SUPREME COURT OF THE STATE OF NEW YORK.
COUNTY OF BRONX: CIVIL TERM: PART IA-26

- x

TAFFANY C. BAILEY,

Plaintiff,

-against-

Index No.:
804445/2022E

2732 BAINBRIDGE ASSOCIATES, LLC,

Defendant.

- x

DR. GALLINA

851 Grand Concourse
Bronx, New York 10451
August 4, 2026

B E F O R E:

THE HONORABLE PAUL ALPERT
Justice of the Supreme Court

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

HARRIS, KEENAN & GOLDFARB PLLC
Attorneys for Plaintiff
233 Broadway, 9th Floor
New York, New York 10279
BY: MARITZA MING, ESQ.

THE LAW OFFICES OF LEON R. KOWALSKI & ASSOCIATES
Attorneys for the Defendant
350 Fifth Avenue
New York, New York 10018
BY: JOSEPH W. SANDS, ESQ.

Ephraim Jacobson
Senior Court Reporter

COURT OFFICER: All rise. Jury entering.

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

THE COURT: You may be seated. Good morning, everyone. We got a little bit of a late start today. I know somebody's got an appointment this afternoon. We're going to try to get through it this morning, if we can. Counsel, you may call your witness.

MS. MING: The plaintiff calls Dr. Gallina to the stand, Your Honor.

COURT OFFICER: Remain standing. Raise your right hand. Do you swear or affirm to tell the truth and nothing but the truth.

THE WITNESS: Yes.

COURT OFFICER: Have a seat. Speak loud and clearly into the microphone. State your professional title, name and business address for the record.

THE WITNESS: My business is Jason M. Gallina, MD, PC. My name is Jason Gallina. My business address is 135 Madison Avenue, fifth floor New York, New York.

COURT OFFICER: Thank you.

J A S O N G A L L I N A, a witness called by and on behalf of the Plaintiff, upon being duly sworn, testified as follows:

THE COURT: The witness is sworn. Counsel, you may inquire.

MS. MING: Thank you, Your Honor.

DIRECT EXAMINATION

BY MS. MING:

Q Good morning, Dr. Gallina. Can you please explain to the jury what type of doctor you are?

A I'm an orthopedic surgeon with a specialty in spine surgery.

Q And please tell us are you duly licensed to practice medicine?

A Yes.

Q And where are you so licensed?

A In New York and New Jersey.

Q And can you please briefly just walk us through your educational background that led up to you achieving that license?

A Sure. So I went to high school in a private high school in New Jersey called Dwight-Englewood. From there, I graduated and attended Brown University. From Brown University, I went to medical school, UMDNJ Robert Wood Johnson Medical School. So that's four years of additional training after college. After medical school, I decided to become an orthopedic surgeon and applied for a residency in orthopedic surgery, where I did four additional years at St. Luke's Roosevelt Hospital in Manhattan.

Within the field of orthopedic surgery, I then decided

to specialize in spine surgery. I did a year of fellowship out in Santa Monica, California with Rick Delamarter, and then I came back to New York and opened up a practice, where my hospital privileges in New York are at NYU Hospital and I have affiliations in New Jersey as well.

Q And can you just tell us or explain what orthopedics is just generally?

A Sure. There's lots of different sub specialties within orthopedics. But orthopedics is in essence the treatment of pathology or disorders of the bones, the nerves and the soft tissue around it. So that would be the muscles, the tendons, the ligaments and so on and so forth.

Q And in terms of orthopedic surgery, is there any special or additional training that's required in order to become certified, board certified in orthopedic surgery?

A So once you take the medical boards, then you're a licensed physician, and there's different steps for that during medical school. After that, you start your orthopedic training, which is a surgical subspecialty. There are two steps to the boards. There's a written exam that is taken, and then several years later there is an oral portion of the boards where you collect your cases, and they are then presented in front of a group, and then you finish your boards. Every ten years after that, you have to recertify.

Q And when was the last time you recertified?

A It's changed a little, but I just finished my recertification this year.

Q And you mentioned the fellowship. What did your fellowship focus on?

A So within orthopedics, there's different subspecialties, tumor, pediatrics, trauma, sports medicine, hand, upper extremity, sports medicine. Mine specifically was in spine surgery.

Q Now, with respect to your practice, you maintain a private practice; is that correct?

A Correct.

Q And you also mentioned privileges at hospitals?

A Correct.

Q Which hospitals do you currently hold privileges to?

A In New York it's mostly NYU. I do have privileges at Lenox Hill Hospital, as well. In New Jersey, it's Hudson Regional Hospital.

Q What does it mean to have privileges at a hospital?

A So you have a private practice for surgery, specifically that means that as an outpatient setting you see patients in your office, and I do that once a week. If patients have a surgical problem, you need some kind of environment to operate on them. That would either be an ambulatory center like a surgery center, or in my particular case, it's at a hospital. So the patient would go to NYU, and either you operate on them

and they're discharged the same day, or they're admitted into the hospital with ancillary services for those -- that patient.

Q And in addition to your private practice, do you do any on-call work?

A Yes. So part -- there's various -- depending on the hospital that you're affiliated with, there are different criteria to have privileges at that hospital. It is in fact a privilege to be able to operate at a specific hospital. At NYU, specifically, there's usually educational requirements, in terms of teaching the residents and/or fellows and then you have to take a call. The call is generally one week straight, where any patient that comes into the hospital to their emergency room, the patients are evaluated and treated --

Q Slow down a little bit. I know I told you that we're running short on time, but just slow down a little bit.

A Sorry.

Q That's okay.

A That when you're taking call, any patient that comes into the emergency room, you take care of those patients and they're admitted to your service, even though they didn't come to you through your private office.

Q So, in addition to your private practice, you teach residents at NYU in these -- and you do on-call work?

A Correct, yes.

Q And in order to have those privileges and to teach at

the hospital, you're required to undergo a screening process for that?

A Yes, they have to give you these privileges.

Q And for how long have you had privileges at NYU?

A Since I came out of fellowship, since 2008.

Q And -- I'm sorry. I'm bad at math. How long have you been a spinal surgeon?

A So I've recerted -- this is the second time I've recerted. So over twenty years.

Q When you mentioned on-call, what type of on-call work is that? Is that related to trauma or something else?

A It could be anything. So it's all related to -- right out of practice, I did take trauma call at St. Vincent's Hospital -- that's no longer around -- and that was general orthopedic trauma call. Here specifically at NYU, it is a spine call. So it's all spine-related pathologies. It could be patients who are coming into the emergency room, or it could be patients who are in house and have an issue that they need a spine consult.

Q Thank you. And is there any way you can estimate approximately how many spine surgeries you've performed?

A It's exceedingly difficult to estimate, but I would say greater than -- depending upon the type of surgery, greater than two hundred a year.

Q Now, Dr. Gallina, as you know you're here to talk about

one of your patients, Ms. Taffany Bailey; is that correct?

A Yes.

Q And when did you first learn that you would be required to testify in this case?

A I was vaguely alerted on Friday that I needed to testify likely in a case, specifically for this patient, probably about 6:00 last night.

Q Now, would it be fair to say that my office requested that you come to this courtroom and testify before this jury in connection with Ms. Bailey's treatment, correct?

A Correct.

Q And prior to coming to court, you and I spoke about Ms. Bailey, correct?

A Correct.

Q And how many times did we speak?

A Last night.

Q And in terms of -- well, let me go back. In terms of testifying in court, how often do you testify in court on behalf of patients you may treat?

A I would say on average, it's probably about once, maybe twice a year. Recently, over the last couple months, I think this year I probably testified two or three times.

Q Do you typically testify on behalf of patients you're treating, or something else?

A I generally testify for patients, but I have done

defense work as well.

Q Now just for the record, what's the name of your private practice?

A Jason M. Gallina, MD, PC.

Q How many offices does your practice consist of?

A Again, it's changed over the years, but currently, I see patients in one or two locations.

Q And would it be safe to say that as part of your practice you employ staff to keep your office running?

A Yes.

Q And approximately how many employees do you have, more or less?

A So I have four full-time employees and about three part-time employees, and then of course we outsource billing and other -- other portions of the practice.

Q And would it be fair to say that your staff still has to be compensated when you're out of the office and away from the office not treating patients, and in court providing testimony?

A Yes, very much so.

Q And do you charge a fee for the time that you have to be out of the office and away from your practice, Doctor?

A Yes.

Q And with regards to this case, what is your fee, Doctor?

A I believe it was thirty thousand dollars.
Q And can you tell us in terms of what that fee entails?
A It's basically me coming here today and testifying about my treatment for the patient, in lieu of the other work that I would normally do today.
Q Now, just briefly, because it inevitably comes up, approximately how many times have you testified on behalf of a patient that you were treating that my law firm represented?
A I believe it's somewhere between one and two or three times.
Q It's not my law firm, but Harris, Keenan & Goldfarb?
A Yes, I believe it's about three times.
Q Have you had occasion to appear in court on any other matters, where I was the attorney representing a patient that you may have treated?
A Yes.
Q How many times did that occur?
A Once.
Q So this is the second time we've met?
A Correct.
Q And now, turning your attention to the treatment of Ms. Bailey, do you have a copy of your records?
A Yes, in my bag.
Q Can you just explain -- I'm sorry, Doctor. Can you please just tell the jury when it was you first came to meet

Ms. Bailey?

A 12 -- I'm sorry. 12/12/22.

Q Do you recall how it was that she came to you for treatment?

A She was referred to me, but I don't recall specifically.

Q And throughout your treatment of Ms. Bailey -- well, to clarify, how many times have you treated or -- actually treated Ms. Bailey?

A I believe four or five times.

Q Do you want to refresh your recollection by looking at your records?

A Yes. I see the superbill here --

MR. SANDS: Objection, Your Honor. Can we approach?

(Whereupon, the following discussion takes place at sidebar among the Court and Counsel, outside the hearing of the defendant and sworn jurors.)

THE COURT: Objection is overruled.

MS. MING: May I inquire, Your Honor?

THE COURT: You may.

MS. MING: Thank you.

Q When you first met with Ms. Bailey, did you have an opportunity to take a medical history from her?

A Yes.

Q And did you also have an opportunity to review any medical records from any treatment she might have had prior to meeting with you in December of 2022?

A I reviewed some records, but I don't recall specifically when I reviewed those records.

Q Now, before we get into -- and also, did you review imaging regarding Ms. Bailey?

A Yes.

Q Like MRIs and x-rays?

A Correct, yes.

Q And did you review the actual films in -- for Ms. Bailey?

A The films themselves.

Q Thank you. Now, before we get into Ms. Bailey's injuries and accident, I'd like for you just to explain to the jury just the general anatomy of the human spine.

MS. MING: Your Honor, is it okay if Dr. Gallina uses a demonstrative aid of an anatomically correct spine?

THE COURT: Yes.

MS. MING: Thank you.

THE COURT: Just for ID purposes, demonstrative only, I'm going to mark that as Exhibit 12, and that is a model of the spine being presented to the doctor.

(Whereupon, the item referred to was marked Plaintiff's Exhibit 12 for Identification.)

THE COURT: You can step down, Doctor, or you can do whatever you need to deal with -- it might be easier if you step down.

A So there are a handful of anatomic structures that you have to see in the spine, some of which you can see here today and some of which you cannot see today. The spine starts above here in the brain and the skull. Below that is the cervical, thoracic and lumbar spine. The spine consists of bones, and in between the bones are the discs. We label these bones C1, C2, C3, C4, so on and so forth until the thoracic spine. Then the thoracic spine ends at T12, and then the lumbar spine, the lumbar spine into the sacrum and into the pelvis. There's various --

Q I'm sorry. Just to break it down, these areas that you said are labeled C1, C2, C3, what part of the body is that typically known as?

A So those are a part of the cervical spine or the neck, and in between the bones are the discs. The discs -- there's movement that occurs in between the discs, although they're not a true joint. It's fairly technical as to why that's the case, but it just is. The spine has multiple joints that allows the spine to be moved into different positions, so can you move your body in lots of different positions. So it's not just one joint or one level, but multiple levels, that allows you to move.

There are holes within the bones that we typically call

foramen, and that's where the nerves run through. So the nerves are being protected by the bones, and the largest one is what we call the foramen magnum, which is a hole that comes from the base of the skull that allows the spinal cord to go into the spinal canal. The spinal canal is then another hole within the bones.

Q Just slow down. Those yellow wires you were pointing to earlier, what are those representing in that structure?

A Each of these are the individual nerve roots, and the large one in the back is the spinal cord, and they are there to transmit signals from the brain to the different parts of the body, and there are holes in the bone that those nerves are going through.

Q And what is the -- you can sit, if you're more comfortable. What is the purpose of the spine? How is it supposed to move or allow you to move?

A So what you can't see here are ligaments and tendons, ligaments and tendons and muscle that are attaching. You can't see the organs in front of the body. So when we want to move our body, the muscles contract. It pulls on the tendons, and then the body's able to move in a specific location. There again, the muscles are there to -- for locomotion for someone to move, but it's also there for -- to protect someone in case they fall or if there's an injury.

Q And when you say there to protect someone, can you

explain what you mean? How does the spine protect you?

A So, the nerves doesn't like to be touched. So if the nerves are touched in any manner, then that can cause injury to the nerve, and we can go into the different function of the nerves in a little bit. But to answer your question, specifically, the bones are obviously very hard. So while you want the nerves to be able to move to different parts your body, you want them to be protected, because if they're touched, they can become injured. Different nerves have different types of sensitivities. The peripheral nerves, or the yellow ones coming through the holes, they have a different ability to withstand compression, compared to the spinal cord, which is the center cord-like structure.

Q And is there a certain level of force that the spine is able to absorb at any one time?

A Yes. So force is transmitted to different tissues or structures. Different structures will allow different amounts of force to be compressed on them. So the bone typically will allow more force to go into the bone before it's injured. The nerve will allow less force or, you know, accommodate less force before it gets injured.

Q And I know you told us that the cervical C1 levels are -- typically refer to the neck. Did you tell us about the lumbar L levels?

A Yes. So the cervical spine, again, is the neck. The

thoracic spine is the middle back. There's typically not a lot of motion in the thoracic spine, as the ribcage comes across and attaches to the thoracic spine. The rib cage is there to protect your vital organs, heart, lung, spleen, stomach. Those are organs that are required for you to stay alive. Then in the lumbar spine there's no attachments, and that's where you get the majority amount of your side bending rotation of the lumbar spine. The sacrum is then stabilized by your pelvis and goes into your lower extremities.

Q And what types of everyday functions does a healthy spine allow us to engage in?

A So the spine will allow us to move the body parts in a tremendous number of three-dimensional shapes, and that is because the number of levels with which -- are in different parts of the anatomy. So when we are moving our neck in a specific location, there are lots of different levels that require it to move in those locations.

So the spine has a complex task of preventing excessive movement, which would damage the nerves, but then allowing us to move our necks and/or low backs in particular orientation to be involved in activities of daily living.

Q And you mentioned discs a couple of times. Can you just explain to the jury what a disc is?

A So a disc is another structure, and it's got a very specific composition to it that can get slightly technical.

Again, it's not a specific joint, but there is movement that occurs between two vertebral bodies and the disc. The disc is there to allow this degree of freedom, but also to prevent excessive motion. If the disc wasn't there and the bones were moving very freely, it would impinge upon the nerves, either the peripheral nerves on the side or the spinal cord in the back, and that would cause damage to that. So the disc is there to allow movement, but not so much movement that the nerve would then be irritated or compromised.

Q Is there an analogy you can use to explain to the jury what a healthy disc is supposed to accomplish and what concerns you may encounter when you encounter a bulge or herniation, as you mentioned?

A So there are several different analogies we can use. One is what we call a jelly donut. There's an outside portion of the disc that we call the annulus fibrosis. That's very -- tends to be a little bit more tough, and the inside would be like a jelly -- the jelly part of a donut. In a healthy disc, it is intact. In an unhealthy disc or disc that's injured, the jelly portion of the doughnut can go outside the donut, and therefore touch the structures that are around it. If -- that is what we call a disc herniation.

If the disc is touching a structure that is not very sensitive, a disc herniation may not cause any symptoms at all, or any problems at all. If the disc that's herniated is

touching other structures, like a nerve, then patients can have signs and symptoms of damage to that nerve.

Q And so would it be fair to say that another way of describing that would be like having a full tire on your car, and if the tire deflates, all of a sudden your car is either rubbing against the pavement or just not operating?

A Right. So that's another frequent analogy that we would use, if the air is leaking out of the rubber portion of the tire, then the forces will now go not on the rubber portion of the wheel but on the wheel itself, and that's typically -- and then there would be damage to the wheel. In that analogy, the wheel would be the bone. That's one way that we describe patients who have arthritis, is if there's damage to the bone, or joint, really, and that's a way to explain that phenomenon.

Q And I'm going to get back to arthritis, but just briefly in terms of a bulge and herniation, can you just explain the difference, if any?

A Sure. So some of that is semantics. A lot of it is a way where different physicians can describe different pathologies or problems to each other. So if I said that somebody had a disc bulge, that may mean that the disc is injured and that is protruding out into or around the nerves. It may not be touching the nerves, but it may be in proximity to the nerves. That's versus disc herniation, where the disc is now herniated or into the canal or the foramen and typically is

touching a nerve, but not always.

Q I'm sorry, go ahead.

A We can describe disc herniations or bulges based on the location with which the disc is herniated, the size that it is or if it's still in continuity with the disc space itself. So just calling something a disc bulge, a disc herniation, a sequestered fragment, these are part of the story but not the entire story.

Q Just to clarify, if you have back pain, that does not mean you have -- necessarily have a herniation or a bulge, correct?

A Absolutely. So patients come in --

Q Absolutely yes or absolutely --

A Absolutely, you are correct. Absolutely it doesn't mean that you have a disc herniation. There's a lot of different -- what we call differential diagnosis, or many reasons as to why patients have a complaint or a symptom like back pain or neck pain. It could be tumor, an infection, arthritis. It could be a fracture, it could be a disc. The disc itself could be injured, the disc could be herniated, resulting in impingement. So there's lots of different things that can cause a patient to come in with a complaint.

Q And I know you mentioned the direction. Does the direction of the herniation or bulge, is it relevant in terms of the impact or the severity of an injury?

A So I would say location is probably a little more of an appropriate term rather than direction, but yes, depending upon where the disc herniation is, you can have a smaller disc herniation that's right where the nerve is and someone would be symptomatic. You can have a very large disc herniation, if it's nowhere near where the nerve is, the patient would be asymptomatic.

Q So you can have a bulge and herniation and not have any symptoms, correct?

A Correct.

Q But if the bulge or herniation touches a nerve, it's a different story?

A Correct. Typically, that would be painful for people.

Q Now, we've been talking about the -- generally about herniations or bulges touching the nerves. Let's talk about the neck, to start with. How many nerves are in the neck, approximately?

A Right. So there are seven bones and there are eight nerves, also, a slight mismatch.

Q And with respect to a bulge or herniation that is pressing upon a nerve, what type of symptoms would you expect to see in a patient?

A So based on the portion of the nerve that's being compressed will tell you the symptoms that a patient will present with. A nerve is a structure where if you cut it in

half and you look down the pipe, there's basically like different wires of that nerve. So if it's touching the painful portion of the nerve, then the patient will come in with pain in the distribution of that nerve that is being irritated. If it's a sensory portion of that nerve, it will have more sensory issues. If it's the motor portion of the nerve, then they may have weakness.

And then there other functions of nerves, something that we call proprioception. That word means if I close my eyes, I'd know where my nose is in space. That's a nervous function. So if somebody has irritation or injury to a nerve, they may lose that function of proprioception, knowing where their body part is in a three-dimensional space.

Q What is the concern for a doctor, when a patient has a bulge or herniation that's impinging one of these nerves that can cause symptoms like you described?

A So the first thing we want to do is come up with a diagnosis why is this patient coming in with the complaints with which they have. The next thing we want to do is confirm it with imaging and a physical exam, and then we come up with a treatment plan. That treatment plan, generally, although not always, goes with the most conservative treatment, the thing that has fewest side effects, to more aggressive treatment. So in this particular case, it would be physical therapy and oral medication. If a patient fails that, then injections. If they

fail injections, then ultimately surgery, keeping in mind the patient's other medical comorbidities that may influence the decision-making.

Q So would it be fair to say that the first step would be that conservative management of physical therapy and things of that nature, as you just described?

A After diagnosis is made, yes.

Q And the next progression of that you mentioned was injections. What's that level of progression of treatment called?

A More invasive, slightly more invasive.

Q And I'll get back to the injections a little later. And then last but not least, last resort is surgery; is that correct?

A Correct, yes.

Q Now, let's talk briefly about arthritis, because you mentioned it earlier, and can you just explain to the jury generally because we've all heard the word arthritis, we all feel like we know what it is. But can you just explain to the jury just very generally what it is, when it begins to manifest in our bodies?

A Sure. So there are actually a lot of different types of arthritises, it's not just one. The one that we -- that we colloquially think of when someone says arthritis is degenerative arthritis, something that slowly occurs over time.

People can get posttraumatic arthritide, people can get inflammatory arthritis. That would be like a rheumatoid arthritis. So the arthritis is really just injury to the cartilage when two bones articulate with each other, which means that they move next to each other. The easiest example of this would be the knee. It's a fairly simplistic joint where the knee flexes and extends, and at the articulation of those two bones there's cartilage. That cartilage allows the bones to not rub up against each other. When there's injury to the cartilage, that by definition is arthritis.

The problem with cartilage that there's no blood supply to that area. So when cartilage get damaged, it generally does not regenerate, and so therefore patients can become symptomatic or have pain associated with that. The reason the pain exists is because if you touch two bones on each other, that is painful. Touching two articular cartilages to each other is not painful. But when the bone starts to rub upon the bone, that's when patients typically have pain.

Q So the cartilage is like a cushion?

A It's in essence like a cushion, yes.

Q I'm sorry. I just have to simplify it. So based on your description, would it be fair to say that you can have arthritis and not be symptomatic?

A There can be what we call radiographic evidence of arthritis, and patients can be either minimally symptomatic or

asymptomatic from it.

Q And you mentioned posttraumatic arthritis. Would it be fair to say that that's arthritis typically associated with an injury following a trauma of some sort?

A Yes. So, again, arthritis is an injury to the cartilage. If somebody has an injury and there is damage to the cartilage, then that is caused from the injury itself.

Q And does posttraumatic arthritis develop at the same rate as, let's say, degeneration?

A No, they are completely different disease entities.

Q Can you just explain why?

A Degenerative changes occur over time, meaning that patients gradually have these symptoms. Posttraumatic arthritis would be an acute setting where a patient has injury, so therefore the changes occur more rapidly, and they're symptomatic more rapidly.

Q Now, let's go back to Ms. Bailey's accident, treatment and injuries. I'm going to ask that any answers that require an opinion, Doctor, be to a reasonable degree of medical certainty.

Okay?

A Yes.

Q Now, as part your treatment of Ms. Bailey when she first came to you in December of 2022, you mentioned you took a patient history; is that correct?

A Correct.

Q What does a patient history entail? What is the importance of a patient history?

A So first, you know, the initial visit that we have we write a note afterwards. It's meant for medical documentation. It's called history of present illness, and that is basically a story that someone -- that's being told. So someone presents and describes what they're complaining of, the reason why they're there to see you, what their concerns are and what prior treatments they typically have had prior to seeing you. After you take that history of present illness, you then do physical exam, look at any other materials they may have, imaging or medical records, and the whole purpose of it is to come up with a diagnosis, and based on that diagnosis then come up with a treatment plan.

Q And, Doctor, can you just explain to the jury what the terms subjective and objective evidence in terms of the medical profession and its significance?

A So subjective evidence would be something that is relying upon the patient describing things. It's from, you know -- the colloquial term is POV, point of view. Objective evidence would be someone gathering data from a scientific perspective. So, you know, if there was rainfall and you looked into a glass, you could measure very specifically how much rainfall there was. It's not up for debate, it's objective. Sometimes there are shades of gray. Some things are slightly

subjective but more objective.

The whole goal is to try to come up with an accurate diagnosis. So you're taking someone's subjective complaints, what they're describing, the objective data that you have, physical exam and imaging and any other objective data that you may have, imaging and so forth, and come up with a diagnosis and an appropriate treatment plan.

Q Now what type of -- what type of testing or -- is considered objective evidence in the profession?

A A physical exam would be considered objective, x-rays, MRIs, CT scans would be considered objective. EMGs, nerve conduction study tests would be considered objective. Those types of things.

Q And when you took a history from Ms. Bailey, what did you learn from Ms. Bailey with regards to her accident?

A That she was involved in a slip and fall on 3/22/22.

Q And did she tell you what she fell on?

A While I don't have it here on this record, based on subsequent records, she slipped on water.

Q And did she fall to the floor?

A Yes.

Q And with respect to the -- let me go back a little. When you take a history, is the medical diagnosis concerned about the mechanism of injury?

A It can be, but also it cannot be. In other words, if

someone presents with a tumor, you may not really care how the tumor got there, the tumor needs to be treated. So from a medical perspective, we want to get an accurate diagnosis, but it's --

Q It depends.

A Right. So it depends.

Q And in this particular case, were you able to identify the mechanism of injury, or, in other words, what type of injury Ms. Bailey sustained on March 22, 2022?

A Yes, it was her slip and fall.

Q And are you familiar with the term hyperflexion injury?

A Yes.

Q Can you just explain what an hyperflexion injury is?

A So there's various motions that a neck can go into, flexion, extension, rotation and side bending. So when someone has a fall and hits the back of their head, that mean the forces of the floor -- the floor is static -- and the force of the head hits the floor and caused a patient to go into flexion.

Q And again the head is supported by the neck, correct?

A Correct.

Q And is that the type of injury that you sometimes see in car accidents with a seatbelt?

A Yes.

Q Or is this something different? I just want --

A It can be the type of injury that occurs -- you can

also get an extension injury with seatbelt injuries, but yes, these are the types of injuries you can get.

Q Is the level of force relevant in terms of the amount of, I'm going to say, hyperflexion?

A Right. So it's the level of energy. But the energy equates to force, and that will be one portion of the amount of tissue damage that occurs.

Q And in this particular case, what part of the body did Ms. Bailey indicate to you hit the floor?

A She indicated that she injured her head, hit the floor, injuring her neck and low back.

Q And did you review Ms. Bailey's treatment in the emergency room that day?

A I reviewed it at some point in time. I don't remember specifically that day.

Q Do you recall whether she had any complaints in the emergency room on the day of the accident?

A Yes. I believe she complained of neck and low back pain.

Q And despite the complaints of neck and back pain, did you -- did you see any type of imaging in those records?

A I reviewed the actual images myself.

Q Let me go back, because that was a bad question. With respect to the emergency room, after reviewing records did you determine whether she had an x-ray or CT scan or anything of

that nature?

A I do not believe she had any objective radiographic evaluation of her.

Q And is that something you would typically see in a patient reporting a head strike and back injury at the pain levels she was reporting?

A Yes, typically, we would get some type of imaging, most basically an x-ray.

Q But that didn't happen in this case, correct?

A Not to my knowledge.

Q At some point, did you also review records related to her treatment at CitiMed?

A Yes, at some point in time.

Q And do you recall approximately how many days following the emergency room visit she reported to CitiMed?

A I don't recall.

MS. MING: I'd like to show these records to Dr. Gallina just to see if it refreshes his recollection.

THE COURT: These are CitiMed records?

MS. MING: Yes.

THE COURT: Showing Exhibit 5?

MS. MING: Yes, Your Honor. This is on 3/24/22.

Q That was approximately two days following the accident, correct?

A Yes.

Q And as part of your treatment of Ms. Bailey, you mentioned that you reviewed the records at some point; is that correct?

A Correct.

Q And were Ms. Bailey's complaints during her treatment at CitiMed similar to the complaints she made in the emergency room?

A Yes.

Q What were those complaints?

A Neck and low back pain.

Q And at some point, Doctor, she also complained of head pain, correct?

A Correct.

Q And that eventually resolved?

A Correct.

Q Now -- by the way, as part of the review of the records, Ms. Bailey's first visit was with a physiatrist; is that correct?

A Correct.

Q Can you just briefly tell the jury, is a physiatrist a doctor like any other doctor?

A Yes.

Q What's the physiatrist's specialty?

A Physical therapy, in essence.

Q But the physiatrist is not a physical therapist, per

se?

A Correct.

Q And would it be fair to say that they typically coordinate conservative treatment; in other words, that they would typically coordinate physical therapy or an imaging and evaluate the patient's needs?

A Yes. I think an appropriate analogy would be almost like a primary care surgeon and an orthopedic surgeon.

Q Thank you, Doctor. And after you reviewed -- withdrawn.

As part of the treatment at CitiMed, do you recall what type of treatment she did have?

A She had physical therapy, chiropractic treatment, oral pain medication and, ultimately, injections.

Q And do you recall for how long she had this treatment?

A Before she saw me?

Q Yes.

A From 3/24/22 to 12/12/22.

Q Now, as part -- in addition to reviewing the records from CitiMed and taking a history from Ms. Bailey, I know you said you examined her. We'll talk about that. Did you have an opportunity to also review any images that were taken at CitiMed?

A Yes.

Q What images did you review, Dr. Gallina?

A On that day I read an MRI of the lumbar spine, thoracic spine and cervical spine.

Q And when you say you read, you mean you read the film or you read a report?

A Read the films.

MS. MING: Your Honor, at this time I would like to have the doctor walk us through the MRIs Ms. Bailey had, which have been marked for identification as Plaintiff's 5A collectively as part of the CitiMed records that are -- can I approach the computer?

THE COURT: You may.

MS. MING: Your Honor, I'm going to move on. It was connected before the jury came, now it's not. I'm going to move on.

Q Dr. Gallina, while I try to resolve our technical difficulties, can you just explain to the jury what images she had in that very first -- the first couple of months of treatment?

A So she had an MRI of the cervical, thoracic and lumbar spine. An MRI uses magnets to form a three-dimensional image.

Q I'm glad you explained what an MRI is. Can you just explain to the jury just briefly -- we know the name, but can you just explain the purpose of an x-ray, CT scan, MRI and the differences between them?

A Yes. So there's three general modalities and they're

looking at different things. The first thing is an x-ray. It's a one-dimensional image. So you're looking at the bones. It doesn't look at the nerves, discs, muscles or tendons or ligaments, it's only looking at the bones. So predominantly it's looking for any instability or any fractures of the bones. It's a fairly cheap study to get and it is very quick to get. So it's typically what we would start off with.

An MRI will give us more definition of the soft tissues, meaning the nerves, discs, the muscles, and is a longer study to get, and it uses a magnet, so there's no radiation, and it forms a three-dimensional images that you can then evaluate those structures.

A CT scan is similar to an MRI, but it does give you radiation. It's much quicker than an MRI and it's a high-definition 3D image of the bones. So while you can see some soft tissues, it's primary focus is to look at high definition of bones.

Q So in this particular case, you reviewed MRI films?

A Correct, yes.

Q At any point up until that point had she been ordered to have any x-rays?

A No, I don't believe so.

Q And you told us that you reviewed the films, not the reports. Can you explain to the jury why?

A Sure. So as a surgeon we see things differently than,

let's say, a radiologist. A radiologist is there to describe what they're seeing in terms of certain verbiage or words, to describe what they see. So if someone doesn't see the film, they can make an interpretation from it. A surgeon like myself, we're there to look at various surgically-oriented anatomy and problems. So our goal is to look at the films and to see from a very specific point of view is what the diagnosis is and if it correlates to somebody's complaints that they have, and more importantly, from a surgical perspective what type of surgery they need and how we're going to perform that surgery.

So if we -- if we're just looking at the image -- I'm sorry -- the reports themselves, we, at times, may miss certain information that's appropriate for us or important to.

Q Would it be fair to say that if you're the surgeon and you're performing the surgery, you want to see for yourself what it is that's going on in there?

A Correct, yes.

Q And let's start with the cervical spine. Hopefully, we'll be able to play that soon. Can you walk us through your observations with respect to the images taken and the date that the cervical MRI was taken? Let's start with that MRI.

A So my read is an MRI of the cervical spine performed on 4/28/22 reveals disc herniations at C4-C5, C5-C6 and C6-C7.

Q Can you just explain to the jury what that basically means with respect to her cervical spine or her neck?

A Yes. So if we go back to our model, we have one disc that's in between two bones. So this is the C1 bone, this is C2, C3-C4, C4-C5, C5-C6 and C6-C7. The discs are in between the named bones. So C4-C5, C5-C6 and C6-C7, those discs are not herniated, no longer in the disc space, and is now compressing the nerve. We call it a pinched nerve, because the nerve is being compressed or pinched in between the disc and the bone in the back. That's why we call it a pinched nerve.

Q A pinched nerve sounds like it's nothing, Doctor. Can you explain in this particular case, Ms. Bailey's case, what a pinched nerve translates to in terms of the impact on her?

A So, yes, pinched nerves can be short-lived or be very mild in nature. They also can be very significant and life-changing. It depends on the degree of inflammation of the nerve, how irritated the nerve is, and for how long the nerve is irritated tells us the severity of symptoms and how disabled somebody would be. So if they have severe compression and severe inflammation of the nerve, then -- then the -- it will be very disabling for them and they'll have a lot of difficulties with their activities of daily living.

Q And walk us through the lumbar spine images you mentioned. First off, did you review the lumbar spine images or films?

A Yes. So the MRI of the lumbar spine performed on 4/7/22 reveals a lateral recess stenosis at L4-L5.

Q That was a mouthful for me. Let's -- can you break that down in a way that we just understand.

A So, again, in the lumbar spine there are named vertebral bodies or bones L1, L2, L3, L4, L5 and S1. S would be the sacrum, L stands for lumbar. So at the L4-5 level there is some stenosis or disc herniation that's irritating the nerve in a specific location. Again, we label these with specific words to describe where the stenosis is or where the pinched nerve is or where the lumbar radiculopathy -- that's the medical term -- is, and that helps differentiate what type of treatment one would have.

Q And you mentioned radiculopathy. Can you please explain to the jury what radiculopathy is?

A Radiculopathy is an inflammation of the nerve root. So the nerves are coming off of the brain, going down the spinal cord, and off the spinal cord there are each of the individual nerve roots. When a nerve get injured in the spinal cord, that gives you very different symptoms than if the nerve root gets irritated, which we call a radiculopathy. Opathy just means inflammation of the nerve, and a radiculopathy is inflammation of a nerve.

Q How do you diagnose a radiculopathy, Doctor?

A Radiculopathy is a clinical diagnosis, meaning that someone comes in complaining of those symptoms, and that is then corroborated on physical exam and the imaging.

Q In Ms. Bailey's case, did she make complaints to you regarding her activities of daily living and what was going on with her?

A Yes.

MS. MING: I'm sorry, Your Honor. My colleague is going to try to help set up the monitor.

THE COURT: Why don't we take two minutes so everyone can use the restroom. Please don't discuss the case amongst yourselves. We'll take a few minutes to get the computer screen working.

COURT OFFICER: Jury exiting.

(Whereupon, the sworn jurors exit the courtroom.)

COURT OFFICER: Jury entering.

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

THE COURT: You may be seated. Counsel, you may continue.

MS. MING: Thank you, Your Honor.

Q Now Dr. Gallina, if you can turn the screen so that the jury can see it. Just explain to us what we're looking at.

A Sure. So this is an MRI. So, as we stated before, his looks at the nerves and the discs very well. It looks at the bone, but not as well as a CT scan would. There are different images to make a three-dimensional picture. I'm going to show you two of those images, so it's really two images. This yellow

line helps to denote which of the images we're looking at and they correlate with these images together. So as I scroll on one image versus another, it will -- the line will appear and scroll on the other image that indicates the right side of your body. This indicates the left side of your body. That's how we correlate these two images.

This image cuts straight down your body, and it's opening like a book. This image is cutting you like this and opening you up, looking like you're slicing meat at a deli. This is what we call a sagittal image. This is the front of your body, the back of your body, the head and the foot. So this is the brain, the brain stem and this is the spinal cord.

These are the bones. This is C2, C3, C4, C5, C6 and C7. The solid structure is your spinal cord going down the spine, and the white fluid is what we call CSF. It's the fluid that bathes the spinal cord.

The first thing we notice on the center cut at C2-C3 disc space, there's white CSF surrounding the spinal cord at most of the level. Then we got down to these levels, there's really no CSF in front of or behind the spinal cord, and then it opens up again the low levels of compression. The discs are supposed to be in the disc space. C2-C3 and C3-C4, the discs are mostly in the disc space.

Then below, you have discs that are now herniated out the back and is now compressing the spinal cord, and the other

images will show you that it's compressing the cord and the images -- and the neuroforamen as well. But that's occurring here at C4-C5, C5-C6 and C6-C7.

If you go to the axial image, which are these images, which are these images here, this is the C2-3 level. This is the front of your body, the back of your body. This is a mirror image of yourself. So this is the right side of your body, the left side of your body. There are lots of structures you can see, like the trachea and esophagus in the front. But this is the disc, this is the spinal cord, this is the spinal canal with the white CSF that's there. It's nice and wide open, so you don't see much of disc herniation at this level compressing the spinal cord.

When we go down to the C3-C4 level, you can see that there's a smaller disc herniation that's punctate like this. At the C3-4 level it's not encroaching the neuroforamen, and it's not significantly encroaching the spinal cord. As we continue down the C4-C5 level, you can see that this disc is now broadly based compressing the spinal cord, and the cord, instead of being around like this, it's becoming kidney bean-shaped, and there's encroachment on the right and ultimately the left neuroforamen. The neuroforamen is where the nerves come off the spinal cord and go out the neuroforamen to the rest of your body. That's C4-C5. There's some subtle what we call gliosis or inflammation within the spinal cord at this level.

When we go to the next level, you can see that there's a larger disc herniation that's behind the body a little bit here at C5, and then it continues down to this level where the neuroforamen are a little bit wider than the C4-5 level, but still slightly asymmetric on the left side, and this spinal cord, this central disc herniation is now compressing the spinal cord.

We come down to the C6-C7 level, again, we have broad-based disc herniation, where the disc is compressing the spinal cord a little bit more on the left side compared to the right side. But there's foraminal encroachment on both sides. Then we go back down to C7-T1. You can see that that white CSF is fully surrounding the cord and nice and wide open again. The neuroforamen are open and there's no compression on the cord.

This is, you know, a pretty good disc, what a disc should look like, where it's what we call concave on the disc, and that disc isn't protruding or touching the spinal cord.

Q What level is that disc?

A That's C7-T1. That's going into the thoracic spine, the junction of the cervical spine into the thoracic spine.

Q And in the prior images where you saw the cord compression, we're referring to the spinal cord, correct?

A Correct, yes.

Q And just show -- if you can just show the jury the lumbar images.

A I'm sorry.

Q Can you look at the lumbar MRI?

A Yes.

Q Actually, I'm sorry, Doctor. You mentioned inflammation. What on the images -- where on the images did you see that inflammation?

A The gliosis, on the sagittal image, it's this white sort of scar tissue that's within the spinal cord itself, and it comes up to this area here. It's a different echogenicity. In fairness, it is we call early myelopathy. So it's the -- as spinal the cord gets damaged, the longer that the damage is there, the brighter that whiteness becomes, the more significant it becomes.

Q And what is the significance of the inflammation that you mentioned?

A So there's a difference between irritation of the spinal cord itself and the peripheral nerve roots. When the nerve root is being compressed, it is giving inflammation in the root that's going to the rest of the body, the arm, the hand and so on and so forth. When the spinal cord is being compressed, that's what we call an upper motor neuron finding, and that's when it's in essence what we call slow paralysis. So the patients come in complaining of different signs and symptoms, and on physical exam, there are different physical exam findings that we can find with that cord compression.

Q And after reviewing these images and taking a history from Ms. Bailey, did you form an opinion to a reasonable degree of medical certainty as to whether she sustained injuries with respect to that accident of March 22, 2022?

A Yes. I believe the accident in question resulted in these symptoms.

Q And you mentioned the spinal cord compression. What are the concerns when one has spinal cord compression as is depicted here?

A So the spinal cord acts differently than the nerve roots. The spinal cord would be more like the brain. So if you have inflammation of the brain, in that particular case we would call it stroke. This is not a stroke, but it is an upper motor neuron finding. So if someone has injury to the spinal cord itself, that injury can be permanent and it can at times be difficult to reverse. So anyone who has neurologic dysfunction associated with that spinal cord inflammation, even with surgery we may not reverse the damage in the spinal cord.

The reason why we do the surgery is to halt the progression of the damage to the spinal cord. That's different than the nerve roots that typically respond a little bit better to reverse the damage to the nerve roots.

Q That was going to be my next question, the difference between the damage to the nerve root. Now, can you walk us through the lumbar images that you reviewed.

A So, again, this is a sagittal image coming across our body like this, where it gets opened up like a book. This is the axial image cutting like this. There's all different anatomy that we can see. This axial image is very high here. So when we can see that the spinal cord ends right about here. So this is solid cord structure, and on the axial image that's the cord there. After that, these look like strands of spaghetti, because now we're getting into what's called conus, which are each individual nerve roots. Incidentally, this is the right kidney, the left kidney, this is the vertebral body, pedicle, lamina, spinous process.

So as we come here, the first thing that we can see on the -- on the sagittal is that the disc actually looked okay. This nice black annular ring with white nuclear center at each of these levels, these are the way that the discs are supposed to look. Sometimes with cases there can be degeneration or tearing of the disc. In this particular case, it looks okay.

Q What levels are those?

A These are L5-S1, L4-L5, L3-L4, L2-L3, L1-L2, and then it's the thoracic spine going up. When we come down to -- this is a fairly normal level. Again, this is the axial image. It's got a nice black annular ring, nice white nuclear center. This is all in the front. This is the nerve root right there. This is another nerve root right there. This is the thecal sac or conus. Again, you can see each of the individual nerve roots in

the conus. She's in a supine or laying down position. That's why all the roots grab these, pulling the roots down to the back, and the white with CSF is hanging up, because the CSF is less dense than the nerve roots. And this is a fairly normal level. You can see the neuroforamen nice and wide open, the nerve are not being pinched or compressed at all by the discs.

We come down to a lower level here at L4-L5, you can see the disc is one nerve root, and that's the disc that's compressing that nerve root, and it's impinging the nerve between the disc and the bone. This is the facet, and at this next level this is the disc herniation here. As you can see, it's little bit worse on the left side compared to the right. The right neuroforamen is narrowed, but on the left side, it's a little bit worse, and that is -- this is the root here, and that's the root that's being compressed by the disc in that far side.

Q After reviewing the films, did you form an opinion to a reasonable degree of medical certainty as to what injury, if any, Ms. Bailey sustained to her lumbar spine?

A I'm sorry. I couldn't hear you.

Q What did you determine after reviewing those images?

A That her subjective complaint corresponded to the imaging, and it was the result of the accident in question.

Q So, in other words, the images provided objective evidence of her symptoms that she was complaining of?

A Correct, yes.

Q Thank you, Doctor. You can go back. Now you mentioned that you examined Ms. Bailey. Can you walk the jury and the court through what your examination entailed?

A Sure. So there's various maneuvers that we do to evaluate a patient. The first thing we do is ask them to range their motion of the body parts, like the flexion, extension, rotation, side bending. We then ask the patient to undergo various tests, like motor strength and/or sensation, and then some provocative maneuvers. That would be -- that we put the body part in a specific position, and that's in preparation to see if the neuroforamen causes any irritation. The neuroforamen are holes in the spine. These holes are different than, let's say, a hole in a wall. A hole in the wall that carries a power cord through that, it's very static, it stays in one position. So the power cord pushed through the hole and it stays like that at all times.

The neuroforamen changes in diameter based on the body position that someone's in. So there's various maneuvers that we can do to get the neuroforamen to become smaller if there's a disc herniation that's partially blocking that hole and there's nerve coming through. When we make that nerve smaller in a specific location, it can cause inflammation of that nerve, and in the neck it's called Spurling signs, in the low back it's called straight leg raise.

Q And you conducted both the Spurling and the straight leg tests?

A Correct.

Q On Ms. Bailey that day?

A Yes, correct.

Q Did you also inquire about her activities of daily living?

A I did on, especially on subsequent visits we did what's called Oswestry Disability Index or a Neck Disability Index. That's where she fills out a questionnaire of the things that she can and cannot do, and it comes up with a percentage of how disabled she is.

Q Now, Doctor, after reviewing the history, conducting that examination of Ms. Bailey and reviewing medical records related to her emergency room treatment, CitiMed, at that very first visit were you able to form a diagnosis for Ms. Bailey?

A Yes.

Q And can you share with us what the diagnosis was?

A Cervical and lumbar disc herniation, resulting in radiculopathy.

Q You've already explained the radiculopathy. Can you please explain to the jury in terms of your evaluation of the treatment she had undergone, did you formulate a plan with respect to treatment for Ms. Bailey?

A Yes. She was going to continue nonoperative treatment

in the form of physical therapy and injections, and we discussed surgery for her.

Q And why did the topic of surgery come up?

A It comes up for a few reasons. One is she's failing or has failed nonoperative treatment, meaning the conservative treatment. She's surgically indicated for surgery, meaning that she's a surgical candidate, she can have surgery. The timing of the surgery depends on the risk-benefit profile, how risky she believes that the surgery would be, or any other treatment, for that matter, and what she believes the potential upside or benefit is of that treatment, in this particular case, surgery.

Q And with respect to Ms. Bailey, following that visit in December of 2022 was any decision made with regards to surgery at that point?

A No.

Q And did there come a time that you saw her again in 2023?

A Yes.

Q When did you see Ms. Bailey again?

A In 2023 I saw her on 5/15/23.

Q And can you explain to the jury in terms of that visit, did you take an updated history from Ms. Bailey?

A Yes.

Q And did she have similar complaints? Different complaints?

A Yes. In essence, the visit was similar or the same.

Q And did you examine her on that day?

A Yes, and in essence it was similar or the same.

Q And did you conduct that Spurling or straight leg test?

A Correct, yes.

Q And at that point, did you make a recommendation to Ms. Bailey with regards to surgery -- surgical treatment, I should say?

A Yes. We discussed once again what her treatments would be. They would include nonoperative treatment. She still hadn't received x-rays, so we wanted to see some x-rays of her cervical lumbar spine, and then we discussed her cervical treatment options. She had some family members there and, you know, right now we're just describing it at surgical treatment options, but for patients like herself, there are a few other surgeries that she is a candidate for. So we went into great detail regarding those surgical and nonsurgical treatment options and what the risks and benefits of those would be.

Q Now, Doctor, Ms. Bailey explained to the jury that you were very stern when you were providing her with your recommendations. What were your recommendation with respect to Ms. Bailey's future treatment and her prognosis and future care?

A Yes. So whenever there's a conversation with the patient, there's a relationship that forms between a patient and the physician. Sometimes that relationship can be more

paternalistic, like a parent saying you should do this. At other times, it's more open-ended that says these are your options.

She has a slightly complicated medical history. Every patient, although they have the same diagnosis, may not have the exact same treatment options, and there's various risks and benefits to different treatment options. She has a little bit more complicated medical history, so there are very specific risks and benefits for her for different surgical and nonsurgical treatment options, and --

Q Let me stop you there. What is the complication with respect to Ms. Bailey's candidacy for surgery and specific treatments?

A So there are generic -- more generic risks that are associated with, let's say, the injection, the procedure of the injection, the medications, bleeding, infection, you know, the injection can irritate the nerve. They can inject a nerve. I don't give the injections --

Q Let me stop you there because I know we glossed --

MS. MING: Your Honor, you can let me know when to stop to take a lunch break.

Q Because we glossed over the injections. We're making it sound like a flu shot. Can you just explain what the cervical and lumbar epidural injections Ms. Bailey underwent in this case, what that procedure was and where did she have those

injections?

A So an epidural injection is an epidural, just like a pregnant woman would get an epidural. In this particular case, for a pregnant woman it's in the lower back, but it can be in the lower back or the neck. It's called an epidural injection because it's given in the epidural space, which is where the nerves are. The nerves are being compressed and irritated, which is causing inflammation in the nerve. The medication is being given around those nerve to try to decrease the inflammation that's being caused from the compression. We could give similar medications orally. There's different routes you can give medication.

Q Almost like oral steroids?

A Like oral steroids, but they have secondary side effects for those medications. So if you can't get that medication orally, you ingest it, you digest it, the medication goes to all your organs, so, therefore, you have some of the secondary side effects of the medication. The injection is not given orally, it's given locally, albeit a very deep local injection, and so, therefore, the medication goes into the bloodstream less significantly. It still goes, but less significantly. Therefore, there are fewer systemic side effects from the medications themselves. There are, however, an increased risk of the injection and the procedure of getting the injection. So the medications they're giving you for the

injection and so on so forth, so there's a specific risk profile of the injection versus the oral medications. Each of those --

Q I'm sorry. Before -- are patients awake for this procedure?

A They can be in various states of sedation. So sometimes they're completely awake, sometimes they can be very sleepy. It depends on the patient and the specific situation. One global -- there are lots of different risks of the injection. One global risk of injection specifically for her is that it can increase your glucose. All steroids can increase your blood sugar count. That's not necessarily prohibitive if somebody has controlled diabetes. But if somebody's an uncontrolled diabetic, then that potentially could be problematic. That then has to be weighed with what do we think that this injection is going to be curative; meaning that if the injection that she got was going to make this all go away, then we'd say maybe it's worth bumping up blood sugar a little bit to cure your problem.

If, however, we know that the success rate of that injection may be lower, because she failed previous injections, or in this particular case, so much time has gone by, then the efficacy of the injection is likely going to be less significant. So, therefore, the risk of the injection, particularly the blood sugars, may outweigh the potential benefit of improving the injection.

Q So, in other words, that's just a way of saying she was not a good candidate for future injections?

A Right. So that's our way of saying listen, you can have an injection, I'm happy to provide an injection for you. But do I think that that is the best route for you to go? No, I do not.

Q With respect to the Spurling test, is that an objective test or subjective test?

A That's objective.

Q With respect to the straight leg test, is that also an objective or subjective?

A Objective as well, yes.

Q Now, you mentioned that you had an in-depth conversation with Ms. Bailey at that second visit. What did you recommend at the end of that second visit?

A So I recommended additional images, and we essentially talked just like I'm talking about to you about the risks and benefits of nonoperative and operative treatments. I think, you know, I probably came across strongly that I did not believe that nonoperative treatment will give her long-term pain relief or symptom relief, and I gave her, just as though I'm giving to you, all the reasons why I believe that.

Q Why do you believe that, Dr. Gallina?

A I believe that the likelihood that she'll get long-term relief of her symptoms with nonoperative treatment is very, very

little. I believe that the risks of those nonoperative treatment, both for her medically is very high, given her diabetes. I have concern with a whole other complicated segment, you know, people who have diabetes have a high blood sugar count, and having sugar in their blood make it difficult for nerves to regenerate. Her nerve is already damaged. So even after surgery if you have diabetes, there's less -- it's less likely that the nerve will completely regenerate even after surgery. So -- and she's already failed nonoperative treatment with prolonged treatment. So I think that she needs surgery. There's various different types of surgeries that --

Q Let me stop you there. You said that the nerve is already damaged. What evidence do we have that the nerve is damaged?

A The evidence that we have is that subjectively she's complaining of these symptoms in the distribution of the nerves that are being irritated. Objectively, on my physical exam, there are indications that the nerve is damaged, and then there's another spine surgeon that's giving similar, also different, physical exam results.

Q Let me stop you there. Did you recommend she get another opinion --

A Yes.

Q -- after your conversation?

A Yes.

Q And in terms -- well, I think this would be a good place to stop.

THE COURT: Sidebar.

(Whereupon, the following discussion takes place at sidebar among the court and counsel, outside the hearing of the defendant and sworn jurors.)

THE COURT: Members of the jury, we're going to take a break for lunch. It's just about 1:00. We'll break for an hour. Please be back here at 2:00. Please do not discuss the case among yourselves or with others. Enjoy your lunch.

COURT OFFICER: Jury exiting.

(Whereupon, the sworn jurors exit the courtroom.)

THE COURT: One of the jurors had a scheduling conflict. So we really needed to get the doctor done today, as she could not come back, so we had to let her go from the jury and substitute somebody, and that's why the makeup of the jury is different.

Counsel, continue direct examination.

MS. MING: Thank you, Your Honor.

CONTINUED DIRECT EXAMINATION

BY MS. MING:

Q Now when we left off, I believe we were going to be discussing additional films that are in evidence, Lenox Hill Radiology records.

MR. SANDS: Judge, this is where I have my objection.

THE COURT: She hasn't introduced anything yet. Hold on.

MS. MING: Your Honor, at this point --

Q Dr. Gallina, did you review the films from Lenox Hill Radiology?

A Yes.

Q And what films did you review?

A MRIs and x-rays.

Q And can you approach the screen, Doctor?

A Yes.

Q To clarify, you reviewed the actual films, not reports, correct?

A Yes.

MR. SANDS: Judge, same objection.

THE COURT: Same ruling. He's a treating physician. He used those records in his analysis.

A Sorry. These films look like they're the old films from --

MS. MING: Let me just -- I'm returning the CitiMed, Your Honor. I'm going to skip ahead while that loads.

THE COURT: Okay, come back to it. Have a seat.

Q Now, I believe -- they came up.

THE COURT: Yes.

A Would you like to look at the cervical or lumbar?

Q Whenever you prefer. Just let us know what you're looking at, and walk us through the -- what the imaging reveals.

A So this is going to be a new MRI that we obtained. This is the sagittal image, this is the axial image.

THE COURT: Can we have a date on those records, please.

THE WITNESS: Yes. The date of this is December 9, 2025.

Q I believe that you also have 2023 images.

A Not on --

Q All right. You can start with the --

A Okay.

Q To be clear, this is the cervical MRI, x-ray or lumbar?

A So this is the lumbar MRI. Again, this is the L4-5 level. The yellow line is through the L4 level, the L4-5 level. This is the sagittal image, and this is the axial image. Again, if you can see here, right at the disc space, this is the right nerve root, this is the left nerve root. If you progress one image further, you can see that this is the left disc herniation. That's the part that's touching the left nerve root, and this is the right disc herniation that's compressing the right nerve root. The neuroforamen is here, and the neuroforamen is here. So this disc herniation is much more

lateral than we would typically see.

When we come to the sagittal image, this is on the right-hand side. So you can see this R, and this is the yellow line, indicating where we are, that corresponds to the disc herniation here and this is the nerve root there. This is in the neuroforamen. So the foramen is like this, the nerve is coming out at us like that. This is the nerve root and this is the disc herniation, showing that the disc is herniated, touching that nerve.

When we're coming to the other side, it misses it slightly, but again, this is the disc herniation here, this is the nerve root, and when we come over on this side, the root is here, the disc herniation is there. So that's the lumbar MRI. On the cervical MRI, this is that small punctate C4 --

Q I'm sorry, Doctor. Just tell us the date of that MRI that you are --

A I'm sorry.

Q Just tell us the date of that MRI.

A The date is July 13, 2023, and this is the patient. This is the sagittal image, this is the axial image, this is the C3-C4 disc space. So this is C2, C3, C4, and again we see the C3-4 disc herniation that's punctate in nature. It's not compressing the neuroforamen on the right or the left side, nor is it compressing the spinal cord, and it looks stable or similar to the previous exam.

Here, at C4-C5, we have a progression of the disc herniation. Now it's the hemi-canal, so it's centrally located, right greater than left sided, with a disc herniation compressing the right neuroforamen and the nerve root, and compressing the spinal cord. And incidentally, we can see a progression of what we call endplate sclerosis, which we didn't talk about too much last time. But this is the white portion of the vertebral body. This disc is no longer within the disc space, it's now herniated to the canal.

So this disc herniation that is in the canal is no longer functioning, and this is the analogy that we originally said about the tire, how if air leaks out of the tire and there's no longer air within the rubber, the forces now are going on to the wheel of the car and therefore there's going to be damage to the wheel of car. In that sense that's what's happening, there's progression of that endplate sclerosis or that whiteness, where the bone is reacting, because more forces over time since many years ago are now compressing on the bone.

Q But to clarify, Doctor, this is a year after the accident?

A Correct, 2023, correct.

Q You said progression. What do you mean by progression?

A Progression means that the disc -- you have to realize that this MRI is like a Polaroid picture. I'm taking a picture of you, and with time there's going to being changes that occur.

So if I sequentially take pictures of somebody, that's is essence what the MRI is doing, and the x-ray and/or CT scan. So it's showing to see if there's been any dynamic changing of this, and in fact there are some changes that we can see.

So this is C4-C5. Again, there's disc herniation compressing the cord, that's coming down below the vertebral body, continuing below the vertebral body, and now at the next disc space, it's centrally located compressing the spinal cord. Going another click, it's centrally located, compressing the spinal cord and the neuroforamen, and again, now it's more broad-based, centrally located. The neuroforamen on the right side looks to be tall. The neuroforamen on the left side is now compressed. That disc is now encroaching on the left neuroforamen, and it's now pinching the nerve between the disc and the bone or the facet as posterior, that continues, and then again we go to C7-T1, which is this disc, which is normal and out of the diseased area.

I believe we have x-rays here that we can go through also. So this is what we call an AP view. The date of this film is September 17, 2025. This is the side view or the lateral view, same date. You can see that the spine is straight up and down. These are the ribs. So this is T12, L1, L2, L3, L4, L5. This is the SI joint and the pelvis, that's the pubic symphysis. All this air here is all the gas from the colon. What we see on this trajectory is that there's no evidence of

instability of scoliosis, that the film is straight up and down.

On the side view, we're looking to see if there's any disc space narrowing or disc space collapse. It looks pretty good. There's no instability on the lateral view. Everything looks fine. On the lateral view of the cervical spine, which also is dated July 17, 2023 this is the skull, this is the jaw, this is her dental work. This is the C1 bone, this is the C2 bone, 3 bone, 4 bone, 5 bone, 6 bone and 7 bone. These discs are C2-3 and C3-4, at C4-5. They're now narrowed, and you've got anterior osteophyte formation, C4-5, to a lesser extent C5-6, and then again at C6-7, and while the shoulders are obscure on C7-T1, you can see some preserved disc space which corresponds to the MRI and normal disc on the MRI. That's the side view.

The front view of the neck is fairly unremarkable. There's no scoliosis. Her head is standing above her shoulders, the clavicles are symmetric, they're not leaning one way or the other. This is her first rib. That's her trachea that you can see the air in. Everything looks okay.

Q When you say okay, what do you mean by that? She's okay?

A Yes, meaning that this is isn't a concerning image. The other images are the concerning images of everything I pointed out.

Q You mentioned osteophytes?

A Yes.

Q And can you tell us if you see evidence of that posttraumatic arthritis that you spoke about?

A So the arthritis again would be the articular cartilage, and that would be within the facet joints in the back. If you remember the model, the joints are coupled like this, the bones are articulated with each other with the cartilage that's there. I don't see any arthritis that's in the facet joints. We colloquially call, commonly call the disc space narrowing and the bone formation here at these other levels arthritis. It's not technically arthritis, because it is not a true synovial joint. There is movement that occurs over the -- through the discs, but it's not actually a joint. These images of x-rays were taken on July 17, 2023, which is after, way after the accident that occurred.

So at this point in time there are changes in the forces that are going through the neck, and so the bone is now reacting to those forces, because the disc is no longer within the disc space. So this was some of the changes that we would anticipate to see.

Q Thank you, Doctor. And at some point, you mentioned earlier that Ms. Bailey went to seek a second opinion?

A Correct.

Q And did you have an opportunity to review the records of the second opinion?

A Yes.

Q And who did she seek a second opinion from?

A Dr. Brisson.

Q And did you recommend Dr. Brisson?

A I did not recommend Dr. Brisson. I recommended a second opinion.

Q And after reviewing those records, were you able to determine what type of examination Dr. Brisson conducted?

A Yes. So he did a similar history and physical exam, and then continued to follow her over a period of time with followup exams.

Q And following -- at some point, do his records reveal a recommendation for treatment for Ms. Bailey?

A Yes. He was recommending surgery of her cervical spine. However, she was deferring that surgery because of her blood glucose levels and her diabetes.

Q You said deferring?

A Correct.

Q And now I want to go -- and you said he was recommending a cervical surgery. What levels, if you recall?

A My recollection was it was the same levels that I was recommending, which was C4-C5, C5-C6 and C6-C7.

Q Now, Doctor, can you explain to the jury, because you told us that there are different options that you discussed with Ms. Bailey, in your opinion what is the surgery that you

recommend -- let me rephrase that.

What is the surgery that you're recommending or recommended to Ms. Bailey?

A It's called a three-level C4-C5 C5-C6 C6-C7 Anterior Cervical Discectomy and Fusion. What that means is that anterior means we go through the front of the neck, we take the discs out --

Q Let me just slow you down a little bit. I know this is like routine to you, but for us we have to process, at least for me, step by step.

A Sorry.

Q You said anterior or posterior?

A Anterior.

Q What does the word anterior mean in that regard?

A So there are three or four surgeries that she's a candidate for, and the one that I'm recommending is anterior through the front of the neck. She is also a candidate for a surgery in the back of the neck called posterior cervical decompression fusion, but I am recommending and Anterior Cervical Discectomy and Fusion.

Q That was the same surgery that Dr. Brisson recommended?

A Correct, yes.

Q Can you explain to us what the surgery entailed and what type of procedure? Invasive? Not invasive?

A It's microscopic surgery, although it does require

incisions. Patients typically do pretty well from the surgery. In essence, it requires taking the disc away. Once you take the disc away, you put a piece of bone where that disc was, and we'll plate and screw over the bone to heal the bone. The sections end up fusing or there is no motion.

MS. MING: Your Honor, can the witness use a demonstrative aid of the fusion that he's describing?

THE COURT: Yes.

Q Will this aid you in explaining the procedure to the jury?

A Yes.

Q Now, first of all, you said you take the disc away, like you're taking away. Do you mean --

THE COURT: Hold on one second. Why don't we just get an easel.

MS. MING: That would be great.

THE COURT: You can start explaining. Forget the easel.

A So first I'll say that part of the deep discussion and concerns that she had for surgery was that she was getting what's called fusion surgery. Fusion surgery is where the vertebral bodies --

THE COURT: Hold on one second. Why don't we put that up on the easel, so you don't have to hold it up.

A So as I was saying, the one concern that she had with

the surgery was that she was going to get a fusion surgery, and one of the deep conversations that I had with her was the difference between fusion surgery and what we call artificial disc replacement surgery, which was one of the reasons, although not the only reason, that I was recommending that she obtain a second opinion, as I didn't think she was a very good candidate for artificial disc replacement, and thought she was a better candidate for a fusion surgery. That's because the amount of disc space collapse that she had on the x-rays that we had obtained, which is one of the reasons why I sent -- one of the reasons why I sent her for a second opinion.

The surgery itself requires an incision typically on the left-hand side of the front of the neck. The incision goes through the subcutaneous tissue, through a small muscle called the platysma muscle, and then we continue that dissection down to the front of the spine. There are, however, structures that are in front of the neck that are what we call vital structures. So the tubes that are responsible for breathing and swallowing, those are moved mediately to the inside.

On the outside is what we call the carotid sheathe. That has the carotid artery, jugular vein and the vagus nerve, and those are large structures that if they got injured, you know, those are serious structures to injure.

Q Is that a risk with this surgery?

A Yes. So if there is injury to the carotid sheathe or

to the trachea and esophagus, then that -- those are, you know, significant injuries. The dissections continue down to the front of the spine, which is where this is. We then place some pins in between the vertebral bodies that were are operating on. The discs are collapsed, so those pins are there as a jack, sort like a jack in a car where you're changing the tire. So they go into the vertebral bodies. We put that jack on those pins and then we start removing the discs. We remove it from the front all the way to the back.

The reason -- one of the reasons we did the surgery from the front of the neck and not from the back of the neck, is because we can't move the spinal cord out of the way to get to the discs that are in the front. If we did so, the patient would be paralyzed, so we did the surgery from the front. We take a burr and we resect portions of the bone so we can get all the way back to where the disc is herniated into the canal, and then we remove the disc that's herniated in the -- centrally at the spinal cord level, and then within the neuroforamen.

So this picture here -- okay. They're showing an iliac crest bone graft, which we did not do in this portion of the surgery. We did take a piece of bone. That is what we call cadaveric bone. So somebody who's already died, we take their bone, and once the disc is removed we place their bone in between the vertebral bodies, and then we put a plate and screw over the expanding vertebral bodies to prevent that bone from

backing out. Over time on serial x-rays you will see that one bone is fused to the other bone, so there is no longer motion that's occurring at those levels.

Q You said you take a bone from someone that has already died and you place them in the neck?

A Correct, yes.

Q And why is that done?

A There's various different products that you can use, but this -- this bone is devoid of cells. They kill all the cells off, and we need something to keep this disc space extended. We have those pins in there as that jack, but once we remove those pins, the disc space is going to collapse, irritating the nerves, because there's no space for the nerves in the neuroforamen. So the way we were able to remove those pins is by having that bone plug or the bone that's there, that acts as scaffolding to keep that disc space tall.

Q Thank you, Doctor. And is this a surgery you perform in your office or somewhere else?

A In the hospital.

Q Now, will this surgery help restore her range of motion?

A No, this surgery is designed to limit her range of motion at the segment where we did the surgery, which again is one of the concerns she had, because she wanted a motion preservation technology, like artificial disc replacement.

That's technology where she would be able to continue to move her neck in a normal fashion. However, I don't believe she's a candidate for that.

Q And why is this permanent loss of range of motion a good outcome for Ms. Bailey?

A So she needs decompression of nerves. Once we take the disc out, we need those bones to fuse, because we need to put something within the disc space. So the goal is to limit the range of motion at those levels.

Q Will this surgery basically restore Ms. Bailey to -- let me rephrase that.

Will this surgery basically restore Ms. Bailey to, I mean the way she was before the accident?

A No, I don't believe so. There's two things that need to occur. One is she will lose range of motion, because she has a three-level fusion. Two, if we are removing the ear tint off of the nerve, that's the goal of the surgery. But the nerve needs to regenerate, and as we discussed before for all patients there's no guarantee that the nerve will completely regenerate, and in particular if a patient has some other medical comorbidities, like diabetes and high blood sugar, it's less likely that the nerve will completely regenerate after the surgery.

Q In your opinion, Doctor, why is it necessary for Ms. Bailey to undergo this three-level cervical fusion?

A Well, one is for quality of life. If she doesn't want to continue to live in pain, then I recommend the surgery. Two, is that she's already taking a significant amount of pain medication, which can have some negative side effects associated with it. So those pain medications are meant for short term, not long term, and so if she's using it as a long-term treatment, she's likely to have negative sequelae associated with that medication. Then, there's the reality of the neurologics that she has. She's having early myelopathic signs that Dr. Brisson saw on physical exam. So it's no longer just radiculopathy, but a myelopathy, which means that there is damage to the spinal cord.

Myelopathy is a whole 'nother disease entity. Patients typically progress in a step-wise deterioration fashion, meaning there's periods of plateau and there's periods where she gets worse, and then she continues to worsen in a stepwise fashion. That's what we call the natural history of this disease. And so if that's to occur, even though in patients who don't want to have surgery, they are typically forced to have surgery at some point in time because their neurologics are aggressive in nature.

Q When you say neurologics, what are you referring to?

A Meaning, for somebody who has myelopathy, it would be a patient who has difficulty with fine motor coordination of her hands. We typically tell patients that they wobble like a

drunken sailor, which means that they're off balance quite a bit. So they have not only just a radiculopathy picture, where they have pain in distribution, but they have spinal cord involvement as well.

Q So would it be fair to say that the goal here is to try to save this nerve and prevent any further damage?

A Right. In an ideal world, it's to reverse the damage which is done. In a realistic world, it's to prevent further damage.

Q What is your fee for performing surgery, Doctor?

MR. SANDS: Objection, Your Honor. May we approach?

THE COURT: You may.

(Whereupon, the following discussion takes place at sidebar among the court and counsel, outside the hearing of the defendant and sworn jurors.)

THE COURT: The objection is overruled.

Q Dr. Gallina, what is your fee to perform this surgery?

A I believe it's like one hundred thousand dollars.

Q And in addition to the surgeon's fees, are there also hospital fees associated with the surgery?

A Yes.

Q And what are the hospital fees associated with this surgery?

A In a straightforward case, it could probably be about

five hundred thousand dollars, but that would be for somebody who's often healthy and has a fairly straightforward course. Somebody who's sick with other comorbidities, they may have a prolonged stay, which obviously --

MR. SANDS: Your Honor, I would object to hospital fees.

THE COURT: Same ruling. Overruled.

Q Aside from a hospital stay, following the cervical fusion is physical therapy recommended?

A Yes.

Q What is the goal of physical therapy?

A The goal is in the acute phase, subacute, then of course the chronic phase. The acute phase would be to limit the amount of pain that she has and to restore the immediate activities of daily living, and then as you go to the more chronic phase, it's to try to strengthen the muscles and make her more functional in nature.

Q So is it fair to say you expect it to get worse before it gets better?

A Yes. There's an acute exacerbation of her degree of disability directly after the surgery, and then it will gradually get better with time.

Q Now, Doctor, you also mentioned earlier that you recommended a procedure to her lumbar spine, correct?

A Correct.

Q What is that procedure?

A So it's not a fusion surgery. So it's very different than the cervical surgery that we're recommending. This is purely decompression-type surgery, where we would make an incision in the small of the back. We move the muscles out of the way, we unroof the nerves, meaning, taking the analogy of this room, if the ceiling above us is the lamina or the bone, if we the people are the nerves and the floor is the disc, she has a pinched nerve, which means the disc is herniated into the canal and is pinching us between the floor and the ceiling.

So we take the ceiling off of the nerves. In the lumbar spine, we can move the nerves out of the way, because it's not in the spinal cord, and then we remove the floor. So we've in essence removed the ceiling and we've removed the floor. All we leave is the side walls and the people. The side walls are the pedicle, another bone, and the people are the nerves. So we've decompressed the nerves.

Q And does that mean that you're removing a piece of bone?

A So we've removed a bone and we've removed the disc.

Q And will that restore her range of motion to her lumbar spine?

A It doesn't negatively affect her range of motion. It will, if anything, on some occasions can lead to too much range of motion in the future. But often patients are able to have a

fruitful life and never know it, so long as the nerves regenerate.

Q So the goal again of this surgery is to take that pressure off of the nerve and hope to heal -- that the nerve heals, basically?

A Correct, yes.

Q Now, Doctor, you mentioned that you examined Ms. Bailey last week.

A Yes.

Q And has -- in terms of your recent examination, all the records you reviewed, the records from the second opinion, the imaging following your 2022 visit, have any of those records changed your opinion as to the medical necessity of this three-level cervical fusion that Ms. Bailey requires?

A No.

Q And does it change your opinion with regards to the laminectomy to her lumbar spine that you are recommending?

A No.

Q And you mentioned earlier that it's not a matter of if, it's a matter of when. What did you mean by that?

A So in the lumbar spine, if she can tolerate the symptoms, then for as long as she can tolerate them, then she doesn't have to have the surgery. The only caveat to that, is that there's a risk to not having the surgery or delaying surgery, meaning that the longer the nerve is compressed, the

less likely that the nerve will regenerate with chronic inflammation of the nerve.

In the cervical spine, she doesn't have just a radiculopathy, she is beginning to have a myelopathy from damage to the spinal cord. So as the neurologics progress, although patients -- it's very common for me to see patients who may not want to quote-unquote jump into surgery, and in those scenarios if -- the longer they wait, if they have worsening of their neurologic function, they end up having the surgery despite them not wanting the surgery, because the neurologics make them much less functional.

Q Now with respect to Dr. Brisson's records, you mentioned that the surgery was deferred. So Ms. Bailey was moving forward with the surgery or attempting to move forward?

A Correct. So any time that we have surgery and the patient agrees to have surgery, they need to get -- they have to get medical clearance to have the surgery, and especially these days it's quite common for patients to not be medically optimized to have surgery. So we don't tell patients that they are going to be fine with surgery. There are intrinsic risks to the surgery, especially patients who have other medical comorbidities like diabetes. So what we tell patients is that we are going try to medically optimize you to make sure -- to try to make sure that you have the best medical outcome from the trauma of surgery, realizing that surgery is a trauma, is a

controlled trauma, but it is a trauma.

Q Now, Doctor, do you have an opinion within a reasonable degree of medical certainty as to whether the injuries to Ms. Bailey's back and neck are permanent?

A Yes, I believe they are.

Q And do you have an opinion as to the permanency of these injuries?

A In terms of a percentage?

Q Whether they are permanent?

A Yes, I believe they are permanent.

Q And that's also based on a reasonable degree of medical certainty?

A Yes.

Q Now, the surgery to Ms. Bailey's spine would not just be one level, it's a three-level cervical fusion that you're recommending, correct?

A Correct.

Q And what does that mean for the surrounding discs in her cervical spine?

A Yes. So one misconception that people have is that if you have a fusion, that there is not going to be any motion of the neck anymore. There will be motion, but just not at the levels that we are doing -- that we do the fusion surgery on. So if you take your finger and you bend your finger, you have to realize that there are three joints in your finger. So if we

fuse one joint, the other joints can continue to work, just not this joint. And so one of the reasons in the cervical spine and the lumbar spine that patients maintain range of motion, is because they're going to maintain some range of motion at the levels above and below where the surgery was performed at the ACDF levels. That disease entity is what we call adjacent level disease.

Now the -- what we call the moment arm, or how much due to the fusion, the forces are larger at the levels above and below. So the reason why we pointed out at C3-C4 that there was a small disc herniation at that level is because now there's already a disc herniation, a not normal disc. It didn't progress the way that the other levels progressed, but if we fuse C4-C5, C5-C6 and C6-C7, it is very possible that C3-C4 becomes symptomatic down the road.

Additionally, we showed you that C7-T1 was a fairly normal disc that can stay normal, or motion can occur there and lead to further degeneration of C7-T1. We're more concerned at C3-C4 than we are C7-T1, but that would require additional treatment, whether it's nonoperative treatment with physical therapy and injections and oral medications and/or ultimately additional surgeries in the future.

Q Doctor, do you have an opinion within a reasonable degree of medical certainty, whether following the surgery and given time and age, Ms. Bailey will require future surgeries?

A Yes, it's my belief that there is a very significant chance she will require additional surgeries.

Q Why is that, Doctor?

A Again, because the formation of adjacent level disease in the setting of a smaller disc herniation at C3-C4 that's still present.

Q Now, Doctor, I want you to assume that Ms. Bailey testified that she cannot work, she cannot walk, sit for too long, enjoy --

MR. SANDS: Your Honor, that was not the testimony.

THE COURT: Objection sustained. I don't think that was the testimony.

MS. MING: I'll rephrase my question.

Q I want you to assume that Ms. Bailey testified before this jury that she cannot enjoy time with her family, her -- the kids in her family, that she cannot function, sleep or perform other activities of daily living without Percocet. Is that a recommendation -- recommended long-term treatment for the type of injures Ms. Bailey sustained?

A No, which is why I would recommend the surgery.

Q And did you have an opportunity to review records from her pain management doctor, Dr. Una?

A Yes.

Q And what type of pain medication is Ms. Bailey on?

A She was -- I believe, if I recall correctly, she was on

narcotics and muscle relaxers.

Q And so, Doctor, what is your prognosis with regards to the permanency of Ms. Bailey's injuries?

A It's very guarded. It's very guarded.

Q And what is -- is that to a reasonable degree of medical certainty?

A Yes.

Q What do you mean by guarded, Doctor?

A Meaning she's sick. She's got medical problems with her diabetes and she's got nerve compression. So she needs long-term care. And it's not the most straightforward cases -- case. It's cases that are not uncommon. We see patients like this quite frequently. But she needs treatment, and it's going to be both surgical and nonsurgical.

Q Now, Doctor, you also mentioned earlier that you evaluated her disability status based on an index?

A Yes.

Q What is that index?

A So it's the Oswestrey Disability Index, and then there's a cervical.

THE COURT: You may need to spell that.

THE WITNESS: Oswestrey, O-S-W-E-S-T-R-E-Y.

A In essence, they're -- both for the lumbar and the cervical spine, they're indices that we take to see if patients -- how struggling patients are, what activities of

daily living they can perform, and then there's a score that's put to it. There's various reasons as to why we do these indices, but it's basically to try to put a numerical number on how disabled they are.

Q Do you have an opinion as to a reasonable degree of medical certainty as to whether Ms. Bailey is disabled?

A I'm sorry.

Q As to whether Ms. Bailey is disabled?

A Yes, I believe she's disabled.

Q Do you have an opinion to a reasonable degree of medical certainty as to whether that disability is permanent?

A Yes, I believe it's permanent.

MS. MING: That's all I have for you. Thank you, Doctor.

MR. SANDS: Your Honor, I would like an opportunity to review the doctor's files.

THE COURT: Take a few minutes. We'll give you an opportunity. We'll take a ten-minute break. Please don't discuss the case among yourselves or with others.

COURT OFFICER: Jury exiting.

(Whereupon, the sworn jurors exit the courtroom.)

COURT OFFICER: Jury entering.

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

THE COURT: You may be seated. Mr. Sands, cross

examination.

CROSS EXAMINATION

BY MR. SANDS:

Q Good afternoon, Doctor.

A Good afternoon.

Q Do your employee have the day off today?

A I'm sorry. Can you please repeat?

Q Sure. Can you hear me?

A A little bit, yes.

Q Do your employees have the day off today?

A No.

Q Your office is open?

A Correct.

Q So people are back at your office earning money, right?

A They cost me money. I don't have anyone seeing patients or operating under my guidance. I'm a sole practitioner, so my office staff members are overhead for me.

Q But they're doing the normal activities, such as sending out bills, that nature. They're busy working today, right?

A They are office employees, yes.

Q So I'm just trying to get a handle on the thirty thousand dollar figure. You said that that's a fair reimbursement for the money you've loss?

A Yes, among other things.

Q What other things?

A Sure. College is very expensive, medical school is very expensive. Residency, at the time, I believe I got paid 28,000 dollars every year.

Q Doctor, I have to interrupt. What does that have to do with what you're charging for today?

A What I'm saying is that all of this goes into how much money people -- their expenses in life go all the way back through everything. So it's my day-to-day expenses, it's historically how much money I have, it's my malpractice insurance. There is overhead that people have.

Q Do you pay higher malpractice insurance because you're here today?

A No, it's a fixed fee.

Q Right. So you would agree with me that your fee here should fairly and adequately compensate you for what you could've earned on this day. We're on August 4, right, 2026. So your fee here today should fairly and adequately compensate for what you could have made today, right?

A Which would be the three cases that I have had to cancel to get here today.

Q And what were those three cases?

A ACDFs, lumbar decompression, and anterior posterior fusion.

Q Now you've really confused me. Doctor, you said just a

few minutes ago that the fusion that you wanted -- recommended the plaintiff, you would charge one hundred thousand dollars, correct?

A Correct. That's what was charged by the billing company.

Q But yet you're telling me today you're missing out on thirty thousand dollars that you could have earned doing three procedures, right?

MS. MING: Objection, Your Honor, as to form.

THE COURT: I'll allow it. You can explain, Doctor.

A Sure. So there's three surgeries that were being -- that we're doing today, and that would be reimbursed by whatever the insurance company would reimburse.

Q Which would be around thirty thousand dollars?

A It depends on the insurance.

Q But yet Ms. Bailey's surgery would cost -- which is one surgery -- would cost one hundred thousand. Does that make sense?

A I think if you understood the insurances and surgery and reimbursements, that would actually make a lot of sense, yes.

Q Are you implying that her case, those things would be any different from the three people you canceled today? Do you have any proof that you could offer this court of that?

MS. MING: Objection, Your Honor.

THE COURT: Objection sustained; argumentative.

Q Well, Doctor, you said you would have collected thirty thousand on three procedures. What proof do you have that you would have collected more money on just Ms. Bailey's procedure?

A I'm sorry. Please repeat that.

Q Yes. You're implying that you could collect three times as much money for doing just one surgery?

A I'm not following your logic.

Q Here's the logic. You said three surgeries that you canceled today equals thirty thousand, right? That's what you just told me?

A I'm saying that I had three surgeries today. We bill out a certain amount of money. I certainly didn't come with my billing record today to prove to you how much money I would have or would not have made today. The purpose of my testimony today was not about me and defending how much money I'm making. The purpose of me arriving today was to describe my decision-making from a medical perspective. So I'm not prepared here today to just discuss the exact finances that I make on a day-to-day basis. I think that's outside the scope of what I was called to do today.

Q Well, you say that, but just a few minutes ago, you opined you would have charged one hundred thousand dollars. That's what you told this jury, wasn't it?

A What I said was that a typical three-level ACDF, while I personally do not do the billing, there's an outside billing company. It is not outside the realm of normal for them to charge one hundred thousand dollars for an ACDF.

Q Would it be outside the realm of normal for you personally to be reimbursed one hundred thousand?

A It depends on the insurance. Again, this is an extremely complicated topic, but it depends on the insurance. It depends on the situation.

Q Could you give me an average?

A I'm not here today with any of my billing information. If you would like me to get that billing information, I'm happy to get that to you.

Q Sadly, we don't have that time. But then what was the basis of you throwing that figure out to the jury?

A Of one hundred thousand dollars?

Q Yes. If you admit that's based on a lot of complicated insurance issues, why did you throw that figure out to the jury?

A Because I would say that that across the board for a lot of orthopedic spine surgeons, for a three-level ACDF that would be, if not completely accurate or within the ballpark of what they would charge.

Q Would they actually collect it?

A Again, sir, it depends on the insurance, it depends on the scenario. It's such an open-ended question, I can't answer

that for you today.

Q Would you agree that the answer is you really don't know?

A First of all, I didn't hear your question. But --

Q Would you agree that the answer is you really don't know what they would collect?

A As I sit here today, I don't do the billing. I'm a physician, so I hire an outside company to do the billing. If you're asking me specifics on my billing, I cannot answer. If you're asking me what -- generally, what an orthopedic spine surgeon charged for a three-level ACDF, I would say one hundred thousand dollars is probably accurate.

Q But you can't tell me specifically if that's what they actually collect? I'm just trying to get a yes or no on that.

MS. MING: Objection, Your Honor.

Q I just want a yes or no.

A I can't answer that yes or no. I answered it --

THE COURT: He can't answer is the answer.

Q We'll move on. In addition to your duties coming to court and testifying, you -- I believe you said you did that two or three times in the past few years. Is that what you said?

A No, I said I average probably once or twice a year.

Q Would you agree that in addition to coming here to court, since you're doing here today, that you also prepare reports to plaintiff's attorneys during the course of

litigation?

A If I was asked to do so, yes.

Q Are you asked to do so?

A At times I've been asked to do so.

Q How many times are you asked to do so?

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

Q Sir, I'm sure you're aware that most cases don't reach this stage, right?

A Yes.

Q They resolve before this stage?

MS. MING: Objection, Your Honor.

THE COURT: Objection sustained.

Q Would you agree with me that you're asked to prepare reports more than once or twice a year?

A They would be more than once or twice a year, but not a significant number compared to what other physicians typically so.

Q Doctor, let's talk about -- well, first of all, how many reports do you have in front of you?

A I have the office visits reports.

Q And how many are there?

A Three reports and a billing sheet.

Q So three reports. Now I believe in response to one of the first questions that was asked you, you said you had seen the plaintiff four or five times. Do you recall saying that?

A Yes.
Q Would you care to change that answer?
A There are three reports here.
Q So the answer --
A So I saw the patient three times.
Q Are you trying to mislead the jury?
A No, I wasn't looking directly at my office visits, so I estimated it at that time.
Q And the estimate was wrong?
A It's three times.
Q So we can agree the estimate was wrong?
A It's three times.
Q Now when you first saw the plaintiff's attorney -- the plaintiff, in December of 2022, who arranged that visit?
A My office.
Q Who contacted your office?
A I cannot tell you.
Q Were you aware at that time that this case -- that the plaintiff already had a lawsuit pending?
A I didn't make their appointment.
Q Well, that wasn't the question. Were you aware that there was a lawsuit pending?
A On their first office visit?
Q Correct.
A No.

Q When did you become aware there was a lawsuit pending?
A I don't recall.
Q Before today, right?
A Well, definitively, I can tell you last night when they asked me to testify in this case, that's when I last recall it occurring. Whether it was before that, I don't recall.
Q So when you saw the plaintiff for the first time, you didn't know she had a lawsuit?
A I don't believe that I documented anywhere in here that it was part of a lawsuit.
Q But you did document the she was involved in a slip and fall, correct?
A Correct.
Q So you did document that, and that didn't -- what was the purpose of documenting that?
A To document mechanism of injury.
Q Well, was that relevant because you knew there was a lawsuit pending?
A Everything that's in this note is not done for legal purposes, it's done for medical purposes.
Q So -- by the way, so you say slip and fall. Obviously, we know you didn't witness the accident. So is it fair to say you don't know the forces involved, right?
A I'm sorry. Can you repeat it?
Q You don't know the forces that were involved in the

accident?

A Well, based on the description of the accident, I can opine about the forces of the accident.

Q The description of the accident, all that's contained in your report is slip and fall?

A There are other reports that I reviewed to come here today.

Q That's not noted in your report?

A You're asking me to opine not based on these medical notes, but based on notes that I reviewed as to the mechanism of injury and how I believe she got injured.

Q Doctor, when you prepare a report such as the one -- let's look at the first one you prepared in December of 2022, right?

A Yes.

Q In general terms, I'm sure you would agree in preparing a report, you realize that someone may -- other than you may eventually read the report, right?

MS. MING: Objection.

THE COURT: I'll allow it. Overruled.

A Yes.

Q In other words, such as another doctor, right?

A Correct, another doctor can read the report.

Q Yes, okay. So because another doctor may end up reviewing the report, it's very important to be accurate in the

report, right?

A We try to be accurate in everything that we write, yes. I try to be accurate in everything that I write.

Q It's important to be thorough in the report?

A It is -- we try to be as thorough as we can with the information that we have at the time.

Q It's important to note everything you've read, everything, every observation you've made, right?

A Yes. Please keep in mind, this is not a legal document, it is a medical document that is often used in legal purposes. This is a medical document that's made when we see the patient.

Q A medical document that may be relied upon by other doctors who review it down the road, right?

A I don't really know what you mean by --

Q Dr. Brisson may --

MS. MING: I'm going to object. He didn't let him answer the question.

THE COURT: Let him finish his answer.

A I don't know what your response is to rely upon. Most physicians that I know do independent evaluations of patients, particularly if they're getting a second opinion and we're asking them for their opinion.

Q So, Doctor, I'm going to ask you then to look at your report from May of 2023, okay.

A What's the exact date, please?

Q Sure. May 15.

A Sure.

Q If you look at your report from the date of December 12, 2022 and May 15, 2023, I'm not asking you to read all -- both the reports in their entirety, but they're word for word identical, aren't they?

A Is that a question or --

Q Yes, it is.

A Okay.

Q Aren't they word for word identical?

A I'd have to read them and see if they're actually word for word. But if you're telling me they are, then I take your word for it, yes.

Q So it's a cut and paste job, right?

A It's not a cut and paste job, it's an EMR job. So it's electronic medical records, and that's how we make sure that things are consistent within the chart.

Q So for example, in the May report you refer again to they. I believe by the term "they," you're referring to she; is that correct?

A I don't know. You'd have to ask her her pronouns.

Q All right. They have received a total of one injection. Now, do you note anywhere that in fact the plaintiff had two injections?

A It's not in this report that they had two injections. Are you referring to cervical injections or total injections?

Q I'm referring to total injections.

A I don't know that this is in reference to the total number of injections or the specific body part injections.

Q Well, but still, you're right, this notation doesn't state whether we're referring to cervical or lumbar?

MS. MING: Objection. It's the first and second paragraph.

THE COURT: What's the objection? I don't have the records in front of me, so you have to explain.

MS. MING: They're in evidence, but he's misreading. The first paragraph is about cervical and the second is about lumbar. It says one each.

MR. SANDS: It says in the second -- I would note the line is they have received a total -- total is the word -- of one injection. That's what's said in December of 2022, that's what's said in May of 2023.

A That's in reference --

THE COURT: Hold on. You have a right for redirect.

MS. MING: Okay.

Q So you agree you just copied that -- that notation from the December of 2022 report, you just copied verbatim into the 2023 report, right?

A What I said was it's part of the EMR system. I think that you're the directing whether I copied and pasted -- it's pulled forward from the EMR system.

Q But in 2023, in May of 2023, you did do a separate physical exam, right?

A Correct.

Q Fair enough. So those findings shouldn't be just pulled forward and copied, should they?

A No, it's a repeat of the physical exam findings that I confirmed on this new visit.

Q Fair enough. But yet, the findings are the same in terms of restriction of motion, right?

A Correct, there is no change in physical exam.

Q And that's from a -- that's a six-month period, right, December of 2022 to May of 2023, no change in your physical examination findings, correct?

A Correct.

Q And by the way, Doctor, in the interest of completeness, when you refer to the MRI findings, referring to your May of 2023 report, you state "MRI of the cervical spine reveals disc herniations at C4-C5, C5-C6 and C6-C7," okay. You don't refer to impingement. You don't refer to anything beyond that there are disc herniations, correct?

A It's not going to alter the -- my opinion or the -- change the course of the treatment, no.

Q Well, Doctor, again, you just said earlier in response to my question that you believe a report should be thorough and complete, did you not?

A What I described -- your definition of thorough can change based on the reason why someone's there. So the important portion of this visit is to come up with a diagnosis and treatment. I could speak for ten hours on just radiographic findings. That doesn't add to the case of the change of plan for this specific patient. So, you know, it's really what the purpose is of why I'm evaluating the patient.

Q You're evaluating the patient to note what symptoms they have, what the imaging shows, right?

A Those are some reasons. But patients typically would like a diagnosis from me and a treatment plan. That's the majority of the reason why I'm seeing patients.

Q Now, May -- after May of 2023 you didn't see the plaintiff until last week, correct?

A I'm sorry. You faded off. Please repeat your question.

Q After May of 2023, you did not see the plaintiff again until last week?

A Until when?

Q Last week.

A Correct.

Q And you were aware that this trial had already started,

had already begun, right, with jury selection? You knew that, didn't you?

A I wasn't aware of this trial until last night.

Q You weren't aware when you saw the plaintiff last week that she was involved in this trial?

A I was not aware of this trial until last night.

Q Who contacted you last week to arrange for the plaintiff to see you?

A No one contacted me. They contacted my office and my office made an appointment for her.

Q Who contacted your office?

A I don't answer the phones. I can't tell you that.

Q So, Doctor, are you a member of the American Medical Association?

A Yes.

Q Are you aware of their ethical standards?

A As I sit here -- I mean, I'm aware of ethical standards within medicine. Am I -- do I know the specific AMA guidelines that you're referring to? I don't have them in front of me, so no.

Q Let's just talk about a few of them. Would you agree that one of the standards is that doctors should not abandon a patient?

A Correct.

Q They should coordinate care and ensure continuity of

care. Would that be one of them?

A Correct.

Q They should follow up with care. Would that be another one?

A Correct.

Q Between May of 2023 and July of 2026, there's no indication in the report you just gave us of any of that, is there?

A Well, there's no indication that there's a lack of continuity of care for other providers. She came back to see me because she was ready to have surgery. So whether that's in a given timeframe, she comes back to see me at that period of time. If there was an issue where she needed emergent surgery, then that would have been addressed differently.

Q Well, Doctor, we've already established that as a treating doctor, someone who you believed you were the treating doctor, which meant you're in doctor-patient relationship with her, correct, back in May of 2023, correct?

A Correct.

Q It was your obligation -- you were the doctor, she was the patient. It was your obligation under these ethical guidelines we've just discussed to see to it that there was a followup in care, a continuity of care. Those were your obligations, correct?

A I think you're extremely manipulating those guidelines,

personally. I think that there's a patient relationship here. I think that, given the conversations that I had regarding surgical treatment options with the patient and nonsurgical treatment options, I gave up -- came up with a good continuity of care, which included a second and third opinion. She had followup care for various physicians, including myself. Although some time period went by where I wasn't actively treating her within this period of time that you're describing, she was seeking care. So I think all of this was very appropriate. I think you're manipulating --

Q I'm manipulating, Doctor? Really? Doctor, look at your July report from last week. Is there any mention in this report that she saw Dr. Paul Brisson? Is that mentioned in your report.

A No, she came to me to discuss surgery. So the etiology of the report is based on her surgical options.

Q So we've already indicated you had an obligation to enure continuity of care, followup. Did you -- when did you first learn she had seen Dr. Paul Brisson?

A When I evaluated the medical records.

Q And when was that?

A Sometime prior to this trial.

Q When?

A I don't recall specifically when I looked through all those charts, or if I looked through them in stages. I don't

recall.

Q Now, Doctor, then now I'm confused again, because you told us just a few minutes ago you believed you first learned this case was in litigation when you were called to testify. Now you just told me something I believe is quite different. You said that you reviewed records for the litigation. So was that last Friday or was that on another day?

MS. MING: Objection. That's not --

THE COURT: Overruled.

A So I have seen records in preparation for this trial, but there are other records that I've seen in her treatment, including her images. Again, I'm evaluating a patient to come up with a diagnosis and treatment plan, and that's what's documented in the chart.

Q Doctor, I don't think you're answering my question.

MS. MING: Objection, Your Honor.

THE COURT: Objection sustained.

MR. SANDS: I withdraw that. I withdraw that.

Q Doctor, you said you first learned of this trial on Friday, but now you've been talking about reviewing records for this trial, implying that was before Friday. My question stands, when did you review records for this trial?

A So first of all, I think you made a mistake in terms of the timeframe. I said I was aware of this trial for this specific patient last night, and the reason why I could be so

certain of it was I was at my daughter's soccer practice around 6:15. Prior to that, I was aware that there was a trial that was trying to be scheduled on Friday, but didn't hear anything else of it, didn't know the patient, didn't know anything. So I reviewed records last night.

In the course of her care I reviewed portions of records, including images, and that's documented in the notes. Those records that I'm reviewing is in preparation for an opinion on her diagnosis and what treatment options I could provide for her.

Q So we know what records you reviewed that -- from your -- it says in this report -- it does say you reviewed the MRI films. There's nothing in this report that you submitted last week about reviewing Dr. Brisson's report or about reviewing Doctor -- I'm going to call her Dr. Una. I know that's not her last name -- the pain management doctor. There's nothing in this report -- your report -- that you reviewed those records, correct?

A There's nothing in that report, and there's nothing in those reports that would have changed my medical opinion regarding the diagnosis and/or treatment options.

Q But again, we've gone through this that you had a duty to provide continuity of care. So you told me -- it appears as though you're telling me that you first reviewed Dr. Brisson's records last night?

A I didn't indicate that. I said that I did review Dr. Brisson's records last night, but I may have reviewed them earlier, it's just not documented in the chart, and upon reviewing them, it wouldn't have changed my medical management.

Q Doctor, it's a different question. My question is when did you first -- because, again, we've already established you had a duty --

MS. MING: Objection, Your Honor.

THE COURT: Objection sustained.

Q Doctor, you believe that a three-level fusion is a serious procedure, right?

A I'm sorry. You're tailing off again.

Q Doctor, you believe that a three-level fusion is a serious procedure, right, a significant procedure?

A Using the eye of the beholder, yes, I suppose. Is it a significant surgery, yes. Is it a surgery I perform on a regular basis, yes. Those are really your words. I wouldn't necessarily categorize i one way or the other. It's a three-level ACDF.

Q Well, it's a procedure you charge one hundred thousand dollars for. Wouldn't you consider that significant?

A I can't say the prices of anything correspond to the severity of a surgery or lack thereof.

Q Doctor, isn't it true that between May of 2023 and perhaps last week you did not know what care the plaintiff had

for her condition, did you?

A That's a -- that time period, you have to give me a specific day that I saw -- that I was in correspondence with the patient or that I evaluated the patient or that I received a report. I can't say within that period of time.

Q I'll give you specific dates. We have a date of May 15, 2023 and we have an another date of July 29, 2026. Those are the specific dates, okay. So then, again, isn't it fair to say that you had, as of July 29, okay, last week, July 29 of this year, 2026. So between May 15 of 2023 and July 29 of 2026, you did not know what medical care the plaintiff had for her back and neck; isn't that true?

A That's your categorization of it. I don't have documentation one way or another.

Q No one cares what my characterization is. What are the facts? What is the truth?

MS. MING: Objection, Your Honor.

THE COURT: Objection sustained. Rephrase. Argumentative.

Q Doctor, do you have any documentation as to when you learned of what medical care plaintiff had between May of 2023 and July 29 of 2026? As you sit here today, can you tell this jury when you learned for the first time what medical care took place in that more than three years?

A I have an office visit from 7/29/26, and I have an

office visit from 6/15 -- I'm sorry -- 5/15/23.

Q Correct.

A Correct. So those are the two office visits that the patient was evaluated in my office.

Q When did you learn for the first time what medical care plaintiff had in those intervening three years?

A When I discussed her care on the most recent visit, that's when we discussed her care, what care she had previously, what her diagnosis was and what her treatment options are.

Q Doctor, so you first learned that she saw Dr. Brisson last week, right?

A I can't tell you specifically when I evaluated his records and not. I can tell you definitively I evaluated his records in preparation for this trial last night. But prior to that I evaluated the patient as is documented in these notes.

Q There's nothing in these notes about Dr. Brisson?

A Then I received -- if I received records, then I evaluate them. It's not documented in this note.

Q So you have no proof of when you -- other than a few days ago, you have no proof about when you learned --

MS. MING: Objection.

Q -- that the plaintiff saw Dr. Brisson?

MS. MING: Objection, Your Honor.

THE COURT: Basis?

MS. MING: The record. He testified that he

reviewed them.

THE COURT: I don't think that's what he testified to. I'll allow it. Overruled.

A So you're asking for proof, and what I'm saying is that when I'm seeing a patient, these notes are not being generated for legal purposes. It's there as a relationship with the patient to come up with a diagnosis and treatment plan. That's what I can tell you. That's what I can tell you.

Q Doctor, in May of 2023 you made an evaluation of the plaintiff --

A I can't understand.

Q In May of 2023 you made an evaluation that the plaintiff needed three-level cervical fusion and a lumbar fusion, right?

A And that the patient should receive a second and third opinion.

Q And you never followed up on that until last week, correct?

MS. MING: Objection; asked and answered.

THE COURT: Objection sustained.

Q Is there any documentation that in those intervening three years, your office, anyone from your office or you personally contacted her to follow up if she ever scheduled a second opinion, got a second opinion, had a surgery? Do you have any documentation that you, your office ever did that?

A She has office visits. She had an office visit, I don't have records of all those communications with me here today. But there is a relationship that's going on with my office and the patient. She was given a followup appointment after -- in the last office visit. That's documented on the note. And there's communication that goes back and forth with the patient, it's just not in these records that I have before me today.

Q So the answer is there's no documentation --

A I didn't say there's no documentation. Those are your words, not mine.

Q Do you have any documentation with you here today?

A I have just my office notes here today. I quite honestly didn't think I was going to need to defend her continuity of care today. I am a treating physician. My role is to come up with a diagnosis, come up with a treatment plan and educate people like her. I didn't think I was going to come here to defend continuity of care.

Q You didn't think you were here to be cross examined by my?

A Sir, it's not cross examined. You're asking me very specifically about continuity of care. It's not documented in these notes.

Q I'm asking you about continuity of care, because you agreed with me that the American Medical Association, of which

you are a member, says it's one of their ethical guidelines.

A Sir, repeat what you just said to me.

Q Yes. Wouldn't you agree that continuity of care is part of the American Medical Association's ethical guidelines?

A If you're reading to me what the ethical guidelines of the American --

Q I'm not reading anything, sir.

THE COURT: Let his finish his answer.

A I don't have the American Medical Association's ethical guidelines in front of me, and honestly they're not memorized by my by heart. But if you're telling me that's part of the American Medical Association ethical guidelines, then I'll agree with you. If you're asking me if continuity of care is important, I would say yes, continuity of care is important. If you're asking me if I gave continuity of care to the patient, I would say yes. I recommended the patient get a second or third opinion. That's part of the continuity of care. I gave the patient a followup appointment. It's documented in my note.

Q But you have nothing here to show this jury that you followed up to see that she got the second opinion?

A Because, sir, you didn't ask me, nor was I asked by anyone in the court to come in here proving that my office had made followup appointments for them. There are medical records and there are communications in -- that are electronic. There are other forms of communication that occur in my office. I'm

not part of that on a day-to-day basis.

Is this patient part of my care, yes. Do I care about her well-being? I absolutely do. Do I have an opinion as to whether I think she should have surgery? I do. I'm here to give her the best medical opinion that I possibly can. Perseverating about continuity of care in the small parameters that you are is doing a disservice as to this entire relationship that I have with this patient. I'm sorry, that's my opinion.

Q We'll move on. Doctor, again, in terms of the report you just issued --

A Which report are you referring to, please?

Q I'm talking about the report July 29, last week.

A Okay.

Q I would call that just issued. In terms of the report you just prepared --

MS. MING: Objection, as to issued.

Q Issued, prepared. In terms --

THE COURT: Prepared is the word.

Q Prepared. You do say that the plaintiff -- those are your words, disabled, correct?

A Yes.

Q Were you aware that she has a full-time job?

A Yes, it's stated in my note that the patient is in a full-time job.

Q So you would agree with me that if one is working full time they would not be considered disabled, would they?

A I think that's an inaccurate statement.

Q You don't think that's the general definition of disability?

A It depends on how -- what their symptoms are during their employment, how many days off from work they have to take because of their disability or their symptoms, the treatments that they have to do to continue their form of employment. It's complicated and not as straightforward as you're claiming.

Q Do you have any information as to how many days she takes off from work?

A I had asked her on her last visit if her symptoms precluded her from working at times, and she said yes.

Q Is that noted in the report?

A I specifically remember that conversation. It's not documented in the note, but I do recall that.

Q Doctor, let's talk about plaintiff's diabetes. You indicated that several times. Looking at your July 9, 2026 report, first page medications, there's a reference to Percocet. Do you see any references to diabetes medications?

A Under medications, it says diabetic medications.

Q I'm looking at the July 29, 2026 report.

A At the top of the page it says "current medications diabetic medication."

Q Now, Doctor, you indicated that the plaintiff would not be a candidate for steroid injections because of diabetes. Would you agree that the diabetes can also make her not a candidate for surgery?

A As I explained earlier in my testimony, things are based on the risk-benefit profile. So if we thought that the injections would be curative in nature or significantly reduce her symptoms, while there's a risk to the epidural injections because of her diabetes, it may be worth getting those injections.

In my opinion, however, that risk is too high, given the fact that she had a blood sugar of, I think, 500 at a fairly recent hospitalization. So if her blood sugars can be maintained and she can be medically cleared, I believe that surgery would give her more of a definitive treatment, which is why I'm recommending surgery over additional injections.

Q And would you want to consult with her endocrinologist?

A Well, clearly before any type of surgery she would have to have medical clearance and she'd have to be evaluated by the anesthesiologist.

Q And there's nothing in your report about that, is there?

A No. Once a surgical date is selected, then patients start the medical clearance and/or medical optimization process.

Q Doctor, you also used the word myelopathy, correct?

A Correct.

Q Compression of the spine?

A The spinal cord, correct.

Q Spinal cord. Again, I'm going to refer you to your last report, July of this year, last page assessment "clinical disc herniation -- " I'm sorry. "Cervical disc herniation."

Do you see that?

A Yes.

Q Did you mention myelopathy?

A No. Some of this has to do with the CPT codes, they're being pulled from the EMR. So there are CPT codes that pull in portions of this. I'm happy to show you the myelopathy again on the MRI, if you want me to.

Q No, Doctor, you know that's not necessary. Now, Doctor, don't you think it would be important to note in the report?

A I think what's more important is to see it on the MRI and to come up with appropriate treatment options for it.

Q If you know that you saw it on the MRI, why didn't you put if in the report?

A I can't say why that specific word "myelopathy" is not in the report. But what I can tell you is that the treatment for myelopathy is surgery, and that I am recommending surgery for her.

Q Now, Doctor, in addition to the one hundred thousand

fee which we covered, you threw out another number to this jury, which --

A I'm sorry. I can't understand you again.

Q I'm sorry, Doctor. I'm not used to speaking with a mic. We also -- you also threw out a figure of five hundred thousand dollars for the hospital.

Do you recall saying that?

A I do.

Q Do you work in hospital administration?

A I do not.

Q You would agree that being an orthopedist -- orthopedic surgeon is a full-time job, right?

A Yes, along with taking care of my kids, yes, I would say that.

Q It doesn't leave you time to work in hospital administration, does it?

A There are certainly plenty of orthopedic surgeons who work in hospital administration, I just happen to not be one of them.

Q And you don't work in hospital billing, do you?

A I am not a biller, even for my own practice. I outsource the billing.

Q But with regards to the hospital billing, you play no role in that, correct?

A No. I know some general numbers as to what surgeries

cost. But am I billing this specific surgery for the hospital, no. Do I know what the hardware generally costs, yes.

Q Let's go through the five hundred thousand. What would the components of that be? Let's break it down.

A The general components would be the surgery.

Q That's your fee. What's on top of your fee?

A I'm sorry, sir, I was speaking. I'm happy to explain it for you, if you would like.

Q Okay.

A That would include the staff to bring the patient in to the hospital. That would include the holding area with all the nursing staff and secretaries that are there. That would include the nursing staff, which would be people that you see on a regular basis, being the circulator and the scrub techs. In these cases, there's typically three scrub techs, there's one circulator. There are a series of four or five nurses that are in the triage area outside the operating room that help coordinate the operating rooms. There are the neurophysiologists. Those are the -- they're physicians who are monitoring the nerves during the surgery. There's at least two techs that are in the room, depending on upon how long the surgery is. There's an anesthesiologist. There's usually a second anesthesiologist giving the first anesthesiologist a break, or a nurse anesthetist. There's frequently another nurse who gives the circulating nurse a break, and potentially two

other techs that are giving the breaks to -- to the scrub techs.

There's the radiologist who takes x-rays, not a physician, but the radiology tech. There's usually a second or third radiology tech who's giving a break to the first and second radiology techs to take the x-rays. There's typically an assistant for myself, whether it's a resident or fellow or another attending. There are all the medications that the anesthesiologists are pushing.

There are all the disposables, including the mouthpiece and everything that is required for intubation during the surgery. There is positioning on the table and the equipment that is responsible for holding patient. All of the trays that are responsible for all the hardware for this particular surgery. There could be -- there could be ten to fifteen trays. There are the implantables, and each screw for the implantables could be five thousand to ten thousand dollars, depending on the levels that you're doing. There is the plate. That's also about ten or fifteen thousand dollars. So there are a lot of costs that go into it.

Q A lot of that is general hospital overhead, such as the nurses, right?

A It depends on how it's being set up, but depending on the timing of it, if the surgery is done after 3:00, then they have to pay the nurses overtime, all of those techs overtime. So do I know the exact salaries of every single one of those,

no. But I think if you had to ask general orthopedic surgeons what's the general price of a three-level ACDF, what I would anticipate is it would be five hundred thousand dollars.

Q Have you personally seen bills, sir?

A Sir, I'm not a biller. I'm -- I was asked a question as someone whose been around these types of cases previously. So I'm giving you the best answer that I can give you, based on my knowledge of that scenario. You and everyone else in this room, I'm assuming, has never been in that room before. So if you're asking me for what is the experience of that, that's what I would tell you it would be.

Q Well, you've given us, and I appreciate it, Doctor, everything involved in the procedure. What I'm interested in this dollar figure you gave. You've also told us you're not involved in preparing hospital bills, you don't review hospital bills. So what I'm trying to get at is you gave this jury a figure. What is the basis, forgetting about everything that's involved -- I appreciate that, Doctor, but we're trying to cost this out. What is the basis of you giving a dollar figure, when you don't prepare bills, you don't see bills, what is your basis for saying that?

A My basis is general knowledge and conversation I've had with other surgeons regarding what the cost of these types of things would be.

Q Have you had -- have you discussed this with the

administration of NYU Hospital?

A To be quite honest, if I discussed it with NYU, it would probably be more expensive.

Q Have you have had those discussions?

A I've had similar discussions with people at NYU, but not one that, again, I can document in my notes.

Q So you have no documentation?

A I was not asked to provide documentation for the price of the surgery.

MR. SANDS: Thank you, Doctor. No further questions.

THE COURT: Redirect?

MS. MING: Yes, just briefly. Can I have Dr. Brisson's records.

REDIRECT EXAMINATION

BY MS. MING:

Q Dr. Gallina, did anyone ask you to prepare a report in connection with litigation for this case?

A Not that I'm aware of, no.

Q And to your knowledge, have you prepared those types of reports?

A I have.

Q And in the situations where you prepare those reports, are you testifying as a treater or an expert?

A Usually as an expert.

Q Meaning that you don't have a doctor-patient relationship necessarily with the plaintiff that you're testifying in court for, correct?

A Correct.

Q But in this case, you have a doctor-patient relationship with Ms. Bailey, correct?

A Correct.

Q And let me ask you this, Doctor. Should you perform a surgery that was unnecessary?

A No.

Q Could you explain -- I heard all about this continuity of care, as if you abandoned the plaintiff. You gave Ms. Bailey advice to get a second opinion, correct?

A Correct. Everything that this verbiage of continuity of care is basically stating that patients should have followup care. There's always barriers -- there can be barriers to patient care. The important thing is that patients continue to get care, not specifically from me or just from me, but from others as well, which is part of the reason if a patient is not surgical and they're ready to have surgery at this second, that patients don't have some kind of followup, pain management doctors, physical therapists, and in this particular case, another physician. She has my number. She has my information. She knows that if and when she's ready to have surgery that she can follow up with me and have that surgery and those

discussions.

With this specific patient, there was very extensive conversations regarding surgery with her and her family members. They were very well informed about what my stance was of her treatment, where she should be and her different surgical options. I'm certainly not going to force someone to have surgery. It is within her free will to decide if what I'm saying is appropriate or inappropriate, and then she's going to follow up with the doctors the way she feels is appropriate, and that's part of the informed consent. So while there's continuity of care, there's also informed consent.

There are certainly plenty of patients who I have surgical discussions with who decide I'm just not ready to have surgery or I'm just not ready to have surgery with Dr. Gallina, and that's okay. There's communications between my office and the patient. Is it directly done through me, is it documented through an office note? These notes are office notes, they're not other parts of, you know, nonmedical records that exist. There is a relationship that's there. I'm happy she came back to me, and I'm looking for her to get better. That's why I'm giving my opinion as to whether she needs surgery.

Q In fact, Dr. Gallina, in your records, which will be available for the jury, you actually note at that second visit that you had a long conversation with her regarding her treatment, including her sister who's a nurse; isn't that

correct?

A Correct.

Q And both Ms. Bailey and her sister who is a nurse asked many questions of you, correct?

A A plethora of questions.

Q And Ms. Bailey was actually -- she described you as stern and very matter of fact or just very flat, and is that among the reasons you recommended that she get a second opinion?

A I recommended -- there are lots -- first of all, I recommend that all patients get second opinions, but specifically for her. I wasn't here to convince her what she needed. I was here to tell her you're sick, you need treatment. I'm trying to get through to you as to how badly you need treatment, but if you don't believe me, that is okay. I'm okay with it. I'm doing my best to get it through to you. Sometimes people need other opinions. I did not tell her to go to see this specific surgeon. I do not know this specific surgeon other than his reputation. And I wanted her to get a completely unbiased opinion. Go to this doctor, see what he or she has to say, and then that is part of your informed consent, you can make a decision what's best for you based on what two independent surgeons are saying, and we're saying the same, if not similar, things.

Q And Dr. Gallina, with respect to Dr. Brisson, in terms of the findings, were his recommendations any different from

your recommendation?

A No. When I looked at -- his recommendations in terms of her diagnosis is my exact diagnosis. His recommended treatment is my recommended treatment. What I would say, just without speaking to him, I think that I would be more aggressive terms of tolerating a hemoglobin A1C or less control of her diabetes. I would be more aggressive in terms of recommending surgery than he is. He sounds as though in his notes he's slightly more conservative in terms of the bar of when he could operate on her, and my opinion is that the longer she waits, the worse she's going to get, and I think she needs surgery, and that's what I would do. I would say that his physical exam is more geared towards myelopathy, and my mine was --

Q That was my next question, the myelopathy.

A Mine is geared more towards radiculopathy. There's sound medical reasons as to why that's the case. He's getting more of a myelopathic image and I'm getting more of a radiculopathy image, but that doesn't mean that surgery is any less indicated, nor does it mean that it's any less of an urgency. See needs surgery.

Q In fact, in Dr. Brisson's records which are in evidence, it indicates that the patient wants more aggressive treatment to be rid of the severe pain, and when you say that you would be more aggressive in terms of how you would move forward, is that because of the seriousness of the surgery,

Dr. Gallina -- the need for surgery, I should say?

A Yes, that is the -- I'm very concerned with her neurologically, and the longer that she waits to have surgery or if she does not have surgery, that that will lead to even more permanent impairment than she currently has.

Q And with respect to hospital fees, when a patient comes to you and you tell them they need a service, is it not practice that patients will inquire what the fees are?

A Yes. There are times when a patient asks what fees are. There are times when a patient needs to pay out of pocket.

Q And you're not a biller, but you have privileges at NYU, correct?

A Correct.

Q And you teach at NYU?

A Correct.

Q So you're familiar with -- this is a hospital where you conduct surgeries, correct?

A All the time.

Q And with respect to a reference that Ms. Bailey's working, you noted that in your records, correct?

A Correct.

Q But in addition to working, did you become aware that she needs the Percocet to actually do the work?

A Correct.

Q And does the fact that she's taking Percocet make her

any less disabled?

A No, it's just marking the pathology which she has, which is why I'm very concerned.

Q And at the end of the day, the Percocet is not a treatment, it's just helping someone deal with the pain, correct?

A Correct, yes. It should be short-term treatment.

Q And to be clear, just so the jury understands, when you say disabled, because Ms. Bailey's not walking around in a walker, right, hunched over, what is the definition, medical definition that you're utilizing to assess a disability and that you use for Ms. Bailey?

A If she has some impairment that's affecting her ability to do the things that she wants to do or needs to do on a consecutive basis.

Q And when you say it's that she wants to do, can you just clarify what you mean?

A Sure. So a typical conversation that I'll have with patients, especially for the need for surgeries, I'll say you know what kind of things do you like to do? I like to go shopping, I like to go to church. I play with my kids or my grandkids, and I would say well, the symptoms that you're having, is it affecting your ability to do things? Yes. If you take treatment for that, does that -- do those improve your symptoms? Yes. Yes or no, are the treatments that you're

having diminishing in terms of the amount that you can do with those treatments? Yes. And then, for the need for surgery, you know, have you done everything you possibly can to avoid the surgery, meaning all the physical therapy and the injections. If that answer is no, then why do you not finish doing all those nonoperative treatments. Sometimes, like in this particular case, they would say well okay, my blood sugars are too high and there are contraindications to me getting additional treatments. Or some patients will come back and say listen, my symptoms are so severe I don't want to risk having these symptoms be permanent, I would like more aggressive treatment. So treatments are tailored to specific patients' needs.

Q And to be clear, that disability determination is a standard, right. It's not something you just made up. It's not a number you made up, correct?

A Right, and so that's where the Oswestrey Disability Index and the Neck Disability Index, which is basically a cervical Oswestrey Disability Index, comes into play, because there are some that find it important to give a number to this. But really, the question is can your quality of life be okay with your current state, and if that answer is yes or no, that tells us what kind of treatment you have. It's obvious that if somebody got an injection and symptoms went away completely, that they're not going to want to have surgery, because their symptoms were improved, and if you ask patients okay, you got

the injections and you got better, you know, do you want to have surgery, you're going to say no, I don't want to have surgery. If the injections didn't work, they're going to say yes, I want to have surgery.

Q Doctor, by the time somebody comes into your office to see a spinal surgeon -- right, you're not just a doctor, you're a spinal surgeon, correct?

A Correct.

Q By the time they come to your office, is it pretty much the case that they've exhausted treatment by other providers?

A It is often the case, they're not always the case, and certainly there are times where they have received injection, and based on their diagnosis I recommend different types of injections or different types of exercises.

Q But it's fair to say they've had some treatment before they come to you?

A Correct. It's rare these days, given physiatrists and pain management doctors and so on and so forth, that patients come in without any diagnostic treatments. Can it happen? Yes, it can, but --

Q Most people don't wake up in the morning and say I have back pain, I'm going to see a spinal surgeon?

A Correct. They are -- right. It's few and far between that that occurs.

MS. MING: I have nothing further, Your Honor.

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

(Whereupon, the following discussion takes place at sidebar among the court and counsel, outside the hearing of the defendant and sworn jurors.)

(Whereupon, the trial was adjourned to Wednesday, August 5, 2026, at 2:00 p.m.)

EPHRAIM JACOBSON

B

C

D

N

S

T

U

V