn't see this accident happen, correct?

A Correct.

Q Okay. You didn't interview any witnesses?
A No, I did not.
Q And there's no evidence that you looked at the Lincoln Hospital records, correct?
A I did not reference them in my report, correct.
Q And you didn't bring them with you today as part of your file, correct?
A Correct.
Q Okay. So the only explanation of this accident that you've received is from Mr. Urquia, correct?
A Yes.
Q Okay. You didn't do any outside research? You didn't contact any of his coworkers? Nothing like that?
A Correct.
Q You didn't look at any photos or anything?
A Correct.
Q And you'd agree that it's important to get an accurate medical history from the patient?
A Yes.
Q Okay. And if you don't get an accurate medical history from the patient, what happens then?
A That's just a vague statement. You need to make it a little bit more clear.
Q Well, if the patient gives you incorrect information about the mechanism of injury, you testified earlier that it's a

wildly important for the mechanism of injury, for you to know it, correct?

A Yes.

Q So, if you have an incorrect mechanism of injury, that can, for lack of a better word, throw of your diagnosis, correct?

A Not the diagnosis but the mechanism of injury would be wrong.

Q And that could have an impact on causation, what caused it, correct?

A Yes.

Q Okay. So, just to sum it up, if you don't have an accurate description of the accident, you can't make an accurate statement about causation, correct?

A Correct.

Q Okay. You don't know what the injury was that was presented at Lincoln, correct?

A I do know what the injury was that was presented at Lincoln.

Q I'm talking about personal knowledge, what you've seen in the medical records.

A I've seen the Lincoln Hospital records.

Q Doctor, there's no evidence that you've seen them in any document you've written.

A I have not documented but I've seen the records. They

were provided to me at some point. You asked me earlier when did I look at them. You asked me did I look at them before surgery. And I said, at some point, I looked at the records.

Q But you made no notation of it ever in your records?

A Because it was not relevant to my consult.

Q You don't know what type of examination he was given at Lincoln? You weren't there?

A I was not there.

Q Okay. You don't know what complaints he made at Lincoln? You weren't there?

A Correct, I was not there.

Q Okay. And isn't it important to keep accurate and complete records, Doctor?

A Certainly.

Q So that is a pretty major omission that you don't have Lincoln referenced anywhere in your records, correct?

A I have the relevant records for my surgical consult listed.

Q You don't find Lincoln to be a relevant record?

A For surgical consultation post-hospital discharge, post six months of conservative care, no, I do not find it relevant.

Q So, you don't agree that it's essential to have a full history of your patient, right?

A I do believe a good history is appropriate.

Q A good history based solely on what your patient, who's

a non-medical person tells you, correct? That's good enough for you?

A A history of the purpose or the history for the purpose of my consult is what I'm looking for.

Q Okay. You never spoke to his general practitioner, correct?

A Correct.

Q You have no idea what his complaints were before this accident occurred in terms of his spine, fair?

MR. BRENNAN: Objection.

THE COURT: What's the basis?

MR. BRENNAN: He has no basis to ask that question.

THE COURT: Read it back.

(Whereupon, the requested testimony was read back by the Court Reporter.)

THE COURT: I am going to overrule it. You can answer.

A Can you repeat?

THE COURT: Read back one more time. Thank you.

(Whereupon, the requested testimony was read back by the Court Reporter.)

A Correct.

Q And presumably, he had medical treatment before this accident occurred, correct, to parts of his body? We just don't know because you just didn't review it, correct?

MR. BRENNAN: Objection.

THE COURT: What's the objection?

MR. BRENNAN: It's complete speculation.

THE COURT: Yeah. This is a little speculative, Counsel. I'll sustain this one. Thank you.

Q The next visit that you saw Mr. Urquia was on October 30th, correct?

A That is correct.

Q And then it references that when he has pain, he takes ibuprofen, correct?

A The record said that the patient had taken ibuprofen.

Q Correct?

A Yes.

Q Your records, correct?

A My records.

Q Got it. Okay, so that's Advil?

A Yes.

Q He was taking Advil for pain?

A At some point he had taken ibuprofen for pain.

Q Okay. And there's no indication of any prescription pain medicine that he was taking before your neck surgery, correct, Doctor?

A Nothing prescribed by me.

Q Well, no, no. Didn't you ask him if he was taking any medication?

A Yes.
Q And he told you, when I have pain, I take Advil.
A It said the patient had taken ibuprofen, correct.
Q So, he didn't disclose to you any prescription pain medication, correct?
A Correct.
Q Okay. Again, he wasn't having that feeling throughout his body called paraesthesia, correct?
A Correct.
Q Okay. He had no evidence of acute stress?
A Correct.
Q Neurologically, he had no focal defects?
A Let me just reference the note to confirm that. No focal defects, correct.
Q He had full strength?
A Correct.
Q Okay. He had normal reflexes?
A Yes.
Q And he was not taking any prescription pain medicine, right?
A Nothing prescribed by me.
Q Well, Doctor, didn't you ask him, are you taking any medication?
A Correct.
Q Okay. And he told you, yes, I'm taking Advil, correct?

A He said he had taken Advil, correct.
Q Right. So, he was not taking prescription pain medication as of the date of this examination?
A Again, nothing prescribed by me.
Q Do you -- when you interview a patient, do you say, are you taking any prescription pain medicine prescribed by me?
A Possible. It depends.
Q Well, you know that already. So, why would you ask him a question that you already know?
A The patient states that he was not -- he had taken ibuprofen. I don't know if that was the day of, the day prior, or the same day.
Q I understand that. I am talking about prescription pain medication. He wasn't taking any?
A Right. My answer to you was I did not prescribe him anything.
Q And he didn't disclose that he was taking any prescription pain medicine, correct?
A Correct.
Q Okay. So, he wasn't taking prescription pain medicine, fair?
A Fair.
Q Otherwise he was lying to you. Do you think he was lying to you?
MR. BRENNAN: Objection.

A I don't believe so.

THE COURT: Hold on. What's the objection?

MR. BRENNAN: There's other options. Again, the basis is an improper question.

He already passed the point and he answered the question.

THE COURT: Thank you, Counsel.

Go ahead, Mr. Showers.

Q December 11th was the next time that you saw Mr. Urquia, correct?

A Yes.

Q And he was still taking Advil for pain, correct?

A Yes.

Q And you didn't note any prescription pain medicine, correct?

A Correct.

Q He wasn't having that feeling called paraesthesia, correct?

A Correct.

Q He had no evidence of acute stress, correct?

A Correct.

Q He had no focal deficits, correct?

A Correct.

Q You found him to be neurologically intact, correct?

A Correct.

Q Okay. He had full strength?
A Correct.
Q His reflexes were normal?
A Yes, correct.
Q Then you performed your surgery in January 2020, right?
A Yes, correct.
Q And whose Dr. Hanan?
A My surgical assistant.
Q It says, close surgeon, as well.
A He's a physician so we write, close surgeon.
Q Did he perform the surgery or did you perform the surgery?
A Dr. Hanan is a general surgeon. I performed the surgery.
Q You saw Mr. Urquia about two weeks later on February 4, 2020?
A Yes, that's correct.
Q At this time, he wasn't -- this is your first post-op visit, correct?
A Correct.
Q Okay. Again, he was taking Advil to control pain, correct?
A It says he had taken Advil, correct.
Q And he didn't have the paraesthesia feeling?
A Correct.

Q No acute distress?
A Correct.
Q No focal deficits?
A Correct.
Q Same with strength and reflexes were normal?
A Correct.
Q You didn't move his neck now because he had the surgery, right?
A That is correct.
Q And he was in the collar, right?
A Correct.
Q Two weeks later you saw him again?
THE COURT: I'll let you answer that question, Doctor and then we will break for lunch.
So the question was, two weeks later, did you see him again?
THE WITNESS: Yes.
THE COURT: Okay. We'll stop there. We'll break for lunch. I'll ask the members of the jury to report back here at two o'clock so we can get started as close to two fifteen as possible.
Jurors are excused. Enjoy your lunch.
COURT OFFICER: All rise. Jury exiting.
(Whereupon, the sworn jurors exit the courtroom.)
THE COURT: Doctor, you may step down. Thank you.

(Whereupon, the witness was excused from the stand.)

(Whereupon, a lunch recess was taken.)

(Whereupon, the following was recorded and transcribed by Official Court Reporter Renee Scott)

(Continued on next page.)

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

CROSS EXAMINATION (CONTINUED)

BY MR. SHOWERS:

COURT OFFICER: All rise. Jury entering.

(Jury enters courtroom; the following occurred:)

THE COURT: Okay. Welcome back everybody. You may be seated, and we'll continue with Mr. Showers of cross examination.

Mr. Showers, you may inquire.

MR. SHOWERS: Thank you, Judge.

Q. Good afternoon again, Doctor.

A. Good afternoon.

Q. We're right now on two weeks after surgery -- I'm sorry -- two weeks after the last note that we talked about. I think we're about a month after the surgery.

A. Do you have a date of service?

Q. Yes. 2/18/20.

So about one month after surgery; correct?

A. Correct.

Q. Okay. Now, Spurling's is negative; correct?

A. That is correct.

Q. Hoffman's is negative?

A. Yes.

Q. And he has good strength?

A. Yes.
Q. And equal reflexes; correct?
A. Yes.
Q. So based on that progression, would you agree that the surgery was a success?
A. Yes.
Q. March 31st, can you please turn to that note?
Again, he's not taking any pain medication at all?
A. I don't have any listed, correct.
Q. Correct.
He denied paresthesia?
A. Correct.
Q. He denied any problem with speech or swallowing?
A. Correct.
Q. And he was able to raise his arms over his head; correct?
A. Correct.
Q. Okay. If you could continue on to April 28th.
A. Okay. Go ahead.
Q. Okay. Again, he's not taking any pain medication; right?
A. Correct.
Q. And his arm pain has resolved?
A. Yes. Correct.
Q. So he's showing functional improvement after your

surgery; correct?

A. Correct.

Q. Again, he's got no evidence of acute distress?

A. Correct.

Q. No obvious focal defects?

A. Correct.

Q. I'm on the next one June of 2020.

Spurlings and Hoffman's are still negative?

A. Correct.

Q. Sensation is intact?

A. Correct.

Q. Strength is well preserved?

A. Correct.

Q. And you said he's showing improvement; correct?

A. Correct.

Q. And he's directed to continue on physical therapy?

A. Correct.

Q. Again, September of 2020.

A. Are you skipping August of 2020?

Q. I don't have the August note.

August 12, 2020?

A. Yes.

Q. I have that in front of me now. Thank you.

No paresthesia?

A. None reported.

Q. No focal defects?
A. Correct.
Q. No acute distress?
A. Correct.
Q. Normal walking unassisted?
A. Correct.
Q. Strength well preserved?
A. Correct.
Q. Spurling's and Hoffman's are still negative?
A. Correct.
Q. Neurovascularly he's intact?
A. Correct.
Q. And he's continuing physical therapy.
THE COURT: Is that a question, Counsel?
Q. He is continuing physical therapy; correct?
A. Correct.
Q. 9/9/20.
A. Yes.
Q. Thank you.
Still reporting improvement to his arm pain?
A. Yes.
Q. Still denying paresthesia?
A. Yes.
Q. He's ambulating normally, walking normally; correct?
A. Correct.

Q. And Hoffman's and Spurling's are still negative?
A. Correct.
Q. And overall neurovascularly intact?
A. Correct.
Q. Okay. And he's had improvement in his radicular complaints; correct?
A. Correct.
Q. Now, we're at 10/28/2020.
He seems to have stopped physical therapy; correct?
A. Yes. That is correct.
Q. He still denies paresthesia?
A. Yes.
Q. There's no evidence of acute distress; correct?
A. Correct.
Q. No focal deficits?
A. Correct.
Q. And you're sending him for an MRI for the lumbar spine; correct?
A. Yes.
Q. With respect to the lower extremities, you have strength well preserved at five out of five; correct?
A. Correct.
Q. And neurovascularly he's intact?
A. Correct.
Q. Okay. 12/23/2020.

He continues to have improvement with the cervical radiculopathy; correct?

A. Correct.

Q. He denies paresthesia?

A. Correct.

Q. He has no acute distress; correct?

A. Correct.

Q. He has no focal deficits?

A. Correct.

Q. His range of motion in his cervical spine has improved?

A. Yes.

Q. The strength in his upper extremities is still full strength; correct?

A. Correct.

Q. His reflexes are normal; correct?

A. Correct.

Q. Overall, he's neurovascularly intact?

A. Correct.

Q. You are sending him for more physical therapy; correct?

A. Yes.

Q. 2/24/21. Do you have that note?

A. Yes.

Q. Just for the sake of moving things along, 2/24/21 and

4/21, there's no paresthesia, negative Hoffman's and Spurling's, no atrophy in the arms; is that correct?

A. Allow me one moment to look at --

Q. I can go one by one.

A. Twenty-one. That is correct.

Q. Reflex and sensation were intact on both dates?

A. Correct.

Q. And there were -- on 4/21/21, there were no spasms in the neck on either side; correct?

A. Allow me one moment just to confirm.

Correct.

Q. And that's an objective sign. Correct, Doctor?

A. Yes.

Q. Also on that date, 4/21/21, his lower extremities showed no atrophy; correct?

A. Correct.

Q. And atrophy is wasting away of the muscles. Correct, Doctor?

A. That is correct.

Q. And that's from disuse due to pain. Is that correct?

A. A few different reasons but disuse is one of the reasons.

Q. So there were no atrophy here meaning he was using his legs normally; correct?

A. Correct.

Q. Okay. He had normal strength in the lower extremities?

A. Yes.

Q. Moving on to June 30/2021. Still no spasms in the neck?

A. Correct.

Q. No paresthesia?

A. Correct.

Q. No atrophy in the upper extremities?

A. Correct.

Q. Normal strength; correct?

A. Correct.

Q. Normal reflex and sensation?

A. Correct.

Q. And then same findings with the lower extremities; is that correct, Doctor? No atrophy, normal strength, normal reflexes and sensation?

A. Well, but there was muscle spasm.

Q. In the lower?

A. In the lower.

Q. Okay. So that's the only difference?

A. The other things that you asked me before versus before, yes.

Q. Okay. Let's start with the lower extremities.

No atrophy; correct?

A. Correct.
Q. Okay. Normal strength?
A. Correct.
Q. Normal reflexes?
A. Correct.
Q. Okay. Normal sensation?
A. Decrease sensation on the left.
Q. On the left leg?
A. Yes.
Q. Okay. Improvement in the neck still; correct?
A. Moderate tenderness but overall improvement, yes.
Q. In 8/11 -- August, 11, 2021.
Do you have that note?
A. I do.
Q. You listed the neck range of motion was without discomfort; correct?
A. Correct.
Q. So he wasn't having any discomfort when he moved his neck; correct?
A. Correct.
Q. Okay. Spurling and Hoffman were still negative?
A. Correct.
Q. Sensation was normal?
A. Intact, yes.
Q. Okay. Strength was normal?

A. Correct.
Q. And also on September 8th 2021, do you have that?
A. Yes.
Q. Okay. Is there a notation that the neck is doing well?
A. Yes.
Q. The visit this year?
A. Yes.
Q. March 8th?
A. Okay.
Q. Okay. There was no problem with how he was walking; correct?
A. Correct.
Q. Hoffman's and Spurling's were still negative?
A. Correct.
Q. And he's back to using Advil for pain; correct?
A. Ansets.
Q. Which is?
A. It could be any of them: Advil, Aleve, Motrin.
Q. All over the counter?
A. Yes.
Q. Okay. Doctor, just to clarify. You don't have a degree in radiology; correct?
A. Correct.
Q. You're not a radiologist. That's a specialty within

medicine; correct?

A. Correct.

Q. So overall your certifications, you don't have board certification in radiology; am I correct?

A. Correct, correct.

Q. Thank you very much, Doctor.

THE COURT: Mr. Gilroy, are you going to be using the doctor's records up here?

MR. GILROY: I would like an opportunity to take a look at it if the doctor has his chart with him.

THE COURT: Okay. That's fine.

Mr. Gilroy, if you want to come up. You said you want to look at them?

MR. GILROY: I'd like to take a look.

THE COURT: I'd like to marshal because it's getting a little -- over all the place. I'd like to marshal the evidence, get it in order. Okay? These are not in the date order. We'll have to do that at the end of the presentation today.

MR. GILROY: Thank you.

THE COURT: You're welcome.

MR. GILROY: Your Honor, I just asked co-counsel to pull out the last two. We didn't have the last two visits, so I asked him to pull those two.

THE COURT: Okay. Are you okay with those two

having been stipulated in with the records right there?

MR. BRENNAN: Yes.

THE COURT: Mr. Gilroy, you may inquire.

CROSS EXAMINATION

BY MR. GILROY:

Q. Good afternoon, Doctor.

A. Good afternoon.

Q. If you can't hear me or have any difficulty, just let me know. Sometimes I tend to speak softly.

A. We'll do.

Q. Now, just in general, would you say that it is a normal and customary medical practice for you as a physician to accept a complaint of pain if a patient comes to you saying my elbow hurts, my knee hurts, my neck hurts, complaining about some part of their body?

A. Yes.

Q. Okay. And, in fact, that's part of your training. You use that as one of the facts in arriving at a diagnosis?

A. Yes.

Q. All right. And if a patient were to tell you on your first meeting, well, I didn't have any prior or previous injuries in this area. I never had a problem a day in my life with this particular joint or bone. You accept that?

A. Yes.

Q. Okay. Of course, you do your examination. You do

your testing and so on in order to investigate further?

A. Yes.

Q. But that's the touchstone or the starting point; isn't it?

A. Yes.

Q. Okay. In this case, when Mr. Urquia came to you, did you send him for any diagnostic testing on your own?

A. No. I believe he came to me with an MRI already completed.

Q. Okay. And he also I believe came to you with some electrical testing, an EMG I think you mentioned?

A. Yes.

Q. Okay. And an EMG is a study in which a needle is place in the patient's limb and also in the area of their spine. I'm describing it in layman's term but is that what it looks like?

A. Yes.

Q. Okay. And the point is to test the nerve impulse that travel from the spine out to the limbs?

A. Yes.

Q. And now in this case Mr. Urquia had evidence of an impingement, I believe you said, based upon his EMG?

A. He had evidence of radiculopathy based on EMG.

Q. Now, that radiculopathy is kind of complicated, but essentially what it means is disease or a problem due to an

injury to the spinal cord?

A. The spinal cord or the accompanying nerve roots.

Q. Now, those little rubber bands that we saw, I'm not sure what material they were made of, those little things projecting out of the side of that anatomical model of the spine that we looked at, are those the nerve roots?

A. They represent the nerve and the nerve roots.

Q. Okay. And, again, just trying to put it in kind of everyday language.

A herniation of the type that you described is a slipped disc, a disc that's out of place?

A. Yes.

Q. Okay. Again, I'm using layman's terms.

You use much more detailed and nuance language, I'm sure.

A. Yes.

Q. Okay. And if a disc slips in the direction of one of those nerve roots and causes an impingement on a nerve root, you would expect the patient to have symptoms in the limb that that nerve root supplies. Fair?

A. Yes.

Q. Okay. And, in this case, I believe you told us that Mr. Urquia had evidence of an impingement on the left. Is that fair?

A. I said he had what was a paracentral disc herniation,

was biased to the left. I didn't use the word "impingement."

Q. And you mentioned that there was irritation of a nerve root at the level of C5 and C6. Is that fair?

A. Yes.

Q. Okay. Was that on the left or on the right based upon that EMG study?

A. I believe on the right.

Q. On the right.

And with regard to the MRI, he also had an MRI before you saw him. Fair?

A. Yes.

Q. Okay. And did that MRI indicate that the disc was herniated or slipped to use layman's language to the left or to the right?

A. It did indicate that it was biased to the left.

Q. Biased to the left, okay.

And did you feel that there were some inconsistency there between the EMG finding and the MRI finding?

A. No.

Q. Okay. When you did your surgery in January I believe of 2020 --

A. Yes.

Q. -- January 21 of 2020, you indicated that there were no particular complications?

A. Yes.

Q. Okay. After the surgery was done, he made a series of visits to your office and you told us about some of the tests.

When a test is done on a patient, I think you've told us about the Spurling's test?

A. Yes.

Q. Okay. And the result is negative. Just to clarify, a negative result on a Spurling's test is a good result for the patient?

A. Yes.

Q. Okay. Positive -- although if a positive result was seen, then that would be bad for the patient?

A. Correct.

Q. Okay. After the operation, I think all of the Spurling's tests that you performed were negative. Is that fair?

A. Yes.

Q. Okay. Is that an indication that the surgery was a success and that his problem had been addressed?

A. It's an indication that there's no longer compression against the nerve.

Q. Okay. And one of the other things you did in that series of exams after the surgery was to test his range of motion.

Could you tell us why that's important?

A. I'm not sure if I can --

THE COURT: Hold on.

MR. GILROY: I can withdraw it.

THE COURT: I just want to bring something to your attention.

(Discussion off the record.)

THE COURT: Mr. Gilroy, I believe you're withdrawing and rephrase that last question.

MR. GILROY: I'm going to withdraw that last question.

THE COURT: Thank you, Counsel.

Q. Doctor, one of the important things that you test for when you see a patient whose had an anterior cervical discectomy and infusion like Mr. Urquia is how well he can move his neck?

A. Yes.

Q. How well he can turn his head and raise it and lower it. Is that fair?

A. Yes.

Q. And did he have any difficulty whatsoever in turning his head to the left and right on your postop exams?

A. Through some of the physical exam, he had stiffness reported with motion.

Q. And sometimes you measure the distance that someone can turn their head to the left or right in terms of degrees?

A. Yes.

Q. Okay. In your exam of February 24th of 2021, which

would be a little over a year after his surgery, you made a notation that his range of motion of his neck of his cervical spine was 40 degrees and that you considered 50 degrees to be normal. Is that it?

A. Yes.

Q. Okay. And his extension, would that mean his ability to look up?

A. Yes.

Q. Okay. You measured that at 50 degrees out of a possible 60 degrees?

A. Yes.

Q. Okay. And you measured rotation of his neck meaning his ability to turn his neck?

A. Yes.

Q. And you measured his right rotation at 60 degrees, 80 being normal. Is that correct?

A. Yes.

Q. Okay. And his rotation of his neck to his left would be 40 degrees as you measured it when you saw him in February of 2021?

A. Okay.

Q. You don't have your notes in front of you have, so I'm going to hand them up to you and make sure I read them correctly.

A. Sure thing.

THE COURT: You could approach. That's fine.

MR. GILROY: Sorry. Thank you, Your Honor.

A. Yes. Rotation was 40 degrees to the left on this particular visit.

Q. Okay. And being that this was about a year after the surgery, would you expect that going into the future Mr. Urquia's ability to look up and look to his left and look to his right would improve or deteriorate or stay about the same?

A. Tough to say. I mean it depends on many factors.

Q. I see.

And, Doctor, would you consider those values that you got when you measured his ability to turn his neck and raise his head to be impaired?

A. Some were deceased.

Q. Okay. And, Doctor, I would like to exhibit to you several still photographs, while still frames that were taken from a video of Mr. Urquia, which is in evidence, and that video was taken about a year and a half after that January of '21 exam, specifically in October of '22.

MR. GILROY: Your Honor, may I show the witness?

THE COURT: Yes. I just want to make sure what exhibit are we referring to.

MR. GILROY: We took it as 4.

MR. BRENNAN: I don't know about the stills, but the video, I haven't seen the stills.

MR. GILROY: Okay. What I've done is taken about a half of dozen images from a video that's about an hour long.

THE COURT: That's the USB that we were discussing yesterday?

MR. GILROY: Yes, Your Honor.

THE COURT: I think that's Plaintiff's 4. You can broadcast.

MR. GILROY: Thank you.

Q. And I will ask you just take a look at those images and tell us whether that -- you would consider the distance that Mr. Urquia is turning his head to the left and to the right in those images to be normal?

MR. BRENNAN: I would object, Judge?

THE COURT: What's the objection basis?

MR. BRENNAN: Well, obviously, just judging the quality of the images is an issue. The doctor has talked about measuring those distances with a particular device. It's impossible to do so under these circumstances. So that's the basis of my objection. It's pretty speculative and putting me, particularly, an unfair spot here.

THE COURT: You want to the add a question or two to qualify on this?

MR. GILROY: Yes.

THE COURT: Okay. I'll revisit the objection

after a further question.

Q. Doctor, you told us earlier about some of your coping with COVID epidemic and you had several telemedicine visits.

Would you ask a patient on a telemedicine visit to show me how well or how far you can turn your head, raise your head, lower your head, things like that?

A. Not me. I would just be asking them to raise their hands above their head, just checking for motor strength. Difficult checking for range of motion without having the patient's feet planned and their shoulder squared.

Q. Are you able to assess the range of motion based upon those stills?

A. Not accurately.

Q. I'd like to show you another still on the same -- from the same tape.

In this, did you find that the patient had any difficulty in raising his arms?

A. No.

Q. Okay.

THE COURT: Just so we close out, the objection was to the head. The first two images on there, that's rendered mute because the doctor testified that he can't tell based on the photo.

MR. GILROY: Yes, Your Honor.

THE COURT: For the purposes of the record, still

image two was an image with the plaintiff's hands raised above his head.

MR. BRENNAN: And I just ask request that maybe this be preserved in some way so it can be.

THE COURT: Yes. I think we should have a --

MR. GILROY: I'll be able to send them around.

THE COURT: We'll just have a quick description of what's shown in the video. I think that would be helpful. I mean not the video. The stills of the video. Thank you.

Q. On page -- this says it's page 5 of 9.

And would you agree, Doctor, that the patient, your former patient, is turning his head freely as shown in that image?

MR. BRENNAN: Objection.

THE COURT: Sustained.

Q. Would you regard that photo of Mr. Urquia as showing that he has a good range of motion in rotation to his right?

A. Difficult to assess.

Q. And, Doctor, with regard to this frame -- I've identified it. It appears at 0 minutes and 54 seconds of the tape.

In this image, Mr. Urquia is looking to his left.

Do you regard that as a good range of motion to his left?

A. Again, it's difficult to assess without seeing both sides squared and whether or not his feet are planted on the ground. Difficulty to assess range of motion because I can't see if his feet are planted on the ground and both shoulder squared.

Q. Doctor, you treat sports medicine patients. Is that fair?

A. Yes.

Q. Okay. And do you treat soccer players?

A. Regular athletics, I can't say they're soccer players versus pickle ball players.

Q. Parts of the world, it's called football. Here we call something else football.

A. Fair enough.

Q. And would you regard soccer as a contact sport?

A. Yes.

Q. Okay.

Doctor, there's an image from 38 minutes and 44 seconds on the video. And in that one, there are two images of Mr. Urquia I think you saw him looking to his left.

Would you regard his range of motion as good in that as shown in that still from the video?

A. Again very difficult to give a full assessment of range of motion.

Q. Okay. And as part of the evaluation, did you measure

Mr. Urquia's ability to look up?

A. Yes.

Q. Okay. And is that called extension, neck extension?

A. Yes.

Q. And does he appear to have a good neck extension in this image from 38 minutes and 15 seconds of the video?

A. Again, because his feet are not planted -- what you're not taking into account is motion. In that video or in that still, what I'm seeing is I'm seeing lateral bend to rotation, but on one -- in orthopedics, we say one view is no view. You really would need orthogonal views to really get a sense of what the motion is.

So for me, it's tough to assess that. It may look from the naked eye as though he could look up, but the position of his shoulders, they're not squared. His knee is flexed. His other knee is extended. So it is very difficult to assess range of motion with that picture.

Q. Okay. And, Doctor, in addition to being a contact sports, soccer is a game in which players bounce a ball off their heads at time. Is that fair?

A. Yes.

Q. Would Mr. Urquia have any difficulty in bouncing a ball off of his head in a soccer game two years after your surgery? Would you expect that?

A. I would hope, yeah. I would hope he would be able to

do that or at least bounce it off his head.

Q. Okay. Thank you.

That last image that I referred to is at 39 minutes and 52 seconds.

You spoke to us this morning or testified this morning about what you would have expected the staff at Lincoln Hospital to have been focused on when they saw him when he come in on December 27th of 2018 with a laceration on his hand?

A. Yes.

Q. You feel that it's possible that they would be distracted by the presence of that laceration?

A. Yes.

Q. So distracted that they would not listen to him if he had other complaints?

A. No, not the staff being distracted, but often the patients often comment on what's most obvious to them.

Q. Okay.

A. So that's the distraction.

Q. Now, when someone has sustained a trauma to his cervical disc at C4 and C5, that level of the spine, causing, I think you referred to it, a tear or a hole in that disc that causes it to slip?

A. Annular tear, yes.

Q. Is that a painful event?

A. It's painful over time unless there's a fracture in

what we call a fraction destruction injury. Those are typically not painful or obvious at the exciting events, typically.

Q. And if Mr. Urquia made two more visits to the Lincoln Hospital emergency room or to the clinic to have his stitches removed and other visit during the month of January of 2019, do you believe he would have been distracted at that point and so distracted that he would not had mentioned back pain or neck pain to the staff?

A. You don't have a clear understanding of how ER's work. So he's going to see a triage nurse to have suture removed. He's not going to have the opportunity, unfortunately, to say oh, by the way, something else is going on it. So it would depend on the environment he's in. Many different factors influence what patients complain about.

Q. It's part of the protocol to ask a patient how they feel, isn't it?

A. Again, it depends on what --

MR. BRENNAN: Objection. Of what? We talked about an emergency room department as well as a follow-up clinic.

THE COURT: You got to narrow it a little bit.

Q. Okay. In a clinic, would it be part of the protocol for the staff to ask a patient how they were?

A. Again, it would depend on the type of clinic. There are fast track clinics that are run by nurses. There are

clinics that are run by orthopedics or another specialty. It just depends.

Q. Okay.

MR. GILROY: I have no further questions. Thank you.

THE WITNESS: Thank you.

THE COURT: Any redirect?

MR. BRENNAN: Yes, Your Honor.

REDIRECT EXAMINATION

BY MR. BRENNAN:

Q. Dr. Simela, you were shown some still images on cross examination from a video?

A. Yes.

Q. Did I ask you to watch that whole video?

A. Yes.

Q. Have you had an opportunity to watch the surveillance video that were taken of my client?

A. Yes.

Q. When did you have an opportunity to do that?

A. Yesterday.

Q. And, specifically, the video from -- which yielded all those still images, all right, the soccer video?

A. Yes.

Q. Okay. You've offered us a lot of opinions today. I'm curious about your impressions as an orthopedic spine surgeon

having viewed that video?

A. I think it shows someone trying to participate in activities of daily living. It doesn't indicate myelopathy. It doesn't indicate that he's weak in the limbs. It's just someone trying to play a sport. I don't know if he played it well or no. I'm not a soccer player, but it just showed someone playing sports with their kid.

Q. You were asked some questions on cross examination -- I apologize. I don't remember by whom -- whether you have a degree in radiology.

Do you remember those questions?

A. Yes.

Q. All right. What is your personal practice as an orthopedic spine surgeon as it pertains to films and imaging studies and your own use of them?

A. So just to go back to background.

There is no degree in radiology. I will say that. But an intricate part of any orthopedic surgeon's residency training involves looking at films. I cannot fix a broken bone if I have not looked at the films.

And, in fact, I venture to that say that because I have the benefit of examining a patient, which a radiologist does not, I have a better perspective of what the films look like than a radiologist because I can clinically correlate with the actual patient in front of me. All due to my radiologist

colleagues, sit behind a screen. They don't talk to patients.

Q. Do you ever reply upon a radiologist's interpretation of a film in order to form your own conclusions and treatment plan?

A. Never.

Q. Why not?

A. Because, again, I have the benefit of examining the patient, hearing the patient's complaints and symptoms I can correlate with them exactly what's on the screen in front of me, the images that I'm looking at with my own eyes.

Q. And just because I think there was some -- by the existence of the question, maybe some lack of clarity about the following and I want talk to you about the EMG report as well your interpretation of the February 2019 MRI. Okay?

A. Sure.

Q. Can you explain to us why an MRI can reveal a paracentral herniation, biased toward the left, and there still be resided radicular symptoms on a patient?

A. Certainly.

Number one, hand dominance plays a role in the nervous system. It's been well borne out in the literature that people that are right-hand dominate will have symptoms on the right side.

If you take a disc herniation and it is paracentral, that means it's really in the middle, but if you split it like a

clock face from 12 to 6, a portion of it may be bias to the left. That does not mean it's not impacting the right side. And, especially, the anatomic considerations, you can easily get symptoms that are in bilateral hands but you use your right hand more. So you notice the symptoms more.

Q. Thank you very much, Doctor.

MR. BRENNAN: I have no further questions.

THE COURT: Any recross?

MR. SHOWERS: Sure.

THE COURT: Mr. Showers.

RECROSS EXAMINATION

BY MR. SHOWERS:

Q. Doctor, going back to Lincoln Hospital, you mention that it depended on the circumstances as to whether someone would be asked how they're feeling?

A. Yes, depending on the location of the exam.

Q. Whether it was a nurse or a doctor?

A. Correct.

Q. So if a doctor attended to Mr. Urquia on January 11, 2019, would that change your answer with respect to no complaints of any other part of the body except for the right hand?

A. No.

Having vast experience in hospitals, there's a subtlety and a nuance as to who was going to ask the question

and when. ER is not the appropriate place for a follow up about other body parts. It's just not going to happen that way.

Q. You wouldn't had been asked how are you feeling and wouldn't have given an answer about his right hand?

A. Are we referring to a visit after the initial injury?

Q. Yes.

A. Not likely. Especially Lincoln Hospital, if you have context from the Bronx, it's a level one trauma center. That's not the place that's someone to going to ask you. They're going to get you in, whatever is pressing, they're going to deal with. If it's for sutural removal, they're going to do that and send you out. That's the nature of health care in the Bronx.

Q. And if you make a complaint about another body part, it won't even make it into the medical records, is that your --

A. It's not likely to make it into the medical records. Someone may be kind enough to say, hey, why don't you follow up in that clinic or this clinic, but it's not likely to be make it into the medical record.

Q. And you mention Lincoln as a level one trauma center?

A. Level one trauma center.

Q. And their records are no good; is that correct?

A. No, I'm not --

MR. BRENNAN: Objection.

THE COURT: Sustained.

You don't have to answer that.

MR. SHOWERS: I don't have any further questions. Thank you.

THE COURT: Mr. Gilroy?

MR. GILROY: Nothing further, Your Honor.

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

Counselors, can you approach?

(Discussion off the record.)

THE COURT: Okay. Members of the jury, we're going to break a little early today. Okay.

So the presentation of the trial for today is over. Tomorrow I have another matter that I have to handle right at 9:30 so we're not going to start this until 10:30, okay? So we're ending a little early and we're starting a little late tomorrow.

Again, I remind you of the rules that I read in the beginning when you're outside of the courtroom and I'll ask you that you get here at about 10:15 tomorrow morning. So that way you could settle in, get situated, and then we'll bring you down to continue the presentation of the trial, okay? The jury is excused.

Thank you very much. Have a good evening.

COURT OFFICER: All rise. Jury exiting.

(Jury exits courtroom.)

(Trial adjourned to Friday, May 16, 2025 at 10:30 a.m.)