

1 A "Patient followed up on" -- I'm sorry, I got August
2 25th. Did you say 11th?

3 Q I'm sorry, August --

4 A Oh. I saw him on July 14th in my follow-up note.

5 Q I have a date of service on the report for this MRI
6 --

7 A Yeah, that's when the MRI was done. He followed up
8 with me on the --

9 Q Right, okay. So what my question is -- and we have
10 the MRI --

11 A Okay.

12 Q -- report up here. What were the results of the MRI
13 performed on that day?

14 A Okay. Well, I'm just going to refer to my chart
15 note here on the 25th when I see him back. So again, I'm
16 looking at the MRI and the report. I briefly summarize, "MRI
17 and CT show excellent maintenance of reconstruction,"
18 basically saying the C3-4 and C4-5 levels don't have any
19 problem. Again, I make out -- I make a point of stating how
20 the C4 nerve root does not typically give you symptoms down
21 the arm, especially below the elbow. Now he's having symptoms
22 going to his hand. Therefore, I state "The issue of C3-4
23 foraminal stenosis is not a clinical player," meaning it's not
24 contributing to his problems.

25 I also state that -- again, this is where the

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1 radiologist makes a read and I simply disagree. He's stating
2 that the uncovertebral joint arthropathy causes mild to
3 moderate stenosis. When I pointed out to those previous
4 pictures it wasn't the uncovertebral joint, it's the facet.
5 And that's important to make a distinction, because
6 technically when I do the surgery I can do something about the
7 uncovertebral joint. That's something I can nibble away and
8 take care of, and feel and say I'm happy. But the facet joint
9 or if there's a bone spur coming off the facet joint, I can't
10 get to that unless I turn him over and make another incision
11 and nibble from that side.

12 So I mean that's just a technical point that, again
13 -- and I make that distinction how I state it's primarily due
14 to facet problem. But again, I say "Clinically I don't think
15 it's really a problem because C4 wouldn't be causing symptoms
16 down the arm to the hand.

17 MR. EGLET: Page 62 please, Brendan.

18 BY MR. EGLET:

19 Q What did you recommend for Mr. Simao at that time?

20 A Let's see. I also state how the CT shows that the
21 fusion, even at four months out, looks solid. So I recommend
22 we get an EMG nerve conduction study to get a better idea of
23 what's going on.

24 Q And did you place him on Neurontin?

25 A I did.

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1 Q And what is Neurontin?

2 A I also mentioned Lyrica, but basically those are two
3 medications that are -- Neurontin especially is technically
4 used for seizures, but the simple concept is it's a medicine
5 that calms down overexcited nerve impulses. So there's a
6 potential scenario that when you do surgery, even though
7 everything structurally is okay, just the simple process of
8 manipulating nerves, gently moving them around can irritate
9 them. So the Neurontin basically simmers down these irritates
10 nerves, but also simmers down potentially irritated nerves
11 like the ulnar nerve or the median nerve.

12 Q And what is an EMG, a nerve conduction study? You
13 mentioned you ordered that.

14 A Well, EMG stands for electro myography, which is
15 basically putting a needle in a muscle and seeing how the
16 electrical activity is. A nerve conduction study is where
17 you're specifically starting a little nerve -- electrical
18 impulse and you're measuring how fast it conducts down a given
19 nerve. So those two tests together allow you to evaluate
20 whether or not there's any issues with the cervical nerves or
21 the radicular problem, or whether or not there's any issues
22 with the peripheral nerves or the ulnar nerve, the median
23 nerve.

24 Q Could the --

25 A Meaning in the arm.

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1 Q Could either the median or ulnar neuropathy account
2 for Mr. Simao's residual left trapezial pain you documented
3 and the paresthesias involving his left upper extremity?

4 A Oh, classically if you're having trouble with your
5 ulnar and median nerve at the elbow, at the wrist, they would
6 explain potentially symptoms from the elbow down. Classically
7 they really wouldn't cause symptoms with the trapezius though.
8 As far as the numbness going down his arm, it could easily
9 explain that.

10 MR. EGLET: Page 65 please, Brendan.

11 BY MR. EGLET:

12 Q What did you recommend for Mr. Simao at that time,
13 Doctor?

14 A We ordered the tests. Then on 9/17/2009 he came
15 back for the EMG nerve conduction study. And I state there
16 that it shows median and ulnar neuropathy.

17 Q Is this the --

18 A Yeah, that's --

19 Q That's the right report? Okay.

20 A Yeah, we -- this is the next chart note after we
21 order the test --

22 Q Okay.

23 A -- he's following up with the results.

24 Q Thank you.

25 A So basically it confirms that he's not really having

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1 -- EMG nerve conduction study results that show any problems
2 with the spinal nerves or radicular problems with the neck,
3 showing issues with the median and ulnar nerve, or neuropathy
4 as they're traveling in the arm. Specifically I think it has
5 a chart note by Dr. Taylor potentially at the wrist. I say
6 "The patient has some left trapezial pain. Again, state that
7 there doesn't appear to be any structural issues with the
8 fusion. And the plan at that point was to refer him to upper
9 extremity specialist, who turned out to be Dr. Taylor, to
10 further look into the neuropathy.

11 MR. EGLET: And page 69 please, Brendan.

12 BY MR. EGLET:

13 Q What interval of history did you obtain from
14 Mr. Simao when you saw him six months later on March 23rd,
15 2010?

16 A I've got Dr. Taylor's notes. You'll need to -- I'll
17 just refer to it if I may. So March 23rd, 2010. Comes back
18 six months later, "Having primarily left-sided neck pain,
19 trapezial and periscapular radiation." Gives me a secondhand
20 of being seen by pain management, who mentions to him that he
21 still has some C3-4 foraminal stenosis. Again, I go into the
22 discussion about how his pattern does not fit a C4 dermatomal
23 pain pattern. I briefly mention was seen by Dr. Taylor.

24 Just to quickly look at Dr. Taylor's notes on
25 2/10/2009, Dr. Taylor basically reviews the EMG nerve

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1 conduction study, says that he has evidence of carpal tunnel
2 syndrome, which is the median nerve being irritated at the
3 wrist, felt the median nerve was a more significant issue and
4 offered the patient a carpal tunnel release, didn't think the
5 ulnar nerve was much of a problem. As far as I know, the
6 patient chose not to have that carpal tunnel release.

7 So he follows up with me. I briefly mention
8 Dr. Taylor's note. We took x-rays, everything looked good.
9 Technically no significant thenar changes at the physical exam
10 finding. That's briefly to evaluate whether or not he was any
11 -- having any major dysfunction from the carpal tunnel
12 syndrome. Technically the median nerve is right here at your
13 wrist. And if you get severe involvement, you lose this
14 muscle pad on your thumb. That's called the thenar eminence.
15 So it was me just briefly making sure he wasn't having any
16 significant motor problems or muscle problems from the carpal
17 tunnel.

18 At that point in time, since I didn't see any
19 structural issues, I thought he may be having some facet pain.
20 Again, I did not think that, in a general sense, typically
21 C3-4 foraminal stenosis in and of itself would be giving him
22 left-sided neck pain, trapezial periscapular pain. And I also
23 stated how the surgery itself would have addressed that if it
24 was a significant problem. The plan was to send him back to
25 pain management to try some facet blocks, basically below the

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1 fusion.

2 Q Okay. Why did you not feel there was any clinically
3 significant residual stenosis at C3-4?

4 A Again, because we're talking about classically that
5 is a pattern of pain that radiates down to the anterior chest
6 wall right here. So I mean not everything's 100 percent, but
7 it's like any clinical decision, you make decisions based on
8 what's most likely and go from there.

9 Q Would that also be as a result of the fact that at
10 the time of the cervical reconstruction, that the C3-4 normal
11 disc height was restored by the use of the cages?

12 A Right. And base -- I'm sorry.

13 Q Go ahead.

14 A Basically there are studies that show if you go in
15 and just back open that disc, that maneuver by itself will
16 improve the nerve exit holes. So there are some people who
17 don't even bother trying to do anything else other than that
18 because it's reasonably supported by studies. So again, when
19 we did the surgery that's what we did. Again, clinically the
20 patient was having primarily what I would deem not major
21 symptoms or obvious symptoms of the pinched C4 nerve in and of
22 itself.

23 Q Okay.

24 MR. EGLET: Your Honor, you have looked at me a couple
25 times like I had the feeling you wanted to take a break. Is

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1 this --

2 THE COURT: Yes.

3 MR. EGLET: -- a good time?

4 THE COURT: How did you know, Mr. Eglet?

5 Ladies and gentlemen -- that's right, I think we all
6 probably need a break. Reminding you of your obligation not
7 to discuss this case, not to form or express any opinion, not
8 to do any research on any subject connected with this case.
9 Ten minutes please.

10 [Recess]

11 [Within the Presence of the Jury]

12 THE MARSHAL: Remain seated, come to order. Department
13 10 is back in session.

14 THE COURT: Okay, we're back on record.

15 Counsel stipulate to the presence of the jury?

16 MR. EGLET: Yes, Your Honor.

17 MR. ROGERS: Yes, Your Honor.

18 THE COURT: Mr. Eglet.

19 MR. EGLET: Thank you, Your Honor.

20 DIRECT EXAMINATION CONTINUED

21 BY MR. EGLET:

22 Q Okay, Doctor, did Mr. Simao follow your
23 recommendation and return to the pain management center at
24 Southwest Medical for further diagnostic and therapeutic
25 injections in his cervical spine?

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1 A So, just to make sure, we're starting again from
2 3/23/2010, correct?

3 Q Yes.

4 A Okay. At that point I recommended going back to
5 pain management, trying some medial branch blocks to see if
6 there's potentially some facet mediated pain below the fusion.
7 It appears at that point in time that was the last time I saw
8 him.

9 MR. EGLET: Put up page 202, please, Brendan.

10 BY MR. EGLET:

11 Q What procedure was performed by Dr. Siebel on
12 April 20th, 2010?

13 MR. ROGERS: Your Honor. Objection. We're getting
14 beyond the doctor's --

15 MR. EGLET: May we approach, Your Honor?

16 THE COURT: Yes.

17 [Bench Conference Not Transcribed]

18 MR. EGLET: Okay. Are we on page 202, Brendan?

19 BY MR. EGLET:

20 Q So the question was, what procedure was performed on
21 Mr. Simao by Dr. Siebel on April 20th, 2010, Doctor?

22 A Appears that he had a left C3, C4, C5, C6 medial
23 branch nerve block.

24 Q And what is the purpose of that procedure?

25 A Well, in general it's to predict the potential pain-

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1 relieving effect of doing a medial branch oblation. The
2 simple concept is the medial branch is a specific nerve --

3 Q Can you come --

4 A Yeah.

5 Q Come down and explain what you mean? And using the
6 model if you could show and explain what a medial branch nerve
7 block is in the cervical spine, as performed by Dr. Siebel.

8 A So, basically what we're trying to do is trying to
9 see if there's anything else going on structurally that would
10 have caused Mr. Simao to still have some symptoms. So again,
11 we talked about having discs in the front, facets in the back.

12 There's a specific nerve that comes off this nerve
13 that goes and travels on the side of this bone. Okay, those
14 are called medial branch nerves. And those specific nerves
15 enervate or provide the nerve supply to the facet joint. So
16 the whole idea is that if you do a block of that nerve and
17 that temporarily gives you significant pain relief -- most
18 people would say at least 50 to 70 percent -- then that does
19 two things. A, it confirms that you have facet-mediated pain,
20 and B, it also says it would be a reasonable thing to do an
21 oblation. Oblation is where you selectively destroy the
22 nerve. So the concept is, if you knock out the nerve and that
23 connection to the body is no longer there, then you shouldn't
24 feel the pain.

25 So they do the medial branch block, and then while

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1 the numbing effect of the anesthetic's working, they ask the
2 patient to relate how much pain relief they get. If they get
3 good pain relief, then you can do a procedure -- and these are
4 all done via needle sticks -- where you put some type of probe
5 onto the nerve. It can either be a freezing probe, a heating
6 probe, that in a controlled fashion knocks out that nerve.

7 When you do that, that potentially can give you pain
8 relief that lasts up to two years, depending on the technique.
9 If they do get -- if the patient gets good relief, it comes
10 back, if you repeat the procedure, typically it works
11 85 percent of the time. So it is a good option, potentially,
12 for people who have facet-mediated pain. That avoids any
13 major procedure.

14 Now, technically my thought process was simply if
15 you have facet pain at C3-4 or C4-5, that should be adequately
16 addressed by the fusion we already did. Because it's taking
17 away the motion, just like we used to do with hip fusions for
18 hip arthritis in the old days. So that's why I specifically
19 asked them to do C5-6. For whatever reason, I chose to do a
20 few extra.

21 Q Okay. Thank you, Doctor.

22 [Witness Resumes the Stand]

23 MR. EGLET: Now, Brendan, would you bring up page 206.

24 BY MR. EGLET:

25 Q Doctor, what were the results of the medial branch

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1 nerve blocks performed by Dr. Seidel?

2 A Appears that he had only 30 percent --

3 MR. ROGERS: Excuse me -- Doctor, excuse me.

4 Your Honor, same objection, as this is beyond the
5 doctor's treatment --

6 THE COURT: Noted for the record; overruled.

7 THE WITNESS: This is a chart note where the patient
8 follows up after these medial branch blocks, and he has
9 30 percent relief.

10 BY MR. EGLET:

11 Q Now, what is the clinical significance of that
12 response?

13 A Well, that would not justify doing a medial branch
14 oblation, and that would essentially eliminate any significant
15 ongoing facet pain at C3-4, C4-5, or C5-6.

16 Q What did Dr. Seibel recommend for Mr. Simao on
17 April 22nd, 2010?

18 A Well, technically it's Terry Robichaud [phonetic]
19 who's the physician assistant that works with Dr. Seibel, but
20 recommended a left C3-4 transforaminal dural object -- I'm
21 sorry, transforaminal epidural injection.

22 MR. EGLET: Put up page 214, please. Brendan.

23 BY MR. EGLET:

24 Q When did Dr. Seibel perform this procedure on
25 Mr. Simao?

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1 A June 10th, 2010.

2 Q And what was -- page 224, please.

3 A I'm sorry, I didn't see the procedure part of that.
4 Can you flip back to that? There it is, down at the bottom.
5 Okay. Thank you.

6 Q Okay. And --

7 MR. EGLET: Page 224 now, please, Brendan.

8 BY MR. EGLET:

9 Q What was Mr. Simao's clinical response to that left
10 C3-4 transforaminal epidural injection?

11 A Would you mind actually going back to the other
12 note, and go to the technical part where it actually describes
13 the procedure?

14 Q Sure.

15 A Those are important details I like to know about.

16 Was there another page, the second page of that?

17 [Pause]

18 THE WITNESS: Can I read this real quick here?

19 [Pause]

20 THE WITNESS: Okay.

21 MR. EGLET: Okay. So now go to page 224, please,

22 Brendan.

23 BY MR. EGLET:

24 Q What was Mr. Simao's clinical response to the left
25 C3-4 transforaminal epidural injection?

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1 A Looks like this is follow-up. Patient had a 50 to
2 60 percent reduction in his symptoms.

3 Q And did he want to schedule another procedure to try
4 to improve his current pain?

5 A Yes.

6 MR. EGLET: Put up page 231, please, Brendan.

7 BY MR. EGLET:

8 Q When did Dr. Seibel repeat the left C3-4 cervical
9 transforaminal steroid injection?

10 A September 2nd, 2010.

11 MR. EGLET: And page 236, please, Brendan.

12 BY MR. EGLET:

13 Q What was Mr. Simao's response to the repeat left C3-
14 4 transforaminal --

15 A I'm sorry. Not to be technical, but can you show me
16 the next page of that procedure note? Just so I can briefly
17 read it?

18 [Counsel and Witness Confer; Pause]

19 THE WITNESS: Let me just read it real quick, please.
20 Can you scroll down?

21 Okay. Thanks. Well, actually, a very important
22 point.

23 So this is point two-five percent marking. Can you
24 go back to the first one? Because I think the other one was
25 point five percent marking. So go back to the first one, the

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1 second page.

2 [Pause]

3 THE WITNESS: Okay, still point two-five. Okay. Thank
4 you.

5 MR. EGLET: So now go to 236, please, Brendan.

6 BY MR. EGLET:

7 Q What was Mr. Simao's response to the repeat C3-4
8 transforaminal epidural injection?

9 A He states 40 percent reduction. If I was looking at
10 this objectively I would simply want to ask is that the
11 immediate anesthetic phase or is that the long-lasting phase.
12 I don't think he makes that distinction.

13 MR. EGLET: Put up 262 -- page 262, please, Brendan.

14 BY MR. EGLET:

15 Q Doctor, who performed Mr. Simao's transforaminal
16 injection November 11th, 2010?

17 A Let's see. Can you scroll down? Or scroll up?
18 Because I don't see a -- oh, there it is. Nader Helmi. Nader
19 Helmi.

20 Q Dr. Helmi.

21 MR. EGLET: And page 265, please, Brendan.

22 BY MR. EGLET:

23 Q What was Mr. Simao's documented clinical response to
24 the November 11th, 2010, left C3-4 transforaminal epidural
25 steroid injection, as documented by the physician assistant,

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1 Terry Robichaud, on November 23rd, 2010?

2 A Again, let me just briefly read the procedure part.
3 Because it's a different physician here, so.

4 Okay, he follows up, and he states he has 75 to
5 80 percent reduction in his left upper extremity pain.

6 Q And what did P.A. Robichaud document during that
7 encounter with respect to Mr. Simao's evaluation by your
8 partner, Dr. Daniel Lee for a second opinion orthopedic spine
9 consult?

10 A Said he'd been seen by Dr. Daniel Lee for a second
11 opinion. Stated that apparently some rather severe stenosis,
12 and discussed with him possibility of surgical interventions.
13 Should not get better with procedures at this office.

14 MR. EGLET: Page 78, please, Brendan.

15 THE WITNESS: I'm sorry. Can we just go back to there?
16 Just one more little thing I want to --.

17 Now, the little technicality here is we got 75 to
18 80 percent reduction of the left upper extremity pain. And
19 again, when -- is it not -- to make sure I'm accurate. He's
20 having mainly persistent left-sided neck and scapular and
21 trapezial pain, correct?

22 BY MR. EGLET:

23 Q Well --

24 A And then we got paresthesias --

25 Q But it says, after -- "upper left extremity," he

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1 said he was "and left-sided neck pain."

2 A Right. And then he adds that down lower, so I just
3 want to make sure we're good to go on that. Okay.

4 Q Okay.

5 MR. EGLET: And so now page 78, please, Brendan.

6 BY MR. EGLET:

7 Q What did Dr. Lee document on his evaluation of
8 Mr. Simao on January 27th, 2011?

9 A Looks like he follows up, notes how he got relief --
10 significant relief of the left -- I would assume a typo -- C3-
11 4 transforaminal epidural, looks like a nerve root block.
12 Physical exam unchanged, most of his pain in the trapezius. I
13 think this refer pain for the neck. I re-reviewed the CT scan
14 and MRI of the cervical spine. It shows no cervical stenosis
15 on the MRI. The stenosis that they are calling at the left
16 C3-4 is really minimal.

17 Q So Doctor Lee in fact is noting no cervical or
18 significant cervical stenosis, is that correct?

19 A I would state he's saying it's really minimal.

20 Q Okay.

21 A Yeah.

22 Q Now, what did Dr. Lee recommend at that time? Your
23 partner, Dr. Lee?

24 A New MRI.

25 MR. EGLET: Page 41, please, Brendan.

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1 BY MR. EGLET:

2 Q What were the results of the repeat MRI of
3 Mr. Simao's cervical spine performed on February 3rd, 2011?

4 A Okay, so this is the radiology report, which may be
5 different from Dr. Lee, but basically states mild narrowing of
6 the left C3-4 neural foramen, minimal retro stesis [sic] C5-6,
7 right para -- mild right paracentral disc bulge at C5-6. Mild
8 narrowing right lateral recess, C6-7. Minor narrowing of the
9 right compared with left neural foramen.

10 Q Now, do any of the findings on Mr. Simao's most
11 recent cervical spine MRI explain his symptoms of left axial
12 neck pain, left trapezial pain, or left upper extremity
13 radicular symptoms?

14 A The MRI in itself, no.

15 Q Why not?

16 A Well, they're basically stating it's mild. And
17 again, as I've stated before, the typical radicular pattern of
18 a C4 nerve pinch in the nerve exit tunnel or the neural
19 foramen would be radiating down to the anterior chest wall.

20 MR. EGLET: Page 79, please, Brendan.

21 BY MR. EGLET:

22 Q What was Dr. Lee's assessment of Mr. Simao when he
23 re-evaluated him on February 24th, 2011?

24 A Follows up. States he can see pain management, no
25 surgical indications at this time, physical exam motor and

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1 sensory is satisfactory. MRI was re-reviewed most recently
2 because the other one was done a year and a half ago. It
3 shows no significant stenosis within the neural foramen of C3-
4 4.

5 Q And what did Dr. Lee recommend to Mr. Simao at that
6 time?

7 A Sounds like plan as above, and it looks like -- I
8 would assume that his plan is pain management, no surgical
9 indications.

10 Q Now, after having done well in his immediate post-
11 operative --

12 A Can I --

13 Q Sure, go ahead.

14 A Is there a way to see that MRI? That was done?
15 Because I've never seen it. I mean, since we're taking the
16 time.

17 [Pause]

18 THE WITNESS: I mean, we've already had one example where
19 the radiologist and I disagree.

20 [Counsel Confer]

21 MR. EGLET: I guess we can't do it right now. Sorry,
22 Doctor.

23 THE WITNESS: I got a laptop in my car.

24 MR. ROGERS: We have an extra one here, if that --

25 MR. EGLET: You could play it over there?

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1 MR. ROGERS: Of course, over the earlier stated objection
2 that it exceeds his treatment, but we'll --

3 THE WITNESS: Well, I would just simply like to -- I
4 mean, I've already had one example where the radiologist and I
5 disagreed, and this --

6 THE COURT: Why, Mr. Rogers, how magnanimous of you.

7 MR. ROGERS: What was the -- ?

8 [Counsel Confer]

9 THE WITNESS: And then could we pull up that report so I
10 can make potentially any comments where if I disagreed.

11 [Counsel Confer]

12 MR. EGLET: It's Exhibit 19, page 41.

13 THE WITNESS: All right, I got the report.

14 [Counsel Confer]

15 THE WITNESS: Do you want me to flip through them?

16 MR. EGLET: Yes.

17 THE WITNESS: I'll do it.

18 MR. EGLET: Is it okay, Your Honor, if he comes out of
19 the box and --

20 THE WITNESS: Why not.

21 MR. EGLET: -- save a little time.

22 THE COURT: We probably should go off record for a
23 moment.

24 [Off the Record]

25 ///

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1 BY MR. EGLET:

2 Q Do you want to look at him on the big screen, to
3 talk about him, Doctor or --

4 A Sure. Are you going to be able to link it onto the
5 monitor?

6 Q We're going to put it on this monitor, it should be
7 there. Here they are.

8 A Okay. So let's start with number three. Okay.
9 That looks okay. So let's go down to four, five. Okay. Go
10 back to that level, five.

11 Q Five.

12 A Could you skip to the next --

13 Q Here's five.

14 A Okay. So this actually C-3,4 as best as I can tell.
15 So there's still a little bit of narrowing of that nerve exit
16 hole. Okay. So, six, is with our technique.

17 [Pause]

18 Q Did you want to look at another one?

19 A Six.

20 UNIDENTIFIED SPEAKER: Six, oh, I'm sorry, I didn't hear
21 that. Six.

22 THE WITNESS: Because I haven't really seen this, we just
23 need to scroll down --

24 Q Okay. Fine.

25 [Pause]

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1 A Yeah. I would have to say. This is a little
2 difficult, because they're sequenced in I can tell they're out
3 of sequence.

4 Q Okay.

5 A So --

6 Q That's fine.

7 A But let me look at on more thing. Just one more
8 sequence.

9 [Pause]

10 A Okay. So briefly looking at his -- can you pull
11 that up on here?

12 UNIDENTIFIED SPEAKER: Sure. It locked up on me. It's
13 not going to happen.

14 THE WITNESS: Number?

15 UNIDENTIFIED SPEAKER: It locked up on me. I'm going to
16 actually start apologizing.

17 THE WITNESS: Okay. Well, let me just summarize it --
18 BY MR. EGLET:

19 Q Yes.

20 A -- I was able to see some.

21 So the things that would take a little disagreement
22 with the report, is I did not see any retrolisthesis at C5,6.
23 I did not see any significant -- and then, again, it only says
24 mild disc bulge at C5,6 or narrowing at C6,7.

25 And I would say the for foraminal narrowing at C3,4

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1 may be a little improved. And that can be explained by simply
2 the fact once you fuse a segment bones spurs and stuff
3 actually can go away. So --

4 Q All right. Now, Doctor, after having done well in
5 his immediate post-operative course following your cervical
6 fusion surgery, why has Mr. Simao developed chronic left axial
7 left pain, left trapezial pain and intermittent left upper
8 extremity radicular symptoms?

9 A Well, I would say the potential causes that would be
10 reasonable as far as the residual left-side at neck, periscap
11 or trapezial pain can simply be the fact that he went so long
12 before definitive treatment.

13 And then you start getting issues of chronic pain,
14 and then you start getting intrusion, pain. And what that
15 means in a simple sense, is the nervous structure from the
16 brain all the way out to the little receptors in your body,
17 when you have chronic pain issues going on the internal
18 architecture of the neurological system can be altered.

19 So what happens is, as the pain becomes more
20 chronic, and I use, you know, I would say that you're at more
21 risk for these neuropathic chronic persistent pain syndromes.
22 Once you start getting beyond a year that the internal
23 architecture of these pathways gets changed.

24 Now what happens is as time goes on, even though you
25 potentially take care of the structural cause of the pain,

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1 because the change in these internal pathways of the nervous
2 system the patient still perceives pain.

3 And patients are at risk for this. Technically any
4 time you're at risk for this. But in general once you have
5 chronic pain syndromes that go beyond a year gradually that
6 risk gets higher and higher.

7 So what happens is, is that there's a potential
8 where even though you take care of the structural issues the
9 pain is persisting.

10 So technically with Mr. Simao, his accident was
11 what, April of '05, surgery wasn't until March of '09, well,
12 we're talking about almost four years.

13 So that's one reasonable explanation.

14 Q So --

15 A The other explanation is he can still have a
16 component of occipital pain, or occipital neuralgia. And
17 that's any time -- again, I've mentioned it, but this
18 occipital nerve you've got basically two that come out on each
19 side, you've got a greater and a lessor, but these nerves are
20 coming out of the spine and they're going through various
21 layers of muscle.

22 And when someone has chronic pain and spasm these
23 various muscle layers are spasms and kind of shearing this
24 nerve as it's punitrating [sic] through.

25 And over time if you have a chronic pain problem

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1 where the spasm component is aggravating this nerve you can
2 get what we call occipital neuralgia. Now that potentially is
3 a real entity that could be contributing to his ongoing pain
4 as well.

5 Q Is the development of neuropathic pain syndrome
6 post-operatively considered a surgical failure?

7 MR. ROGERS: Objection, Your Honor. On this one we do
8 need to make a record.

9 THE COURT: All right.

10 [Bench Conference Not Transcribed]

11 BY MR. EGLET:

12 Q All right, Doctor. The question is, was pending, is
13 the development of neuropathic pain syndrome post-operatively
14 considered a surgical failure?

15 A Well, I would definitely say it's considered less on
16 a desirable outcome. Surgical failure in a general sense I
17 think would imply that something technically with the surgery
18 went amiss. The fusion didn't take, the hardware broke,
19 something like that.

20 Q Do you believe that any surgeon that is -- strike
21 that.

22 Do you believe that surgery that is unsuccessful,
23 means that it was not indicated and/or unnecessary?

24 A No.

25 Q Why?

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1 A Well, I mean, if you take a simple example that's
2 fairly black and white, when you look at what surgeries
3 orthopedic surgeons do, one of the best operations we do are
4 hip replacements. That's a great job of a patient having an
5 operation, feeling better, having more function, less pain.
6 But even that operation is successful about 90 to 95 percent
7 of the time.

8 So I mean, by definition, so what does that mean?
9 That means five to ten percent of the time because it wasn't
10 successful it was unnecessary or not indicated; absolutely
11 not.

12 I mean, in fact it's so extreme that I think even in
13 Nevada it's actually against the law for a doctor to make a
14 guarantee as far as outcome for a surgical procedure.

15 So I mean, anything we do, I mean nothing is a
16 hundred percent. I wish it was, it would be awesome, but it's
17 not.

18 Q Do some patients who have a good indication for
19 cervical spine, a reconstruction in fact, not experience any
20 relief of their symptoms, or have worsening symptoms following
21 surgical reconstructions?

22 A Well, it can occur, and there's all kinds of
23 reasons. Worsening I'd say typically would be because of more
24 likely structural issues with the surgery itself. No relief.
25 And again, it's a spectrum, but I'm sure it's possible.

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1 Q Why do some patients either not improve, continue to
2 have pain or get more symptomatic following surgical
3 reconstruction of the chronic spine?

4 A Well, the answer is basically a spectrum again. You
5 can have the one extreme where technically everything is fine,
6 but things are not improved and you probably have neuropathic
7 pain.

8 Technically you could have, if the surgery was done
9 correctly, but maybe something else has started to become a
10 problem. Or you've got another more definitive down spectrum
11 where the surgery technically has issues; the fusion didn't
12 take, hardware broke, screw went in the wrong place,
13 something.

14 Q What percentage of patients that undergo this multi-
15 level surgery that you perform do not improve?

16 A Well, I would say the vast majority do improve. But
17 at the same time I would say the vast majority of patients
18 don't -- you know, I think what was the timeframe when I
19 actually recommended surgery to when he eventually got it;
20 wasn't it like '07?

21 Q Yeah.

22 A You know, so I would say the vast majority of my
23 patients, because they've gone through a reasonable treatment
24 and we've tried reasonable things, and it's been a reasonable
25 period of time, the vast majority will not delay surgery

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1 another two years.

2 So for that reason in my hands I think a lot of my
3 patients do very good, good, well. Sure, do you I have
4 patients who don't improve, sure.

5 Q What criteria do you use to make surgical
6 recommendations for cervical spine reconstruction in your
7 patients that gives them the best chance of having good
8 outcomes from surgery?

9 A The question one more time, please?

10 Q What criteria do you use to make surgical
11 recommendations for cervical spine reconstruction in your
12 patients that gives them the best chance of having good
13 outcomes in surgery?

14 A Well, I think we've already touched on a lot of it.
15 I think you want to make sure that you've given patients a
16 chance to get better who are going to get better. But once
17 they reach that branch part in the road where chances of
18 improving are low, and that's usually 6 to 12 months once
19 you're into that, then I think that's the time to intervene
20 and take care of the problem.

21 Studies shows, a good example would be spinal
22 stenosis which is an age-related degenerative thing as people
23 are just getting older where there's a gradual narrowing of
24 the spinal canal. And people when they try to stand up and
25 walk they get pain going -- tingling down their legs, studies

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1 show that if you wait more than a year to do surgery the
2 outcomes of the surgery go down.

3 And when you think about it intuitively, I mean, if
4 a nerve is getting squashed, you know, over time there's going
5 to be chronic irreversible changes. I mean, it's just
6 commonsense.

7 Q Now was --

8 A So -- I'm sorry.

9 Q I'm sorry.

10 A So that's one thing. You want to make sure you're
11 intervening at appropriate effective branch points in the
12 timeline, just because you want to, at the beginning you want
13 to give them a chance to get better, because odds are good
14 they're going to get better.

15 But once they get to that three to six months, and
16 as long as they've done reasonable, conservative things, your
17 odds are stacking up against you.

18 Q Was Mr. Simao at increased risk for not responding
19 well to surgical reconstruction of the cervical spine?

20 A I would say yes simply because of the four-year
21 delay.

22 Q If Mr. Simao were at increased risk for not having a
23 good surgical outcome, why do you offer him the surgical
24 reconstruction?

25 A Well, I think it's fair to say it was very dogmatic

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1 to make sure the workup was as fresh as it could be. So every
2 time he came back after a delay of a year, of a year and a
3 half, we always said, okay, well, things could have changed.
4 Let's make sure we get a new MRI. Let's make sure we repeat
5 injections. Let's just don't assume that things haven't
6 changed.

7 So then the scope of what's reasonably possible, I
8 think that commitment to being dogmatic and making sure the
9 workup is recent and fresh minimizes that chance. Does it
10 eliminate it? No.

11 Q All right. You've explained to us that you believe
12 that he has the development of neuropathic pain syndrome, as
13 well as potentially you have occipital neuralgia, which you
14 explained to us.

15 What is the treatment for neuropathic change
16 syndrome?

17 A Again, there's a whole spectrum. Some people make
18 it better just taking Lyrica or Neurontin. But for those that
19 are persistent and non-improving, the treatment's typically a
20 spinal cord simulator or some type of neuro modulation.

21 Q What is a spinal cord stimulator?

22 MR. ROGERS: Oh, objection, Your Honor.

23 MR. EGLET: May we approach, Your Honor.

24 THE COURT: Yeah. Sure, come up.

25 [Bench Conference Not Transcribed]

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1 BY MR. EGLET:

2 Q Okay, Doctor. The question that was pending is
3 what is a spinal cord stimulator?

4 A Well, the general answer is you have these
5 electrodes which do neuromodulation. The simple concept is
6 you have a device that's low profile and it has multiple
7 electrodes and it lays on top of neurologic structure. It can
8 lay on top of a nerve, it can lay on top of a spinal cord.

9 And what it does, it has multiple programming
10 capabilities that's typically attached to a very complex
11 internal device called a pulse generator. What it is, is a
12 mini-size computer with a battery or a power source and it can
13 do all these configurations to modulate the electrical
14 impulses as they're traveling through these neurologic
15 structures; either the nerves or the spinal cord.

16 So the whole idea is that these altered neurologic
17 pathways basically need to be calmed down. It's like
18 listening to the radio but there's too much static, it's just
19 annoying. So what it does is it changes that perception from
20 pain to typically a gentle buzz or vibration.

21 So what it's doing is technically in a layman's term
22 kind of down-regulating or simmering down these over-excited
23 inappropriate impulses that are traveling through these
24 pathways in the nervous system.

25 Q Okay. And would come out of the box, Doctor, and

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1 using the spine, if you could explain to the jury how a spinal
2 cord stimulator, a Texas 5 [phonetic] cord stimulator, we're
3 talking for about Mr. Simao, would be surgically placed?

4 A So the spinal cord stimulators are placed in the
5 spinal canal. They sit on top of the spinal cord. So if you
6 -- can you pull up a -- that's okay.

7 Q Do you want the animation?

8 A No. No, it's okay. I was just going to show them a
9 spinal cord.

10 So when you look at a spinal cord the pathways that
11 are going back up towards the brain, providing sensation and
12 pain, primarily on the back side.

13 So what we do, is you make a small opening to get
14 into the spinal canal and you insert this device. Okay. And
15 that device sits on top of the spinal cord. Technically it
16 sits on top of the spinal sac, and then there's usually a thin
17 layer of fluid and then the spinal cord.

18 And then it's connected via a cable to this pulse
19 generator which classically is put on the patient's right butt
20 cheek. Those are separate incisions. Sometimes you need to
21 make an additional incisions just to connect the cables. And
22 then it's placed wherever it's deemed to be appropriate, to
23 get good coverage.

24 Typically you'll get a trial done first, or
25 extembula [phonetic] needle sticks. Pain management will

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1 place what they call percutaneous leads, which are smaller
2 leads. They're basically in the shape of small cylinder tube,
3 and they can be placed in various configurations.

4 The idea is that's done awake and the patient's able
5 to give feedback saying: Oh, yeah, that's the spot, that's
6 not it. And then the pain management doc will move that
7 around until he gets what we call the sweet spot. Meaning
8 it's getting good stimulation in the area we want it.

9 And then the patient -- they will make temporary
10 connections to an external version of the pulse generator, and
11 then that's typically you want at least a five-day trial where
12 they're adjusting it, and getting a chance to really use it,
13 so they can be in a good position to say: Yeah, that was
14 really helpful, or, you know, it didn't really make a
15 difference.

16 Q And this is a pain management device?

17 A Yes. By definition it's to manage, but -- yeah.

18 Then if this trial is successful then they'll come
19 to me and I'll place the permanent one in.

20 Q Okay. All right. Thank you, Doctor.

21 And if you could take a look at this animation we
22 have, and tell us, is this, I know in simple forms, how the
23 stimulator is placed and how it works? Is this the battery
24 stimulator, if it's placed surgically in the hip to the butt?

25 A Yes.

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1 Q Okay.

2 A There's the connection cables. Most commonly it's
3 placed in the lower thoracic or mid-back, but selectively it
4 can be used up in the neck. There's a good picture of this
5 electrode, and it's basically spread out; it looks like a
6 paddle sitting in the spinal canal.

7 And typically this can be a device that has a remote
8 programmer so the patient can have multiple settings.

9 Q That's what this is, the program?

10 A Yes. And newer the devices the patients can have up
11 to 16 different settings, and they can adjust the intensity,
12 turn it off, turn it on. I had several patients where it's
13 very helpful, the lives for those who need it.

14 Q Okay. Now is a neurostimulator also an effective
15 treatment for occipital neuralgia?

16 A It can be. Typically the treatment will be try some
17 injections, first. Pain management may try some blocks to --
18 do long-term blocking of the nerve. They may try ablation,
19 but they can also, it's very common to use these percutaneous
20 leads as well.

21 Q And is it your opinion, as one of Mr. Simao's
22 treating physicians that he needs placement of a
23 neurostimulator to most effectively treat his neurogenic pain?

24 MR. ROGERS: Objection, Your Honor, foundation, and the
25 disclosure issues that we discussed.

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1 MR. EGLET: Same argument, Your Honor.

2 THE COURT: Noted for the record. Do you want a
3 continuing objection, Mr. Rogers?

4 MR. ROGERS: Absolutely.

5 THE COURT: Very well, I'll note it for the record.

6 THE WITNESS: Answer?

7 THE COURT: Overruled. Yes.

8 THE WITNESS: Repeat the question, please.

9 BY MR. EGLET:

10 Q Is it your opinion as one of Mr. Simao's treating
11 physicians that he needs placement of a neuro or spinal cord
12 stimulator to most effectively treat his neurogenic pain?

13 A Well, the clinical answer would be he at least would
14 need placement of a trial.

15 Q Okay.

16 A And the trial is important, because the trial tells
17 you whether or not to do the permanent.

18 Q Okay. What I want you to do for us now, Doctor, is
19 if you key in, I'd like you to outline for us the cost
20 associated with the surgical placement of this spinal cord
21 stimulator.

22 A Do you want to tilt that a little bit so I can --
23 it's not important, I guess.

24 Q Yeah. I'm just -- this is for the jury --

25 A Okay, good.

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1 Q -- to see, and I'm going to just write on it and
2 have you -- so you mentioned a trial stimulator would be the
3 first thing.

4 So what would be the costs for the trial stimulator,
5 including the surgeon's costs, anesthesia fees, surgical
6 center, supplies, all of that?

7 A And the facility --

8 Q The facilities.

9 A -- basically everything?

10 Q Yeah.

11 A So, I'm sorry, for the trial?

12 Q For the trial of the stimulator?

13 A Approximately \$84,000.

14 Q Eighty-four thousand?

15 A Yes.

16 Q Okay. And then the permanent placement of the
17 stimulator by the spine surgeon, what are the total costs; the
18 surgeon's fees, the anesthesiologist's fees, the hospital or
19 surgery center's fees, the cost of the stimulator and
20 equipment and all of that?

21 MR. ROGERS: Objection, Your Honor. The doctor's
22 testified only to the trial not the permanent --

23 MR. EGLET: Your Honor, he has testified to both this
24 trial and the stimulator, we're entitled to outline the cost.

25 THE COURT: Overrule the objection.

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1 THE WITNESS: If the trial is successful and a permanent
2 implant is indicated those costs altogether would be
3 approximately 212,000.

4 BY MR. EGLET:

5 Q \$212,000?

6 A Yes.

7 Q All right. Now, the -- is there normally a revision
8 of the pulse generator battery that is done?

9 A On general the pulse generator, depending on how the
10 patient uses it, may be replaced anywhere from three to seven
11 years. I think a reasonable average is five years.

12 Q So the stimulator would have to be surgically
13 replaced?

14 A We were just talking about the pulse generator.

15 Q The pulse generator.

16 A Which is basically the, you know, which is the power
17 source and the computer.

18 Q And you said --

19 A Average, five years.

20 Q Every five years on average. And what's the cost of
21 that?

22 A Approximately 141,000.

23 Q Okay. Now is there usually in people Mr. Simao's
24 age, a revision that has to be done for the leads, at least
25 once?

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1 A Well, the leads typically aren't as durable in the
2 cervical spine, because there's simply a lot more motion. So
3 there is a higher incidence of needing to replace the leads or
4 revise a connection cable.

5 Typically if there's a problem it's usually right
6 where it's going in. So on average that revision is
7 approximately every two to three years for cervical. And --

8 Q Every two --

9 A Every two to three years. So say every two years.

10 Q And what's the cost of that?

11 A Approximately 103,000.

12 Q And then is there a requirement, any requirements if
13 there's any follow-up? I mean, is this thing programmed with
14 a computer or something?

15 A Typically what happens is, the patient, the first
16 initial period over the first three months may need more
17 frequent follow-ups to just fine-tune the programming.

18 So basically that involves seeing the doc and then
19 having the clinical specialist from the respective company
20 that makes the implant and altering the programming.

21 Q Okay.

22 A So average costs for that, including everything,
23 it's typically about a thousand dollars.

24 Q And then you said that's how often?

25 A I would say in the first three months, it's twice.

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1 Q Okay.

2 A And then after that it varies. I would say I
3 typically would see a patient back maybe every six months.

4 Q Okay. The follow-up is for programming in the first
5 three months, you say how many times?

6 A Twice.

7 Q Twice, at --

8 A Approximately a thousand dollars.

9 Q One thousand dollars per visit?

10 A Yes.

11 Q So \$2,000. And then you said -- then the
12 reprogramming is every six months?

13 A On average, yes.

14 Q So that would be \$2,000 annually?

15 A Yes.

16 Q Now, these neurostimulators, or spinal cord
17 stimulators, are these something that normally are placed in,
18 those are placed in the patients, these are lifetime things?

19 A Typically they keep them a long time. Yes.

20 Q All right. Now, is the need for the placement of
21 the spinal cord stimulator in Mr. Simao directly and causally
22 related to the motor vehicle crash of April 15, 2005?

23 MR. ROGERS: Same objection, Your Honor.

24 THE COURT: Same, duly noted for the record. Overruled.

25 THE WITNESS: Assuming, based on everything we've talked

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1 about on the issue of chronic pain, a four-year interval, yes.

2 BY MR. EGLET:

3 Q Based on -- Doctor, based on your experience in your
4 treatment of this patient over the last number of years, and
5 your understanding of his chronic pain, is it more likely than
6 not that he's going to need the permanent placement of the
7 spinal cord stimulator?

8 A Again, I would -- the permanent is contingent upon
9 the trial. I'd say it's definitely more likely than not, he
10 at least needs the trial.

11 Q I understand. But my question is this, Doctor:
12 based on your experience and your understanding of his chronic
13 pain, and your treating patients like him in the past, and
14 this type of neuropathic pain, and understanding his problems,
15 and based on year's experience, is it more likely than not
16 that he will end up having a permanent placement of a
17 stimulator?

18 MR. ROGERS: Objection; asked and answered. The Doctor
19 already --

20 THE COURT: Noted for the record.

21 MR. ROGERS: -- responded to this.

22 THE COURT: Overruled.

23 THE WITNESS: I would say over my experience most of the
24 patients I send for trials do have successful trials; so the
25 answer is yes.

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1 BY MR. EGLET:

2 Q Thank you. Now, after your extensive evaluation,
3 your treatment, your surgical interventions with Mr. Simao,
4 have you reached any conclusions with respect to what injuries
5 he sustained directly and causally by the April 15th, 2005
6 motor vehicle crash?

7 A I would say --

8 MR. ROGERS: Objection; foundation.

9 THE COURT: Overruled.

10 THE WITNESS: I would say that in a simplistic sense he
11 injured the C3,4 and C4,5 levels, with the least significant
12 component being discogenic.

13 BY MR. EGLET:

14 Q As well as intractable post-operative neuropathic
15 pain syndrome?

16 A As well as what appears to be neuropathic pain.

17 Q And occipital neuralgia?

18 A And/or occipital neuralgia.

19 MR. ROGERS: Objection; leading, Your Honor.

20 THE COURT: Sustained.

21 BY MR. EGLET:

22 Q Are your conclusions regarding causation more likely
23 right than wrong, Doctor?

24 A Yes, they're more likely right.

25 Q And beyond that are you certain?

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1 A Yes.

2 Q And could you please -- strike that.

3 Hypothetically, if someone told this jury -- well, I
4 think I've already asked you. You answered that. You've
5 already asked and answered that.

6 Has the medical care and treatment rendered by you
7 and all of the physicians at Nevada Orthopedic and Spine
8 Center, all of the treatment from University Medical Center
9 and PBS Anesthesia, been necessary and reasonable and causally
10 related to the injuries Mr. Simao sustained from his April
11 15th, 2005 motor vehicle crash?

12 MR. ROGERS: Objection; compound and the doctor hasn't
13 been identified as an expert to comment on other providers.

14 MR. EGLET: Your Honor, speaking objection. You ruled on
15 this --

16 THE COURT: I agree. I agree.

17 MR. EGLET: -- he's a treating physician.

18 THE COURT: Overrule the objection.

19 THE WITNESS: Yes.

20 BY MR. EGLET:

21 Q Now was the billing associated with all of the above
22 treatment that you have described for us and provided to Mr.
23 Simao, customary and reasonable for patients in Clark County
24 Nevada?

25 A Yes.

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1 Q Are your conclusions regarding the care rendered to
2 Mr. Simao and their associated costs, more likely true than
3 not true?

4 A Yes.

5 Q Okay. And beyond that are you certain?

6 A Yes.

7 Q And have all the conclusions you have shared with us
8 here today been to a reasonable degree of medical probability?

9 A Yes.

10 Q And by that you mean that your conclusions are based
11 on medical reasoning?

12 A Yes.

13 MR. EGLET: Thank you, Your Honor. I pass the witness.

14 THE COURT: Mr. Rogers.

15 MR. ROGERS: If the jury would like -- it's up to you,
16 Your Honor.

17 THE COURT: Could counsel approach, please.

18 [Bench Conference Not Transcribed]

19 MR. EGLET: Oh, Your Honor, could I do one more thing,
20 I'm sorry, before I pass the witness? He hasn't started yet.

21 THE COURT: Sure.

22 MR. EGLET: Your Honor, I would ask that this be marked
23 as Plaintiff's next in order. And I would move this into --

24 UNIDENTIFIED SPEAKER: 65.

25 MR. EGLET: 65, move and have it admitted into evidence.

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1 THE COURT: Okay. It should be marked as proposed 65;
2 any objection?

3 MR. ROGERS: Sure. All the objections are stated.

4 THE COURT: Your objection is noted for the record, 65
5 will be admitted.

6 MR. EGLET: Thank you, Your Honor.

7 [Plaintiff's Exhibit 65 Received]

8 THE WITNESS: There actually is one mistake on the bill
9 there. It's two-pages, not one. Two levels, that's all.

10 MR. EGLET: So it's not the right amount?

11 THE WITNESS: Yeah. They just gave one, it's like two.

12 MR. EGLET: Your Honor, if we could go back on the
13 record, the doctor's noted there's a mistake on the bill?

14 THE COURT: Sure. Back on record.

15 BY MR. EGLET:

16 Q Is this referenced -- do you have this referenced
17 anywhere else? What exhibit number is the bills? Is this
18 your bills?

19 A Exactly, it's basically the surgical bill. There
20 was two pages and they only billed one.

21 MR. EGLET: The surgical bill, Robert?

22 MR. ADAMS: From University Medical Center is 9.

23 MR. EGLET: No, for Nevada Orthopedic and Spine Center?

24 MR. ADAMS: 6.

25 THE WITNESS: On the letterhead.

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1 BY MR. EGLET:

2 Q 6.

3 A Yes. So 22851, that's just for one page, so it's
4 two. So that should be 1900 times two.

5 Q Okay. Can you point that out? Okay. Right here?

6 A Yeah. Right here.

7 Q All right. So for the record, Doctor, you're
8 identifying Exhibit 6, page 1, date of service, March 25th,
9 2009. It says "cage interior" and it's only billed for one
10 cage --

11 A Correct.

12 Q -- at 1900 and should be two cages?

13 A Correct.

14 Q So that should be 3800; is that right?

15 A Yes.

16 Q Okay. Thank you.

17 MR. EGLET: Thank you, Your Honor.

18 THE COURT: Okay. Can I see counsel at the bench,
19 please.

20 [Bench Conference Not Transcribed]

21 THE COURT: All right. It seems, ladies and gentlemen of
22 the jury, that we cannot conclude the examination of this
23 witness, so we're going to have to ask Dr. McNulty to return
24 another day. Tomorrow is apparently not the day he can return
25 because of the scheduling of the witnesses.

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1 Mr. Rogers will be calling a witness out of order
2 tomorrow afternoon, so that's what all the discussion was
3 about, scheduling matters. And what that means is, we don't
4 know yet when Dr. McNulty can return, so you'll have to
5 remember what he said and wait until he's concluded his
6 testimony.

7 There are a couple of questions that some of you
8 asked. I'm going to read to him. He may be a proper witness
9 to answer these questions. I don't know. The first one is
10 photos of discs before surgery, question.

11 THE WITNESS: Photos?

12 THE COURT: Photos of discs before surgery.

13 THE WITNESS: What's the surgery?

14 THE COURT: I would -- I would imagine it means, are
15 there photos of discs before surgery?

16 THE WITNESS: You mean like, taking a picture with a
17 camera?

18 THE COURT: I don't know. You know as much as I do.

19 THE WITNESS: Okay. I would say that photos of the discs
20 before surgeries on the MRIs, if you look at the x-rays and
21 pictures when Dr. Rosler did the discograms, those are other
22 pictures that show how the dye is going into the discs, plain
23 x-rays. Those would be the closes thing to photos --

24 THE COURT: Okay.

25 THE WITNESS: -- because obviously, I mean, not to be too

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1 simplistic, but I can't really take a picture of the disc
2 unless you expose it surgically, and so --

3 THE COURT: Okay. I think that answers the question.
4 The second one reads, how can two discs have the same fissure
5 in about the same location, that one is painful and the other
6 has no pain?

7 THE WITNESS: Well, I think there were three discs --
8 well, you had two discs that were painful. I assume we're
9 talking about the discogram? Because we're able -- are we not
10 allowed to ask a question to clarify?

11 THE COURT: No.

12 THE WITNESS: Okay. Assuming it's the discogram, where
13 it talks about the fissures, basically when you talk about a
14 fissure, you're injecting dye into the disc, and you're seeing
15 the dye leak out of the disc and you're assuming it's a
16 fissure. So I made the comment that the cervical discs are
17 different than the lumbar discs. Lumbar discs are more
18 common.

19 A discography is also done of the lumbar spine, the
20 lower spine. Anatomically, that structure is more of a
21 classic disc that's encased with a tough, essentially
22 watertight, seal all around, whereas the cervical discs are a
23 little different. At the sides of the cervical discs, they
24 have these things called uncovertebral joints.

25 And I can actually show you. And these joints --

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1 you see from the front, there's a little prominences of bone
2 that go up, whereas a lumbar disc, everything's fairly flat.
3 So the anatomy and the structure of a cervical disc is a
4 little different, where it's not completely encased in a
5 watertight, tough outer covering.

6 So even in the normal disc, if you put dye in it,
7 you can have some leakage of dye out of the sides. So what's
8 specific about that is that when they did the discogram, they
9 tested three discs, C3-4, C4-5 and C5-6, the painful discs
10 that were reproducing -- this was the mouth pain.

11 We're at C3-4 and C4-5. C5-6 did not cause pain,
12 even though there was leakage of dye. So you can explain the
13 leakage of dye just by understanding that subtle but important
14 difference to anatomy.

15 THE COURT: Any follow-up questions by counsel, either
16 side?

17 THE WITNESS: I'm sorry. Let me --

18 THE COURT: Sorry.

19 THE WITNESS: But I think the question --

20 THE COURT: Sorry, Doctor. I thought you were finished.

21 THE WITNESS: Read your question once more so I make sure
22 I answer it correctly.

23 THE COURT: How can two discs have the same fissure in
24 about the same location, that one is painful and the other has
25 no pain?

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1 THE WITNESS: Well, I'm at a little bit of a disadvantage
2 because I haven't been -- technically been shown those
3 pictures. But just because they have them, quote, unquote, in
4 the same location doesn't mean it discredits or makes it
5 confusing. It just happens to be that way.

6 THE COURT: Any follow-up questions by counsel?

7 MR. EGLET: No, Your Honor.

8 THE COURT: I'm going to be asked that these questions be
9 marked as Court's Exhibits next in order.

10 THE CLERK: Yes.

11 THE COURT: There were a couple of other questions
12 submitted by the jurors, but this witness is probably not the
13 one to answer these questions, so I'm going to ask the Clerk
14 to mark these and just hang onto them for now in the event
15 that we get a witness who can answer them. Then we'll address
16 the questions to that witness, whoever that might be. So I
17 need those two back.

18 With the thanks of the Court, ladies and gentlemen
19 of the jury, you may be excused. I remind you of your
20 obligation not to discuss this case with anyone, not to form
21 or express any opinion, not to do any research on any subject
22 connected with this case. Please return tomorrow promptly at
23 1:00.

24 THE WITNESS: Friday at 1:00 start as well?

25 THE COURT: No. Friday's a noon start.

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1 [Jury Out]

2 THE COURT: Okay. You may be excused if you wish or you
3 can stick around. It's all the same to me, sir.

4 UNIDENTIFIED SPEAKER: I'll talk to you after.

5 THE WITNESS: Okay. Well, I think, for what it's worth,
6 I can make Friday at noon. I think I can do that.

7 MR. EGLET: We have to -- we have to -- and I'll talk --
8 I'll call you tonight. We have to coordinate with Dr. Grover.

9 THE WITNESS: Okay.

10 MR. EGLET: And it may very well be at noon, so -- but
11 I'll let you know.

12 THE WITNESS: So you will try to affirm that this
13 evening?

14 MR. EGLET: I'm going to try to firm that up.

15 THE WITNESS: Okay. All right. I'll get all my stuff.

16 THE COURT: Thank you. Okay. Outside the presence of
17 the jury, Mr. Michalek?

18 MR. MICHALEK: Yes, Your Honor. I understand that the
19 doctor was allowed to give a future care opinion. We are
20 entitled under 26G to a computation of damages. We filed a
21 motion in limine specifically on this issue.

22 And Your Honor, during the hearings on the motion in
23 the limine, specifically said that you hadn't heard anything
24 new, hadn't heard any discussion of any future care. This was
25 a surprise today, that without any prior disclosure, certainly

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1 from a former member of the bench who would know that such
2 documents would need to be disclosed under 26, we haven't got
3 a copy of it.

4 It hasn't been produced to us and certainly not a
5 listing of those damages. And the doctor should not be
6 entitled to give a future care discussion when you violate
7 rule 26 in -- regarding the computation of those damages.
8 There are a listing of another ton of issues that the doctor
9 should not be allowed to testify about.

10 I was beginning to discuss those earlier. We moved
11 onto have his testimony, but the veracity of the witnesses --
12 Your Honor, there was a motion in limine that we filed that
13 said experts, even medical experts, are not allowed to discuss
14 or vouch for the credibility of their witnesses.

15 THE COURT: Mr. --

16 MR. MICHALEK: You granted our motion.

17 THE COURT: Mr. Michalek, I need to stop you there
18 because now, you're repeating argument you made in a previous
19 hearing, in a previous objection. You've already lodged your
20 objection with respect to that. The Court's already ruled on
21 it. I don't intend to allow you to revisit issues that you've
22 already addressed. You've already made your record and the
23 Court's already ruled on it.

24 MR. MICHALEK: Your Honor, my understanding was, when I
25 tried to make that issue earlier, I was prevented from doing

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1 so when you moved onto the other issue. I will note, for the
2 Court, however, that every time there is an objection, three
3 members of the Plaintiff's firm are up there, giving their
4 ideas as to, you know, what should be or should not be allowed
5 into evidence, only two of which are trial counsel.

6 I think the Defendant should be allowed the same
7 leeway. I'm making my objections now. Otherwise, we're going
8 to have a cavalcade of people coming up to the bench, making
9 their arguments all the time. And I don't think that is what
10 the Court wants, either. There was an issue regarding
11 relationship between the doctors and the Plaintiff's counsel.
12 And I believe there was an issue that was raised during the
13 motion in limine.

14 And the Court actually said that there's two
15 separate issues. You prevented us from making an argument
16 about the medical build-up. But you said that the bias of the
17 witnesses was certainly fair game. And I can point to that,
18 actually, in the transcript, Your Honor.

19 THE COURT: Mr. Michalek, now, you're rearguing issues
20 that the Court's already heard. Whether you made the argument
21 or whether someone from your firm made the argument, the Court
22 has carefully considered all of the motions, all of the
23 briefs, all of the arguments and all the objections lodge.
24 And the Court's made a ruling and I don't intend to revisit
25 issues we've already discussed and addressed.

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1 MR. MICHALEK: The reason why I'm going over this, Your
2 Honor, today, is because yesterday, there was a miscitation to
3 the record. I'm pointing out in the transcript what Your
4 Honor actually ruled. There were arguments made by the
5 Plaintiff's counsel, while these motions were denied, that,
6 that is not -- just because there is a minute order that says
7 hey, your motions are denied, that does not accurately reflect
8 what the Court ruled. And if I could --

9 THE COURT: Wait a minute.

10 MR. MICHALEK: If I am allowed --

11 THE COURT: Wait a minute. Wait a minute. Wait a
12 minute. Let me address one thing, because you have misstated
13 what the Court ruled. You said that the Court denied your
14 motion regarding medical build-up. And what happened is, when
15 I specifically asked counsel what evidence do you have that
16 there -- that this case was -- that there was any sort of
17 medical build-up, or that this case was attorney driven,
18 counsel could not respond to that question.

19 MR. MICHALEK: I'm not --

20 THE COURT: You couldn't --

21 MR. MICHALEK: I'm not --

22 THE COURT: -- tell me -- you couldn't tell me one way or
23 the other. And I realize it wasn't you making the argument,
24 but from the Court's perspective, it really doesn't matter
25 whether it's you, or Mr. Rogers or another defense attorney.

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1 It doesn't matter whether it's Mr. Wall, or Mr. Adams or Mr.
2 Eglet. The point is, you've already made your record.

3 MR. MICHALEK: Sure. Your Honor, I think that -- I think
4 I misstated or you must have misunderstood what I was trying
5 to say. I'm not asking for argument about medical build-up.
6 What I'm discussing is, during the discussion of the motion in
7 limine on medical build-up, there was a discussion of bias of
8 the witnesses.

9 And on page 34 of our transcript, we were
10 discussing, Mr. Rogers and the Court, about medical build-up.
11 And we were talking about there, the bias or the prejudice of
12 the witnesses, that they may have some relationships, that had
13 some prior relationships with counsel.

14 And the Court said that we would allowed to go --
15 would be allowed to go into that. You said, okay. The
16 motion, as it was granted, i.e., talking about medical
17 build-up, was granted. With respect to the other issues that
18 you've raised, which I think are important issues for trial
19 purposes, relating to bias of expert witnesses, how many times
20 they've testified for example, for a certain firm and what
21 kind of compensation they've received for their time, I think
22 those are all fair game.

23 And yesterday, there was an argument about, well,
24 the Court's ruling was, we couldn't get into bias or
25 relationships. That's not true. The issue that you granted

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1 the motion in limine on, and I agree with the Court's ruling,
2 was on medical build-up. It had nothing to do with bias or
3 relationships. You said that those things were fair game.
4 And we were prevented from doing that.

5 THE COURT: And I think they are fair game.

6 MR. MICHALEK: And -- well, Mr. Rogers --

7 UNIDENTIFIED SPEAKER: Well, we don't know he's -- she's
8 said --

9 MR. WALL: That's absolutely incorrect. That is
10 absolutely incorrect. What it -- was said in a hearing about
11 relationships between lawyers and witnesses -- you said, if
12 you want to make a specific point on that, file another motion
13 in limine on that point specifically and the Court would
14 consider it and rule on it after we had a chance to oppose
15 it. Nothing has been filed.

16 THE COURT: That's my recollection.

17 MR. MICHALEK: So you're saying, because there wasn't a
18 specific question brought up during pre-trial, we're not
19 allowed to raise it during trial? Motions in limine, Your
20 Honor, are certainly for the Court's benefit and I understand
21 that. But if there's a specific question that comes to our
22 attention, we should be able to raise that issue during trial,
23 not just because we haven't brought that issue in a motion in
24 limine.

25 Motions in limine certainly speed things along, but

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1 there's going to be issues that come up during trial that just
2 can't be raised in a motion in limine, questions we discover
3 through discussions with other counsel or through other
4 witnesses.

5 Just because we didn't raise it before doesn't mean
6 we shouldn't be able to raise it now. I think Mr. Rogers was
7 attempting to ask that yesterday and he was simply precluded
8 from asking any questions regarding bias or relationship.

9 THE COURT: Well, that's not true, Mr. Michalek. You're
10 not really accurately representing the record. Mr. Wall's
11 statement of what occurred is accurate. And the fact of the
12 matter is, if the parties aren't going to comply with the
13 rulings the Court makes in these pre-trial motions in limine,
14 then what's the point of any of them being drafted and argued
15 before the Court?

16 So I really don't appreciate the fact that you are
17 rearguing issues the Court's already heard. The Court's taken
18 a lot of time. I never cut any of you off. I let you argue
19 to your heart's content on each one of these motions in limine
20 and then we made a record. And now, you're revisiting the
21 very issues the Court's already taken the time to hear and
22 rule on, so I wish you would move onto some new material, if
23 you have any.

24 MR. MICHALEK: Your Honor, look, I've been raised for 15
25 years in this jurisdiction and I've been taught by appellate

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1 counsel how to make a record. And I will say, I'm just trying
2 to do my job, which is preserve the appeal. Just because a
3 motion in limine has been filed does not mean the objection
4 should not be raised during trial. It does not mean that the
5 Court can't have an opportunity to change their mind.

6 And what I'm trying to do is twofold. One, preserve
7 the objection. Even though it was filed in a motion in
8 limine, the Supreme Court tells me to raise the issue again
9 during trial, to make the objection. And second, maybe my
10 argument is going to change your mind, in which case I don't
11 have that issue on appeal, I win that issue. And so that's
12 what I'm trying to do. I'm not trying to waste the Court's
13 time. If I bring something up, it's because I'm doing my job.

14 MR. WALL: Well, I don't think it's part of his job,
15 whether trained by appellate counsel or not, to misstate
16 what's in the record.

17 And I bet I can go back through this transcript,
18 just in the last 48 hours, probably, and find eight to ten
19 complete misstatements from Mr. Michalek about what's in the
20 record, absolute misstatements, including the one that he's
21 just -- the several that he has just made today, not even
22 taking into account the ones he made on jury selection after
23 not having been present during jury selection.

24 There are -- to my knowledge, there was not a single
25 question yesterday of Dr. Rosler about any personal

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1 relationships, that Mr. Rogers tried to make, that there was
2 -- that we objected to that wasn't allowed to go into. I
3 don't think there was a single question on that, and that
4 wasn't the subject of what was brought up in the motion in
5 limine. So --

6 THE COURT: Well --

7 MR. WALL: I probably shouldn't have even stood up, but I
8 got to just -- I got it -- if the point of this, from their
9 perspective, is to make a record to preserve it, you know
10 what? That's fine. But don't misstate what happened in this
11 courtroom.

12 THE COURT: Well, I agree, and here's the thing. When
13 Mr. Michalek says that Mr. Rogers was prevented from exploring
14 issues of bias with respect to witnesses that the Plaintiff
15 called, that is simply not true. That is not true.

16 MR. MICHALEK: I'll move on, Your Honor. If that's your
17 recollection of it, I will certainly accept the Court's
18 recollection of it. There was discussion today by Dr. McNulty
19 that he was more concerned with the patient, the Plaintiff,
20 being more concerned about his head symptoms, and that, that
21 overshadowed his neck symptoms. Now, we raised this issue and
22 this came up at the pre-trial motions in limine. And it's on
23 page seven.

24 Well, I'll start earlier, Your Honor. I'll start
25 back at page four. And this is discussion about Mr. Rogers

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1 and he's raising the issue to the Court. And he's talking
2 about it in the context of the motorcycle incident and
3 aggravation of migraines. And he says, it didn't have
4 anything to do with it and if the Plaintiff's doctors are
5 going to get on the stand and testify, that in some fashion,
6 this car accident aggravated migraines, well, the question is
7 how?

8 What kind of migraine is it? Where does it come
9 from? What's the generator? And if this accident could do
10 it, did the motorcycle accident do it? And if the motorcycle
11 accident did it, what's the difference between the two? We
12 need to, now, explore this masking claim that's been made.

13 Essentially, what Dr. McNulty said was, well, the
14 patient was more concerned about the head symptoms. This
15 overshadowed the next symptoms, so there's this masking going
16 on. And on page seven of the transcript, Your Honor said the
17 motion is granted, although if Plaintiff's expert witness
18 identified, and Mr. Rogers has indicated, then I think that's
19 probably fair game for purposes of cross-examination.

20 MR. WALL: That's not correct. We were talking --

21 MR. MICHALEK: It's right --

22 MR. WALL: We were talking about the motorcycle accident.
23 That was the motion regarding the motorcycle accident. Nobody
24 has said that the motorcycle accident caused a migraine or
25 even exacerbated a migraine. This is what I'm talking about,

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1 about misstating the record. That motion -- and I didn't even
2 look at the transcript, but I know what he's talking about.
3 And the motion was on the motorcycle accident. Dr. McNulty
4 never even mentioned it.

5 THE COURT: Well --

6 MR. MICHALEK: Well, Your Honor, the issue is --

7 THE COURT: And again, you know, it was Mr. Rogers who
8 was here arguing it. Maybe that's -- part of the problem is
9 that Mr. Michalek was not here arguing. Maybe that's why you
10 don't recall what happened.

11 MR. MICHALEK: Your Honor, I'm reading directly from the
12 transcript. The issue that Mr. Rogers is raising is this
13 masking claim, this issue that, well, the Plaintiff did not
14 make any complaints of neck pain because it was overshadowed
15 or more concerned about his head.

16 And that specifically was what Mr. Rogers was
17 raising on page four and specifically what the Court said
18 yeah, I think that that's probably fair game. And now, I'm
19 being told that that's inaccurate. Well, I'm reading directly
20 from the transcript.

21 THE COURT: You're reading it, but I don't think you
22 understand it.

23 MR. MICHALEK: Well, Your Honor, I can have Mr. Rogers
24 come up here and tell you what his understanding was of the
25 issue, and what we wanted to preserve and the claims we want

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1 to make. I will tell you that this doctor has testified as an
2 expert. He's vouched for the credibility of the Plaintiff.
3 He's made these arguments about masking, about how -- about
4 how the concern for the head pain is overshadowing the neck
5 symptoms.

6 And I think, as with the motion in limine, if you
7 were saying, well, you know, I'll consider it if someone's
8 made that claim, well, he's made that claim now. So I would
9 ask you take a look at that issue and say well, I think we're
10 allowed on cross-examination to explore that.

11 MR. WALL: This is so confused. Here's what happens. He
12 has a history of migraines. We accept it. We told them that.
13 And then he has this injury. We discussed at the motion in
14 limine that the fact -- you know what? He had migraines
15 before. That's coming in and we agreed. And that's fine.
16 And if they were exacerbated or any head pain is exacerbated
17 by this accident, they can explain that.

18 And if they want to bring in the fact, you know
19 what, he did have migraines before, absolutely, there's --
20 they're entitled. And that was the extent of the motion. So
21 I don't know -- I don't know where you get from the motorcycle
22 accident to masking because they're at polar opposites and
23 none of them were even -- were even relevant to the discussion
24 that we were actually having in the motion in limine.

25 MR. MICHALEK: Your Honor, I'll read from --

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1 MR. ROGERS: Your Honor, just a second.

2 MR. MICHALEK: I'll read from page three.

3 MR. ROGERS: Charles, just a second.

4 MR. MICHALEK: I'll read it.

5 MR. ROGERS: If I might, I remember in the opening, that
6 the Plaintiff took great offense at the fact that I included
7 the motorcycle accident in the record or on the display. And
8 the truth was, I didn't have the transcript at that time, but
9 that was -- my understanding was that if -- that the Court had
10 a qualified position on the motorcycle accident.

11 And that really was the reason that I put it on
12 there. There was no intent to sneak anything in. What Mr.
13 Michalek is saying right now was that maybe the confusion that
14 Dave's pointing at, that --

15 MR. WALL: I'm not confused.

16 THE COURT: I'm not confused.

17 MR. ROGERS: I'll --

18 MR. WALL: None of the court's confused.

19 MR. ROGERS: Your Honor --

20 MR. WALL: I believe Mr. Michalek's confused. And there
21 was --

22 MR. ROGERS: Your Honor, I was --

23 MR. WALL: There is no medical person who can, or has or
24 would ever say that the motorcycle accident has anything to do
25 with any claim we're making in the case.

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1 And so when the order says your motion to prevent
2 unrelated accidents, injuries, conditions is granted in its
3 entirety, one of those things was, specifically, the
4 motorcycle accident because there's no one to testify that it
5 has any relationship to any injury claimed. It is unrelated
6 and that was, in my mind, perfectly clear at the time of the
7 hearing. It is perfectly clear in the order.

8 THE COURT: That's precisely my recollection.

9 MR. MICHALEK: Your Honor, I don't know what in -- what's
10 in counsel's mind. On page three, it says -- this is Mr.
11 Rogers, factually, what's going on in the case is, there's a
12 2005 car accident and the Plaintiff claims that the accident
13 aggravated his pre-existing migraines, which in turn, masked a
14 new injury of cervical problems, for which he later had
15 surgery.

16 That's exactly what Dr. McNulty was saying, that
17 there were more concerns over -- about his head. It
18 overshadowed his neck symptoms. It's -- this is exactly the
19 issue that was raised on page three. I'm not reading this
20 transcript wrong. It's right there. Now, if that -- if the
21 Court's going to deny it, that's fine. I'm not making this
22 stuff up. It's right here in the transcript. I don't know
23 what counsel's recollection is.

24 I'm reading, directly, the words. And he's talking
25 specifically about an accident that aggravated his pre-

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1 existing migraines, which in turn, masked a new injury. So I
2 resent the implication here that I'm coming up here without
3 knowledge of something. I'm looking directly from the
4 transcript.

5 Every time I've appeared in front of this Court,
6 Your Honor, I've had a case citation to back up what I've
7 said. I'm looking at the transcript and reciting it. So I
8 resent these implications and the interruptions, you know,
9 during my argument. You want to deny my motion, that's fine,
10 but I'm reading directly from the transcript.

11 I'm just trying to make a record here and make it
12 clear from the words used, not from someone's recollection,
13 not from someone's understanding, the transcript. And this is
14 the exact issue Mr. Rogers was raising.

15 THE COURT: Defense counsel was never able to link the
16 motorcycle accident to any of the injuries that Plaintiff
17 sustained. You were never able to do so before and I haven't
18 heard you say anything today, that you can now do so.

19 MR. MICHALEK: I'm not trying to link the motorcycle
20 accident. I'm trying to link the issue of, well, is there a
21 -- is there a concern that this head pain is overshadowing
22 neck symptoms? Well, if there is, then why is this being
23 caused? How is this occurring?

24 MR. MICHALEK: Well, guess what? The head pain's caused
25 from this accident. There is some pre-existing migraines, but

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1 the head pain is caused from this accident and that which they
2 treated in April or May of 2005 may have masked some of the
3 neck pain at that time, but it's not -- it's not from a
4 motorcycle accident. It's from the accident in question.

5 MR. MICHALEK: Well --

6 THE COURT: Let's move onto the next issue. We've talked
7 about this one enough.

8 MR. MICHALEK: I have raised that. Fine, Your Honor.
9 The last issue is jury questions. I know that you're marking
10 some that have been given and some that have been not given.
11 I don't know if that occurred yesterday. I know you made a
12 note of exhibits, or I guess, questions that are going to be
13 read at some future point in time. Are those going to be
14 marked for some purpose or --

15 THE COURT: All of the juror's questions -- whether
16 they're read into the record and answered by a witness or
17 whether they're not read into the record, they're all marked
18 and included in the file.

19 MR. MICHALEK: Okay. So even if those -- will those just
20 be held until a witness comes to the stand, apparently, that
21 can answer those?

22 THE COURT: Well, as I told the jury, if it's a proper
23 one to be given, to be asked and inquired into, then I'll ask,
24 and inquire into it and if we have a witness who hasn't
25 already been excused by the Court. We received -- one of the

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1 questions we got today had to do with migraine auras and that
2 related to a witness that was excused yesterday afternoon, but
3 we didn't get the question in until today.

4 As soon as we began, I think, is when we got the
5 question. So I don't know whether we're even going to have a
6 witness who will be able to answer that question. If we do,
7 I'll ask the question of a witness. Counsel'll have to help
8 me keep track of that one. The other one -- I don't even know
9 if it's an appropriate question to ask, but in any event,
10 they're all being marked and included in the record.

11 MR. MICHALEK: So I just, for clarification, Your
12 Honor --

13 THE COURT: Which I told Mr. Rogers at a sidebar.

14 MR. ADAMS: Your Honor, I would just like to address one
15 issue real quickly. And that's basically reiterating my
16 argument that I made at the bench with regard to the spinal
17 cord stimulator as a treatment option for Mr. Simao. As I
18 pointed out at the bench, the Defense took several depositions
19 in this case, many of which were treating physicians. In
20 fact, they deposed Dr. McNulty earlier twice. Okay?

21 They deposed Dr. Seibel on August 20th, 2010. At
22 that time, they asked him several questions about his
23 treatment that he had provided and was providing. At the time
24 of his deposition, he was still treating, and even through
25 this day, by the way, is still treating Mr. Simao. One of the

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1 questions that counsel asked him is, do you have a future
2 treatment plan for the Plaintiff? And he responds at page 53,
3 line 20 through 22, I don't right now in front of me.

4 He's asked further questions of why he doesn't have
5 a future treatment plan right now. He keeps using that
6 phrase, right now. And he says, well, from a diagnostic
7 standpoint and based on the last time I saw him, I would
8 pursue, again, a selective nerve reblock at C4 level. In
9 other words, he needs to do a diagnostic block. In fact,
10 right above that, he says for diagnostic purposes, he needs to
11 do a diagnostic block before he can know what his next
12 treatment plan and future treatment plan is of Mr. Simao.

13 Later on through the deposition, he's asked more
14 refined questions with regard to his future treatment plan.
15 And basically, he's asked a question from an associate at my
16 office, who says okay, assuming that he has a positive outcome
17 from that pain management procedure, what would your treatment
18 options for or your treatment recommendations be for him?

19 And he answers, at page 68 of his deposition, lines
20 one through 17 through 25, again from my perspective -- I'm
21 not the spine surgeon -- but my job is to provide some
22 diagnostics, but also some therapeutic interventions, which
23 range from modalities we mentioned before.

24 Would it be medication management or repeat story
25 injection or considered re-referral back to a surgeon to see

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1 if he felt that he was another surgical -- or other surgical
2 interventions that could help alleviate, just based on those
3 diagnostic results?

4 Then he's asked, again, by my -- by my associate.
5 It says, okay, let's assume that it was negative. What would
6 be your next step? And he says, well, if the results were
7 negative, I'd probably continue to do myofascial treatments
8 for him, medication management. He may not have any further
9 intervention or surgical modalities.

10 Then he's asked, with regard to these modalities,
11 what does he mean by these modalities and he's asked a
12 specific question. At this point in time, is it foreseeable
13 to you that he would be recommended for, say, an implant of an
14 electronic stimulator or other type of pain relief modality
15 such as a morphine pump for -- the response from the doctor
16 was, I could see where some might consider that an option.

17 I don't consider it an option for an intrathecal
18 device right now, again, going back to right now because, he
19 goes on to say, he hasn't done that diagnostic test. Well,
20 guess what, Your Honor? In fact, he does do the diagnostic
21 test in November of 2010. That diagnostic test, as you heard
22 today from Dr. McNulty -- my client received 75 to 80 percent
23 relief. Okay?

24 Based on Dr. Seibel's deposition and his testimony,
25 the fact that he had a positive outcome from that diagnostic

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1 test means that -- now, that spinal cord stimulator is not now
2 just a viable option, but now, it's a recommendation. Why?
3 Because now, we have the diagnostic medical basis in which to
4 recommend it now.

5 The doctors do, not us. The doctors have a medical
6 basis now, based on the diagnostic results, to recommend a
7 spinal cord stimulator as future medical treatment for Mr.
8 Simao. So this whole thing, that they are surprised by this,
9 is simply not true. They learned about it first as a viable
10 option back in August. The procedure's done. The diagnostic
11 test is done in November.

12 They could have re-noticed his deposition. As we
13 heard here today, they noticed some doctors on two occasions.
14 They never made the nexus, Your Honor, from what they learned
15 about in the depo and then seen on the records. If they would
16 have, I'm sure they would have deposed one of the doctors
17 about that.

18 But that being a side, there were several questions
19 about a spinal cord stimulator, morphine pumps and other pain
20 management devices discussed in his deposition. Not one time
21 did Defense counsel ask what the costs of those are. Now, I
22 understand we got to give them their damages, but we don't
23 have to do their job, Your Honor.

24 I mean, he's -- Mr. Rogers is a seasoned attorney.
25 He could have asked that simple question and that would have

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1 been outlined for him. But he didn't. He didn't do that with
2 any of the treating physicians in this case.

3 MR. ROGERS: This one, I'll respond to.

4 THE COURT: Well --

5 MR. ROGERS: Counsel aren't meant to divine a nexus.
6 Counsel are meant to disclose under the rules. They clearly
7 knew this before they came today. They clearly met with Dr.
8 McNulty. They clearly took the time to bring in diagrams and
9 to come up a projection for future damages, never once
10 disclosing that this was an element of damages the Plaintiff
11 would request.

12 We filed the motion because we said, look, fair is
13 fair. We are telling you everything that we're bringing.
14 Tell us what you're bringing. The rules require you to. They
15 didn't. And that was the basis for the objection before you.
16 I understand you've ruled on it, but to pretend that Dr.
17 Seibel's testimony from four months ago constitutes notice
18 when he said, I don't know what's coming, is an absurd
19 proposition.

20 THE COURT: Your response, Mr. Adams?

21 MR. ADAMS: Yeah. You're right. Dr. Seibel's testimony,
22 the procedure that's been done in November, the follow-up that
23 was -- November 11th, the follow-up that was on November 23rd,
24 the referral back to the spine surgeon -- this time, Dr.
25 McNulty's partner, Dr. Lee [phonetic] on two occasions and the

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1 very last record, which was last month, says no surgical
2 options but pain management options.

3 As the doctor testified here today, this is a pain
4 management device. I mean, how many -- there's a litany there
5 now. There's, like, five pieces of either medical records or
6 depositions that they are aware of this.

7 MR. EGLET: And let me just add something, Your Honor.
8 Dr. McNulty is a treating physician. Under the rules in
9 Nevada, treating physicians are not required to do reports and
10 treating physicians are permitted, under Nevada law, to talk
11 about the prognosis, future treatment and ongoing treatment.
12 That's exactly what Dr. McNulty did.

13 And Your Honor, it is -- it is so hypocritical to me
14 that it is beyond comprehension for Mr. Rogers to get up and
15 try to claim ambush and unfair -- when his experts in this
16 case -- I, quite frankly, in 24 years of practice, have never
17 seen any anything quite like this. I've never seen a moving
18 target quite like Dr. Fish [phonetic].

19 You're going to hear from him tomorrow. You're
20 going to see what a moving target defense where this guy is,
21 who will lie on the stand and under oath about anything. And
22 you're going to see that, I promise you, tomorrow. But let me
23 give you an example of Dr. Fish. Dr. Fish does a report in
24 this case.

25 MR. ROGERS: Is this relevant to the issue?

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1 MR. EGLET: Yes. It is.
2 MR. ROGERS: Is this relevant?
3 MR. EGLET: Sit down, counsel.
4 THE COURT: Well --
5 MR. ADAMS: All right.
6 MR. EGLET: You've had your say. I'm going to --
7 MR. ROGERS: Stop.
8 MR. EGLET: -- have my say.
9 MR. ROGERS: Stop. Back off.
10 THE COURT: I think -- I think -- yeah. I think it's
11 fair. I think it's fair.
12 MR. MICHALEK: Your Honor, that's fine and I apologize.
13 I should haven't interrupted.
14 MR. ROGERS: It's not --
15 MR. MICHALEK: I've been interrupted from several --
16 MR. ADAMS: No, no. Let him finish. I want to hear
17 this.
18 MR. MICHALEK: Well, I just need to say this on the
19 record. I've had -- been interrupted several times by
20 Plaintiff's counsel, you know, when I'm trying to make my
21 argument. I don't need counsel to say something. If the
22 Court wants to tell me to sit down, certainly, I will. I am
23 shocked at the lack of respect that is being shown from
24 Plaintiff's counsel in this courtroom.
25 I have never seen it where counsel is going to

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1 threaten someone physically with violence, directing things to
2 take things outside, to yell at other counsel to sit down,
3 shut up. These are things that professional attorneys do not
4 do and I am shocked at the lack of respect that's being shown.

5 And I would ask the Court, on both sides, to direct
6 both counsel, that from now on, proceedings in this courtroom
7 should be directed, and arguments directed, to you. Counsel
8 should not be making arguments to each other, or yelling at
9 each other --

10 THE COURT: That's true.

11 MR. MICHALEK: -- or screaming at each other --

12 THE COURT: That's true.

13 MR. MICHALEK: -- or threatening them in any manner.

14 THE COURT: That's true. Consider yourselves all
15 admonished. Mr. Eglet, please proceed.

16 MR. EGLET: I find it incredible that Mr. Michalek would
17 come up with -- had the audacity to make that remark after
18 some of the things he's said over the last two days and
19 particularly, the extremely cheap shot that he took at Judge
20 Walsh a few moments ago.

21 So you know, he ought to listen to what he has said
22 in this courtroom and have a little introspection when he
23 starts throwing stones at other people. But it is incredible
24 to me that they have an expert, Dr. Fish, who has -- from his
25 first report, changes his opinions in a supplemental report,

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1 changes his opinions again. And I'm not talking modify or
2 supplementing his opinions. Changes his opinions again.

3 Changes his opinions again in supplemental reports.
4 And then, when Mr. Wall, on the day he deposes him, he
5 completely changes all his opinions from all of his reports
6 with no notice to us whatsoever. Now, this is a Defense
7 expert who is required under our rules to do written reports,
8 unlike the treating physicians in this case.

9 So it is so incredibly hypocritical to make that
10 remark when -- and act like, oh, this is unfair, you know,
11 their treating physicians are coming up with these statements
12 that there -- that are -- they were on notice of, as pointed
13 out by Mr. Adams. And it's completely and totally different
14 from what their experts have done in this case. And I can
15 guarantee you to this Court that Dr. Fish is going to come in
16 here tomorrow with completely new opinions that have never
17 been disclosed, Your Honor.

18 THE COURT: Well, I think the record's pretty clear.
19 Mr. Adams made a pretty good record regarding the issue of
20 notice. I think, clearly, there's no surprise here.

21 Anything else you need to address?

22 MR. ADAMS: One last thing, Your Honor. I mean, if
23 Mr. Michalek wants to come to the bench, I welcome him there,
24 but the crazy thing for him to bring this up today is just --
25 I just can't believe it because yesterday, one of my partners

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1 says you know, it looks like you're overpowering the Defense
2 when you three are up there.

3 And so you know what? Today, I made a conscious
4 effort to keep my butt in the chair, except for one time when
5 Mr. Eglet asked me to come up. And that was the argument that
6 I made, because I was well-versed with this issue. Okay?
7 Other than that, I've made a conscious decision to abide by my
8 partner, Tracy Eglet's, recommendation to stay there or just
9 two of us go up there.

10 But you know what? If Mr. Michalek wants to come
11 up, that's fine. I don't know what he's referencing that
12 there's only two trial counsel. If he was here the first day,
13 I believe all three of us made an appearance on the record and
14 he didn't look at that transcript. On the record before the
15 jury panel, there -- the three of us were here.

16 THE COURT: Ms. Eglet was here, too, on the first day.

17 MR. ADAMS: That's true.

18 MR. MICHALEK: Your Honor, I don't think the point should
19 be a cavalcade of --

20 MR. ROGERS: No, no. I'm tired. Let's just leave. I'm
21 done with this.

22 MR. MICHALEK: -- people coming up to the bench. I think
23 that, that doesn't help the process to have five people
24 huddled around there, arguing. My point was simply that if
25 you're going to allow the Defense counsel -- or Plaintiff's

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1 counsel two or three people to come up there and make
2 arguments, then I was simply asking for the same leeway.

3 I don't think it's appropriate to have every
4 counsel, every time, run up to the bench and make arguments.
5 It labors the process in front of the jury. You know, it --
6 the more people that are up there, the more likely it is the
7 jury's going to overhear something. You know, typically, the
8 objections are heard when the jury's excused.

9 That's simply what I was doing, making my record
10 now. You know, I don't want to run up there, and with
11 everybody else and have six or seven people, you know. We
12 just call people and have everybody stand there. And that's
13 not going to look good in front of the jury and it's not going
14 to help the process.

15 THE COURT: Well, it's up to you if you want to approach
16 the bench or not. When I ask counsel to approach the bench,
17 it usually isn't you, you and you, it's counsel, approach the
18 bench. So whoever wants to come up here and have a
19 conversation, feel free.

20 MR. EGLET: Thank you, Your Honor.

21 THE COURT: See you tomorrow.

22 [Proceedings Concluded at 5:01 p.m.]
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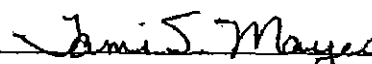
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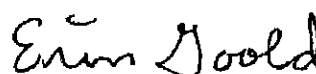
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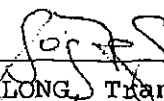
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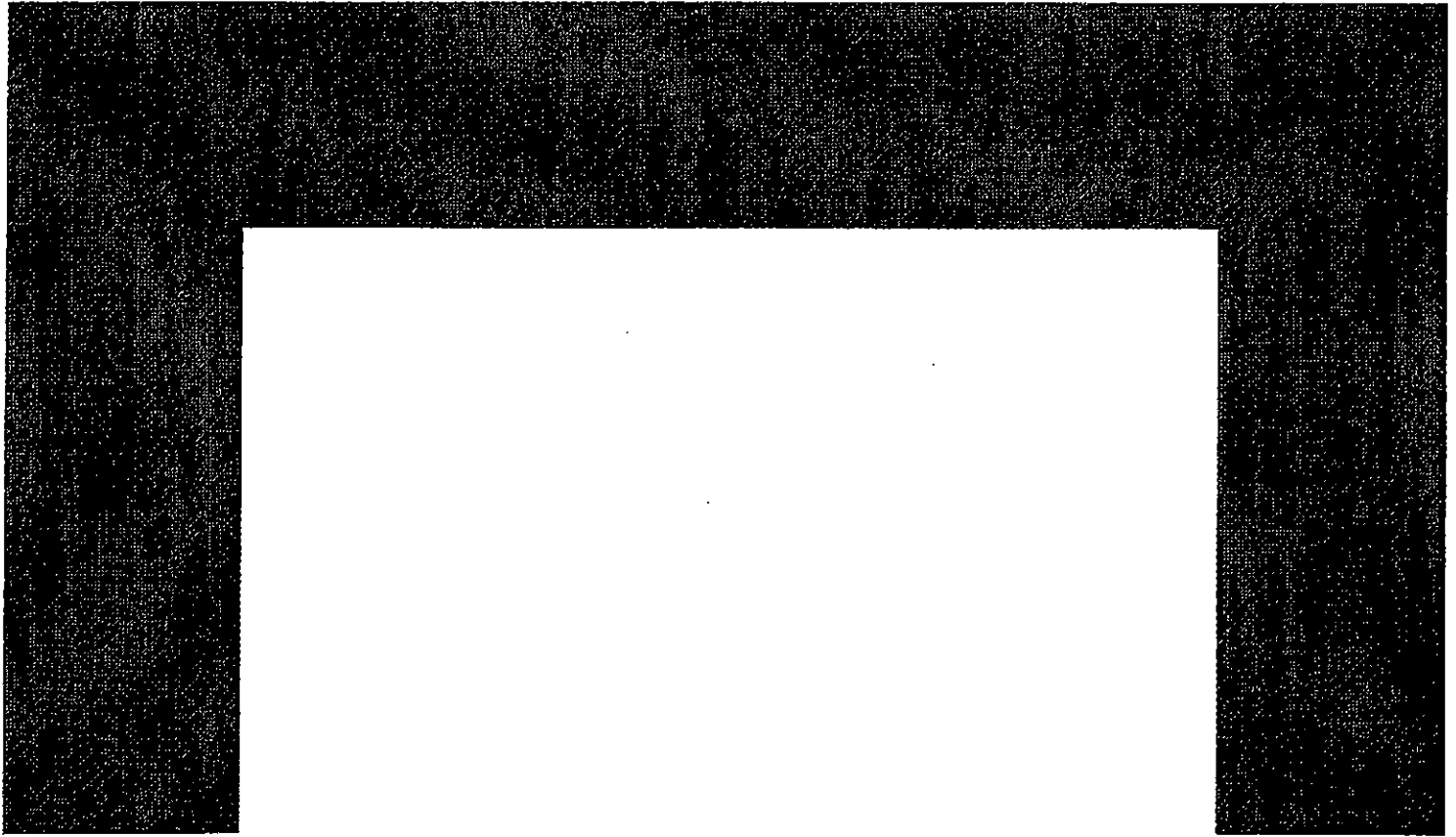
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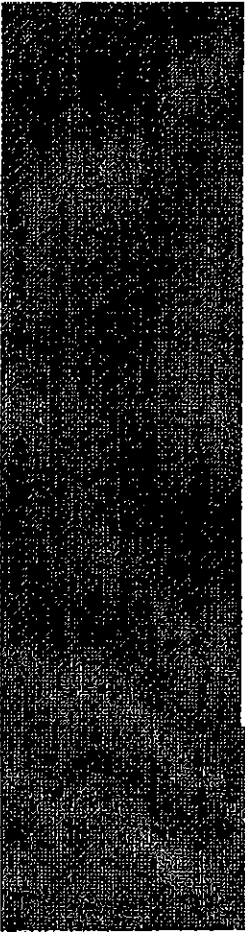
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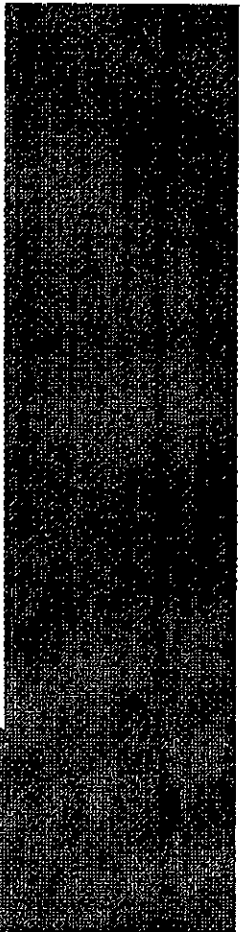
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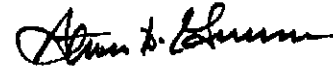
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DISTRICT COURT



CLARK COUNTY, NEVADA

CLERK OF THE COURT

CHERYL A. SIMAO and
WILLIAM J. SIMAO,

Plaintiffs,

CASE NO. A-539455

v.

DEPT. X

JAMES RISH, LINDA RISH
and JENNY RISH,

Defendants.

BEFORE THE HONORABLE JESSIE WALSH, DISTRICT COURT JUDGE

THURSDAY, MARCH 24, 2011

REPORTER'S TRANSCRIPT
TRIAL TO THE JURY
DAY 4 - VOLUME 1

APPEARANCES:

For the Plaintiffs: DAVID T. WALL, ESQ.
ROBERT M. ADAMS, ESQ.
ROBERT T. EGLET, ESQ.
Mainor EgletFor the Defendants BRYAN W. LEWIS, ESQ.
James and Linda Rish: Lewis and Associates, LLCFor the Defendant STEVEN M. ROGERS, ESQ.
Jenny Rish: CHARLES A. MICHALEK, ESQ.
Hutchison & Steffen, LLC

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TABLE OF CONTENTSPageMarch 24, 2011Trial to the JuryPlaintiffs' Witness(es):

None

Defendants' Witness(es):

David Eli Fish, M.D..... 12

David Eli Fish, M.D..... 32

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1 THURSDAY, MARCH 24, 2011 AT 1:00 P.M.

2 [Outside the Presence of the Jury]

3 THE MARSHAL: Department X is now in session, the
4 Honorable Jessie Walsh, Judge, presiding.

5 THE COURT: Thank you. Good afternoon.

6 Okay, we ready to rumble?

7 Here's the thing. I don't want to hear any personal
8 remarks directed at counsel by other counsel. It's not
9 appropriate. I think it diminishes all of us.

10 I don't want to hear counsel say to other counsel,
11 "Sit down and shut up."

12 And frankly, I have never, ever prevented counsel
13 from making a record. I would hope that counsel would be able
14 to make a record in an organized fashion, without re-arguing
15 issues that have already been addressed.

16 So, what I propose is that instead of trying to do
17 this at the end of the day, we address these issues at the
18 beginning of the day. That won't work tomorrow, however,
19 because we start at noon. So next week, if you have issues
20 that we need to make a record of, we will do so at the
21 beginning, which means you'll have to be present at 11:30 and
22 we'll take 20 minutes; whatever you want to put on the record,
23 we'll put it on the record. And we'll take a ten-minute break
24 before we bring the Jury in.

25 Is that agreeable?

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1 MR. WALL: 11:30?

2 MR. EGLET: 11:30 or 12:30, Your Honor?

3 THE COURT: 12:30. Did I say 11:30?

4 MR. EGLET: You did, Your Honor.

5 THE COURT: 12:30 to 12:50 we'll make a record. At 1:00
6 we'll resume our jury trial. We cannot do that tomorrow,
7 however, because we're starting at noon.

8 Are we still starting at noon tomorrow?

9 MR. EGLET: Yes.

10 MR. ROGERS: Yes, Your Honor.

11 THE COURT: All right. Is that agreeable with everyone's
12 schedule?

13 MR. WALL: Yes, Your Honor.

14 MR. EGLET: Yes, Your Honor.

15 MR. ROGERS: It is, Your Honor.

16 THE COURT: Okay. Very good.

17 Any issues we need to address?

18 MR. EGLET: Yes, Your Honor.

19 We have a motion to make, Your Honor. The -- as the
20 Court knows, Mr. Rogers is going to be calling one of his
21 witnesses out of order; specifically who he is calling out of
22 order Dr. Fish, who apparently this is the only day he's
23 available to testify.

24 Dr. Fish is a pain management doctor, and so our
25 motion addresses some of the opinions that he has attempted to

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1 offer in this case, particularly statements from his
2 deposition.

3 Dr. Fish is not qualified to offer opinions
4 regarding Mr. Simao's cervical spine surgeries. As the --
5 I hear an echo -- maybe I'm just hearing voices again.

6 As the Court knows, under Hallmark, two of the
7 requirements is the expert must be qualified in an area of
8 scientific, technical, or other specialized knowledge, and
9 that the expert's testimony must be limited to matters within
10 the scope of his specialized knowledge.

11 Dr. Fish does not have expertise with regard to
12 spine surgery and any opinion attempted to be offered by him
13 must be excluded as being beyond the scope of his area of
14 expertise. And Dr. -- our motion is that Dr. Fish is
15 prohibited from testifying regarding Mr. Simao's need for
16 spine surgery. He's not a spine surgeon. He's never done
17 spine surgery. In fact, he will get referrals from spine
18 surgeons to do pain management diagnostic things, and then it
19 is the spine surgeon along with the patient who makes the
20 decision as to whether surgery is an appropriate treatment
21 option for that patient.

22 Dr. Fish specifically opined in his deposition that
23 Mr. Simao has never been a surgical candidate and that the
24 cervical fusion Mr. Simao underwent was unnecessary and
25 unreasonable. And Dr. Fish should be precluded from offering

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1 any opinions at trial regarding Mr. Simao's need for surgery.

2 Our Nevada Supreme Court has stated that and
3 requires that expert testimony be limited to matters within
4 the scope of the expert's area of expertise. And as the Court
5 knows, under Morsicato, physicians must state, to a reasonable
6 degree of medical probability, that the condition in question,
7 i.e., the need for spine surgery, was or was not caused by the
8 incident.

9 Here, Mr. -- Dr. Fish, a physiatrist and pain
10 management specialist, is not a spine surgeon, has never
11 performed cervical spine fusion or any spine fusion, for that
12 matter, and actually refers his patients out to spine surgeons
13 to make that assessment. He's unable to state to a reasonable
14 degree of medical probability whether Mr. Simao required
15 cervical spine surgery. That's not part of his expertise.
16 Those decisions were made by his spine surgeons. And
17 therefore, he's not qualified to render an opinion on that
18 area.

19 And you know, the Defense is not in any way
20 prejudiced by this because they have, in fact, another expert,
21 Dr. Jeffry Wang, who is an orthopedic spine surgeon, who will
22 be testifying next week, and whom we know, no doubt, will be
23 offering opinions regarding whether he believes that Mr.
24 William -- Mr. Simao was a appropriate candidate for the
25 cervical spine fusions that Dr. McNulty did. But this is not

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1 within the expertise of Dr. Fish. It's outside of the realm
2 of his expertise. It would be improper to allow him to state
3 such testimony.

4 THE COURT: Mr. Rogers?

5 MR. ROGERS: The extent of it, yes.

6 Well, Dr. Fish is qualified because he testified at
7 his deposition that -- when asked that question,

8 "I'm qualified to give that opinion because I
9 see a lot of patients that come through my door
10 who've either had surgery, will have surgery, need
11 surgery, want surgery, don't want it, or are
12 candidates for surgery, and I make that decision
13 every day."

14 Dr. Fish further testified that he has participated
15 in many surgeries, including the spinal cord stimulator that
16 Dr. McNulty testified about yesterday. The fact that he is in
17 the O.R. and part of this process and part of the decision-
18 making process, working along with surgeons every day, makes
19 him more than qualified.

20 If you like, we can make the foundation when he's on
21 the stand and approach this then. But at a minimum he should
22 be permitted to discuss his qualifications before a decision
23 is made.

24 THE COURT: I thought Dr. Fish was a psychiatrist.

25 MR. ROGERS: Oh, no. No, he's --

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1 MR. EGLET: A physiatrist.

2 MR. ROGERS: -- a physiatry specialist.

3 MR. EGLET: Pain management specialist.

4 MR. ROGERS: Yeah. Physiatry, which is a pain management
5 also. And he does surgical procedures all the time,
6 including, as I said, the installment of spinal cord
7 stimulators.

8 THE COURT: Does he perform spine surgeries?

9 MR. ROGERS: That's a question I'd like to ask him on the
10 stand. If I remember his testimony right, he said that he is
11 involved in the performance of some spine surgeries. The
12 extent of the involvement I don't recall off the top of my
13 head.

14 MR. EGLET: He is not involved at all. And I've read ten
15 depositions on this gentleman now, all of them where he has
16 stated, yes, he is involved -- we're not talking about spinal
17 cord stimulators here. That's a different issue. He may be
18 involved with the -- with spinal cord stimulators, but in all
19 -- every deposition, he has admitted that he is not a spine
20 surgeon, he's not board-certified or fellowship-trained in
21 spine surgery. He's never done a spine surgery. He's never
22 assisted in spine surgery. He's never been in the operating
23 room when a spine surgery has occurred.

24 He's not qualified to talk about spine surgery or
25 the need for spine surgery. He refers his patients to a spine

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1 surgeon; specifically, Dr. Wang, who makes those decisions.
2 And just because Dr. Fish makes this self-serving statement in
3 his own deposition that he believes he's qualified to give
4 this testimony or this opinion, that doesn't make him
5 qualified or -- or to make the -- to give the testimony.

6 It's based on what the Supreme Court set forth in
7 Hallmark. He is not qualified in this particular area. He's
8 not a spine surgeon. He shouldn't be allowed to get up on the
9 stand, someone who's never once done spine surgery, been
10 trained in spine surgery, and we're going to allow him to get
11 up and criticize a fellowship-trained, board-certified spine
12 surgeon on whether somebody's an appropriate candidate for
13 spine surgery?

14 I'm not saying he can't talk about pain management.
15 That's a different issue. But when it comes to spine injury,
16 he's not qualified. Plus, it's cumulative. They've got an
17 expert on this. They have a spine surgeon who's testifying
18 next week.

19 MR. ROGERS: Well, they -- if I can respond, Your Honor.

20 THE COURT: Sure.

21 MR. ROGERS: They have another spine surgeon they're
22 bringing in addition to Dr. McNulty for that. So I'm not sure
23 that there are grounds to complain about cumulative.

24 MR. EGLET: He's a treating physician. Totally
25 different.

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1 MR. ROGERS: It'd still be cumulative, whether it's
2 expert or treating. If it's been said before, that's
3 cumulative.

4 Now, if -- at a minimum what we have now is a
5 question of fact for the Court to consider. If Plaintiff's
6 counsel wants to voir dire the witness right now on his
7 qualifications to offer expert opinion testimony regarding the
8 necessity of surgery, then let's bring him in and have that
9 question answered before the Jury comes. And then that way
10 we'll know there won't be error.

11 MR. EGLET: Well, we don't need to voir dire him on this
12 particular issue. I'm -- that's another issue that I want to
13 talk to the Court about, voir diring this witness, but there's
14 no reason to voir dire him on this issue. We know what his
15 education is, we know what his training is, we know that he's
16 not a spine surgeon, we know he's never done any spine
17 surgeries before.

18 We know that he -- that Dr. Wang, primarily, who he
19 works with at UCLA, is a spine surgeon that he works with --
20 probably other spine surgeons as well -- but makes those
21 ultimate decisions with the patients, not Dr. Fish.

22 MR. ROGERS: I'm not sure who "we" are. The question is,
23 is the Court satisfied that there's a lack of foundation, and
24 Dr. Fish's testimony on this question would answer that.

25 THE COURT: The motion is granted.

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1 MR. EGLET: Your Honor, the second issue is we would like
2 to voir dire Dr. Fish outside the presence of the Jury.

3 As the Court knows, there is a significant number of
4 motions in limine, pretrial motions that were granted by the
5 Court, precluding the discussion they're bringing in about a
6 great many issues. Virtually every single one of these
7 issues, Dr. Fish talked about extensively, that the Court has
8 precluded in his deposition.

9 And we want to confirm, in front of the Court, in
10 the presence of the Judge, that this witness understands the
11 pretrial court's rulings and will not violate those rulings,
12 because we've already had that occur in the opening statement.
13 I don't want to see a witness get on the stand and all of a
14 sudden we have more of these violations, more of these things
15 come out, and we can't unring the bell.

16 It would take a very short period of time for us to
17 run through that.

18 THE COURT: Is Dr. Fish here?

19 MR. ROGERS: He is. Shall I -- I don't know where -- he
20 was in the courtroom, and someone asked that he be removed.
21 I'm not sure where he is right now.

22 MR. MICHALEK: I think they asked that he step outside
23 until we were finished, Your Honor.

24 THE COURT: Let's bring Dr. Fish in.

25 [Pause]

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1 THE COURT: Please come forward to the witness box, sir.
2 You want to stand and raise your right hand.

3 DR. DAVID ELI FISH, DEFENDANT'S WITNESS, SWORN

4 THE CLERK: I do. Thank you. Please be seated. State
5 and spell your name for the record.

6 THE WITNESS: David Eli Fish, D-a-v-i-d E-l-i F-i-s-h.

7 THE COURT: Whenever you're ready, Mr. Eglet.

8 MR. EGLET: Thank you.

9 VOIR DIRE EXAMINATION

10 BY MR. EGLET:

11 Q Good afternoon, Dr. Fish.

12 A Good afternoon, sir.

13 Q My name's Robert Eglet. I don't think we've met
14 before.

15 Dr. Fish, I want to go through with you, to make
16 sure it's clear in your mind on the record, what the Court's
17 rulings on this case are, pretrial, and so you understand what
18 you are permitted and not permitted during your testimony to
19 discuss with this Jury, okay?

20 A Okay.

21 Q All right. The Court has ruled that Mr. Simao
22 pulling a muscle in his low back 23 to 24 years ago while
23 moving a keg of beer at California Beverage Company is
24 excluded. You may not discuss that, comment upon it, infer
25 it, or imply that it occurred to the Jury. Do you understand

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1 that?

2 A Yes.

3 Q The Court has also ruled that a motor vehicle
4 accident that Mr. Simao was involved in 25 years ago, wherein
5 he was pulling a boat with his pickup truck, and another
6 vehicle hit his boat and knocked it off the trailer, that's
7 excluded. You can't comment about that, make any reference to
8 it. Do you understand that?

9 A Yes.

10 Q Okay. The Court has ruled that any prior or
11 subsequent injuries, prior injuries or subsequent injuries to
12 this motor vehicle accident that we're here about, and
13 accidents including, but not limited -- including, but not
14 limited -- to the motorcycle accident in 2003 and the
15 motorcycle acc -- and the motor vehicle accident in May 2008,
16 are excluded. Do you understand that?

17 A No, I don't.

18 Q Okay. Well, you cannot comment upon that, you
19 cannot -- you're not to refer to that, you cannot state if
20 anything you say is based upon that. You cannot inform the
21 Jury about that. Do you understand that?

22 A You mean the accident that we're talking about?

23 Q No, no, no. These other accidents.

24 A Oh. 2008 --

25 Q The motorcycle accident.

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1 A The motorcycle accident was in 2005?

2 Q There's a couple of motorcycle accidents, I believe,

3 Is that -- yes. You cannot --

4 MR. WALL: There's just -- I think there's some confusion

5 on this.

6 MR. EGLET: There's just one. Excuse me.

7 THE WITNESS: Just one, yeah.

8 BY MR. EGLET:

9 Q You cannot talk about that. You cannot inform the

10 Jury about that. You cannot state anything about that. You

11 cannot refer to that; imply that it occurred; reference it.

12 A Okay.

13 Q Do you understand that?

14 A I got the motorcycle one. What was the other

15 one?

16 Q Accident in May of 2008.

17 A Oh.

18 Q You understand?

19 A No. I don't.

20 Q Well, I'm telling you that's the Court orders. Do

21 you understand that's a Court order?

22 A I understand the order.

23 Q Okay. Are you going to comply with that order?

24 A I will comply as best I can. I mean --

25 Q Well, are you going to mention that accident to this

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1 Jury?

2 A It depends on the question, I guess.

3 Q Well, if you mention that accident to this Jury
4 you'll be in violation of a Court order. Do you understand
5 that?

6 A Now I do.

7 Q Do you understand there are ramifications for that?

8 A No, I don't.

9 MR. EGLET: Want to explain it to him, Your Honor?

10 THE COURT: Well, the Court would have a number of
11 opportunities, I suppose, to sanction you. I guess the Court
12 would possibly entertain a motion to strike you altogether as
13 a witness and to advise the Jury to disregard any of your
14 testimony.

15 I imagine there'd be a number of sanctions that might
16 come to mind.

17 THE WITNESS: Okay.

18 BY MR. EGLET:

19 Q I'll ask you again. Are you going to mention that
20 2008 accident?

21 A No.

22 Q In front of this Jury?

23 A I hope not.

24 Q I hope not, too.

25 A Yeah.

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1 Q Okay. The Court has also ruled that any unrelated
2 medical conditions, with the exception of a mouth tumor,
3 cannot be mentioned or referred to or the Jury cannot be
4 informed of. These unrelated medical conditions include, but
5 are not limited to, high blood pressure, allergies, colds,
6 flu, and high cholesterol.

7 Do you understand that?

8 A I can't refer to them?

9 Q You cannot refer to that. Do you understand that?

10 A Okay. I understand that.

11 Q You cannot -- the Court has ruled that you cannot
12 infer or imply that there's been any improper use of
13 prescription medications. Do you understand that?

14 A Yes.

15 Q Okay. You cannot testify, infer, imply, insinuate,
16 or in any way suggest that Mr. Simao is a symptom magnifier, a
17 malingerer, manifesting any secondary gain motives, or
18 anything in that area. Do you understand that?

19 A No.

20 Q Well, you can't. That's the ruling of the Court.
21 Do you understand that?

22 A No. I don't understand that.

23 Q Well, that's the order of the Court, sir.

24 A Huh.

25 Q Are you going to comply with that order?

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1 A Yeah, I'll comply, but I don't understand it.

2 Q You're not a lawyer, are you?

3 A No, I'm not.

4 Q Okay.

5 A I'm glad you pointed that out.

6 Q Thank you.

7 So. You are going to comply with that, right?
8 You're not going to suggest any secondary gain, that he's a
9 symptom magnifier, a malingerer, or anything in that area,
10 correct?

11 A I guess not.

12 Q Thank you.

13 The Court has ordered that you can -- that you, nor
14 anyone else, can suggest that this case is a medical build-up
15 case, or attorney or medical-driven. Do you understand that?

16 A Yeah, I understand that.

17 Q You under -- you're going to comply with that?

18 A Absolutely.

19 Q Okay. You cannot mention any collateral source
20 payment. You cannot mention whether there was insurance
21 payments, whether this is covered under insurance, whether
22 this is covered under Medicare or Medicaid, and you cannot
23 mention whether anybody has any liens on this case, including
24 medical liens. Do you understand that?

25 A Yes, I understand that.

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1 Q You're going to comply with that?

2 A Yes.

3 Q Okay. You cannot mention, at this time, any sub
4 rosa vehicle -- video, any video of our client that may have
5 been taken and shown to you. You cannot talk about that, you
6 cannot mention it, you cannot refer to it in front of this
7 Jury. Do you understand that?

8 A Not really, but I'll comply if that's what you want.

9 Q Well, it's what I want; it's what the Court's order
10 is, sir.

11 A Okay.

12 Q You understand?

13 A I understand.

14 Q Okay. You cannot talk about --

15 A But can I -- can I clarify that?

16 Q Yes. Sure. You have a question?

17 A So there was a video taken of him.

18 Q Yeah, you --

19 A I can't say that I looked at any --

20 Q You cannot.

21 A -- of the actions within that video?

22 Q You cannot.

23 A Or motions within that video?

24 Q You cannot. Do you understand that?

25 A (Nodding) Yeah, I understand that.

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1 Q Okay.

2 MR. ROGERS: Your Honor, I'm not sure that that actually
3 accurately states the order.

4 MR. EGLET: That absolutely accurately states the order.

5 THE COURT: Well, the video may not come in at all. If
6 it comes in, it may come in for impeachment purposes, but we
7 don't even know whether -- we don't know what the Plaintiff is
8 going to testify to, so we don't know whether anything that
9 was contained on that video will serve to impeach him.

10 That was my recollection of the Court's ruling.

11 MR. ROGERS: That's mine, as well. But there's a nuance
12 here that I think the doctor is suggesting, that isn't being
13 answered by these questions, and that is, if the doctor is
14 asked how the -- what were the Plaintiff's physical abilities,
15 for example, at the time of the independent medical
16 examination, which was close in time to the surveillance, that
17 he would be able to say, well, I examined him and he was able
18 to do X, Y, and Z.

19 He could also say, also, I'm aware that he could do,
20 for example, lift machinery. Something that was shown in the
21 surveillance, but without even using it as an impeachment
22 tool, he's simply saying, I'm aware that he's capable of doing
23 this.

24 MR. EGLET: Your Honor, that is absolutely not true.
25 Lord knows that the order of the Court is that this video is

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1 completely and totally excluded until the Court hears the
2 testimony of the Plaintiff and, after it reviews the video,
3 determines whether there's anything the Plaintiff testifies to
4 that is inconsistent with what's in the video, and whether
5 it's proper impeachment or not. That's the Court's order.

6 Here's the order, right here.

7 MR. WALL: At the bottom.

8 MR. EGLET: It is further ordered the Plaintiffs request
9 to exclude sub rosa video is deferred until after Plaintiff's
10 direct testimony, so the Defendant can establish how it
11 impeaches the Plaintiff. Defendant is precluded from showing
12 the sub rosa video or referring to it until that time.

13 The order is clear.

14 THE COURT: That is true.

15 MR. ROGERS: I don't think I'm being clear on this one.
16 Because it's something aside from the reference to the video.

17 What it is, is knowledge that the doctor has without
18 even disclosing the source of it. He can say --

19 THE COURT: You know what troubles me, Mr. Rogers. What
20 really troubles me, listening to you. It seems like you're
21 trying to get around the Court's previous ruling. The ruling
22 is really clear. It's right there in black and white, as
23 Mr. Michalek is so fond of saying. It's as plain as it can be.

24 And what I would hope is that there aren't any
25 questions asked this witness or any answers given by this

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1 witness that would violate a Court order.

2 MR. ROGERS: All right.

3 MR. MICHALEK: Your Honor, the only thing I would ask is
4 that maybe at the end of the day, after we've excused the
5 Jury, just -- we won't be able to recall this witness. You
6 know, he'll be out of town performing surgery in UCLA, but we
7 just ask the questions off the record.

8 That way, at least if the video does come in and
9 there's a later Court ruling on it, we could at least have the
10 transcript and we could read those questions to the Jury,
11 should the Court allow them to be read in a -- you know, at a
12 subsequent time. Certainly, that's not going to happen --

13 THE COURT: What questions, Mr. Michalek?

14 MR. MICHALEK: Well, questions about what the doctor did
15 see on the video. I don't know whether those will be
16 relevant. I don't know whether the Court's going to allow
17 them in.

18 But we could simply do that outside the presence of
19 the Jury, after the testimony. Take up maybe five minutes,
20 and if the Court does rule later on that the video is
21 admissible, we could discuss then whether the doctor's
22 testimony would be admissible at that point, and that can
23 simply be read to the Jury, rather than flying him back out
24 from California to answer those five questions .

25 MR. EGLET: Your Honor, we have relied on this Court's

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1 rulings. They're the ones who have put this witness on, on
2 this day.

3 We're not prepared to cross-examine him on this
4 area. We shouldn't have to be prepared to cross-examine him
5 on this area.

6 THE COURT: Well, let me say this. It's already 1:30.
7 We haven't even let our Jury in yet. Is this the only witness
8 we're going to be with today?

9 MR. EGLET: Yes, Your Honor.

10 MR. ROGERS: Yes.

11 THE COURT: We don't have the ability to go past 5:00
12 because the Court has been instructed by the County not to
13 incur any overtime costs for staff, given the economic crisis
14 that the country and this state is in. So I doubt very
15 seriously whether we'll have time to even address that
16 question..

17 Anything else?

18 MR. EGLET: Yes. Moving on, Your Honor.

19 BY MR. EGLET:

20 Q Doctor, the Court has ruled that any photographs of
21 the vehicles involved in this accident or any repair estimates
22 are excluded. I know you were provided photographs and repair
23 estimates. You are not permitted to refer to them, talk about
24 them, or rely upon them. Do you understand that?

25 A Which specific parts again? The photos?

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1 Q Photographs of the vehicles involved in this
2 accident.

3 A Uh-huh.

4 Q And repair estimates of the vehicles involved in
5 this accident.

6 A What about the accident itself?

7 Q Yeah, we're going to get to that. You don't get to
8 talk about the accident either. You don't get to talk about -
9 - you've already been excluded to giving testimony as to
10 whether this accident was severe enough or not to cause an
11 injury. You cannot testify about that.

12 Do you understand?

13 A No.

14 Q Well, are you -- let me ask it this way. Are you
15 going to comply with those Court rulings?

16 A Absolutely, but I don't understand them.

17 Q Well, I'm not asking you whether you understand the
18 basis of the rulings. I'm just understanding -- asking you if
19 you understand that that is the ruling?

20 A I mean, I was brought in here to understand the
21 medicine, and that's a component of what I'm understanding --

22 Q Are you going to comply with the Court's ruling?

23 A I am obviously going to comply with it, but I don't
24 understand it. I mean --

25 Q You are not going to --

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1 A -- I'm doing the best I can to --
2 Q Well --
3 A This was an accident, was it not?
4 Q It was a car accident.
5 A We can't talk about the accident?
6 Q You don't get to talk about this.
7 A That seems kind of strange to me.
8 Q Well --
9 A I don't understand.
10 Q We're not going to re-argue the motions in limine.
11 THE COURT: No, we're not.
12 MR. EGLET: This is the Court order --
13 THE WITNESS: I'm not arguing it. I'm just saying I
14 don't want to -- I don't want to be in contempt of court. I
15 don't want to get in trouble.
16 I'm just saying that it seems strange that we're
17 talking about an accident and I can't even talk about the
18 accident. That just seems strange to me, that's --
19 THE COURT: You know what seems strange to me? That this
20 witness obviously doesn't have any idea what the Court has
21 ruled prior to these motions in limine.
22 Were you about to say something, Mr. Wall?
23 MR. WALL: Actually I was writing a note to Mr. Eglet, to
24 hand it to him.
25 Obviously, no one told him of the rulings.

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1 THE COURT: Yeah. That really concerns me. I hope
2 that's not the case with the other witnesses Defense intends
3 to call.

4 MR. ROGERS: If I could just clarify this question that
5 Mr. Eglet just asked, because it was compound. It started out
6 with photographs and property damage estimates, and that is, I
7 believe, something the doctor is aware of.

8 Then it became a sort of hazy question about not
9 discussing anything about the accident.

10 MR. EGLET: Well, no. I don't think --

11 MR. ROGERS: That is a little confusing.

12 MR. EGLET: I don't think it was hazy. I specifically
13 said -- and this is a very separate court order on this --
14 that this witness, no Defense witness, is permitted to talk
15 about the mechanism of injury.

16 You can talk about the fact that there was a motor
17 vehicle accident, that it was a rear-end motor vehicle
18 accident. But they don't get to suggest or imply that it was
19 minor, that it was a tap, that it was low speed, that there
20 was not much property damage, or anything like that, or
21 suggest that it was such a small accident that these injuries
22 couldn't have occurred.

23 BY MR. EGLET:

24 Q Do you under -- that is the court ruling. Are you
25 going to comply with that?

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1 A Absolutely I comply with it. I just don't
2 understand it, that's all.

3 THE COURT: I don't know that it's necessary for you to
4 understand the legal analysis and reason that the Court made
5 the --

6 THE WITNESS: Yeah.

7 THE COURT: -- decisions it made --

8 THE WITNESS: Yeah.

9 THE COURT: -- after entertaining lengthy argument on
10 both sides by counsel. I think it's only important and
11 necessary that you understand what the Court's rulings are, so
12 that you can follow those rulings and not be in contempt of
13 court.

14 THE WITNESS: Yeah. I mean, I obviously want to do that.
15 I just, you know, the evaluation of the medical component
16 relies on something happening or an injury that has occurred,
17 and it seems strange that I can't talk about the actual
18 mechanism of that injury. It's just --

19 THE COURT: I'm hopeful that the questions will be narrow
20 in their focus so that this witness can comply with the
21 Court's orders.

22 MR. ROGERS: Very good.

23 THE WITNESS: Yeah, please. I mean, if I -- I don't want
24 to be in contempt of court. It seems like there's a lot of
25 rules on here that I didn't know about, and it just seems

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1 strange to me, that's all.

2 BY MR. EGLET:

3 Q That's why we're doing this right now.

4 A Absolutely. I appreciate that.

5 Q Next, Doctor, is you may not refer to the Nevada
6 Highway Patrol incident report and the police officer's
7 opinions pertaining to this motor vehicle accident. Do you
8 understand that?

9 A Yes, I understand that.

10 Q Okay. We talked about property damage estimates.
11 You can't refer or rely or say anything about them. Do you
12 understand that?

13 A Yes.

14 Q Okay. We talked about the nature of the impact of
15 the subject collision, including any reference or comment or
16 testimony that the impact was minor, low speed, a tap, low
17 property damage, anything like that. Do you understand that?

18 A Yes.

19 Q Okay. You may not refer to any alleged federal
20 investigation that's going on -- well, it's over with now, but
21 went on here in Clark County regarding some doctors and
22 lawyers here in Las Vegas. Do you understand that?

23 A Yes.

24 Q Okay. You understand you cannot refer to yourself
25 as an independent medical examiner.

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1 A What am I?

2 Q You are a Defense medical examiner. You are not
3 independent. You cannot refer to yourself as an independent
4 medical examiner. You understand that?

5 A Yes.

6 Q Okay. You cannot refer or imply or make any
7 statements to the Jury that, well, I can't talk about this, or
8 I can't say this or I can't mention this, because the Court
9 has ruled in pretrial motions, or something to that effect; I
10 can't say this.

11 Do you understand that?

12 A I understand that.

13 Q Okay. You cannot speculate, suggest, or imply that
14 there may be medical records out there on Mr. Simao that you
15 or no one else has never seen. Do you understand that?

16 A Yes.

17 Q In other words, you can't say, well, I don't know if
18 there's any medical records prior to this accident which would
19 document that he had a neck pain before this accident, because
20 I don't know, I never saw them.

21 You can't speculate or hypothesize that something
22 may be out there. Do you understand that?

23 A I understand that.

24 Q Okay. Okay, and you are precluded from offering any
25 opinions regarding biomechanics or the nature of the impact of

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1 the motor vehicle collision in this case. Do you understand?

2 A Can I have a list here, so I can know what they are?
3 I mean, I'm not -- this just seems like a very long list. I
4 hope I remember them all. I mean --

5 Q Well, the truth of the matter is, you should have
6 been informed of all this. These -- weeks ago --

7 A Well, I mean, I was informed of some, but I didn't
8 realize this was such a large list. I mean, is there a way I
9 can have it just here, so I can refer to it to make sure?

10 Q I -- you know -- I don't know. This, this list
11 is --

12 MR. MICHALEK: Your Honor, if we could have a little
13 leeway on direct examination to lead him through some of the
14 minefields, so that there won't be any sort of mis-citation or
15 misstating of any of those items, I think we'll be fine.

16 MR. ROGERS: The biomechanical question that Plaintiff's
17 counsel just asked about really is the same as the minor
18 impact and photographs and property damage statement. The
19 doctor's aware, and we'll comply.

20 BY MR. EGLET:

21 Q You can't talk about the opinions and what kind of
22 forces you think were imparted in the crash or anybody's body.
23 Do you understand that?

24 A I understand that.

25 Q Okay. Any of these orders which I just told you

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1 about that you don't understand; you want clarification on?

2 A No.

3 Q Okay.

4 [Counsel Confer]

5 BY MR. EGLET:

6 Q Oh. Oh, finally. The Court has ruled that you may
7 not offer an opinion as to whether Mr. Simao was an
8 appropriate candidate for spine surgery or not. You may not
9 offer an opinion as to whether any of -- whether Dr. McNulty
10 did a necessary or unnecessary spine surgery in this case.

11 Do you understand that?

12 A I, I'm not going to say anything about unnecessary
13 spine surgery, but I --

14 Q You're not permitted to --

15 A I can't say anything about whether or not he is a
16 candidate for surgery?

17 Q That's correct. You cannot.

18 A Okay.

19 Q Okay.

20 MR. EGLET: Thank you, Your Honor.

21 MR. ROGERS: And, Doctor, that was an order entered just
22 before you walked in.

23 We are -- I think are ready to proceed.

24 THE COURT: Okay.

25 MR. ROGERS: Actually, though, could I have just a moment

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1 with him to discuss the order that the Court just entered?
2 THE COURT: Sure. Take a five-minute break.
3 MR. WALL: Actually, Judge, before you depart.
4 Can we have an order from the Court of each and
5 every one of those pretrial motions we discussed with each and
6 every witness that the Defense intends to call so that we have
7 at least some backdrop against which an expert or some other
8 witness knows what they're to testify to and what not to?
9 THE COURT: Yes. So ordered.
10 MR. ROGERS: Okay. If Plaintiff's counsel would kindly
11 provide this list that they just discussed with Dr. Fish, I
12 will happily supply it to every other witness we're going to
13 bring.
14 THE COURT: I would think you would have had your own
15 copy, but -- do you have any objection, Mr. Eglet?
16 MR. EGLET: We'll provide him a list, Your Honor.
17 THE COURT: All right.
18 MR. ROGERS: Thank you.
19 [Recess]
20 [Within the Presence of the Jury]
21 THE MARSHAL: Please remain in order. Department X is
22 back in session.
23 THE COURT: Please be seated. Good afternoon, ladies and
24 gentlemen of the jury.
25 THE PANEL: Good afternoon.

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1 THE COURT: Two quick things. First of all, on behalf of
2 the Court and counsel and the parties, I apologize for the
3 delay. It was unavoidable. There were a number of things we
4 had to discuss outside your presence as a matter of law.

5 Second thing is we have a new substitute clerk,
6 Phyllis Erby [phonetic]. She's filling in for my regular
7 clerk, and I appreciate her service. So I wanted to introduce
8 you to her. I think you met Mr. Castle on the first day of
9 jury selection.

10 I think we're ready to proceed, Mr. Rogers.

11 The new witness, we need to ask him to stand and be
12 sworn, please.

13 DR. DAVID ELI FISH, DEFENDANT'S WITNESS, SWORN

14 THE CLERK: Please be seated. State and spell your name
15 for the record.

16 THE WITNESS: David Eli Fish, D-a-v-i-d-E-l-i-F-i-s-h.

17 DIRECT EXAMINATION

18 BY MR. ROGERS:

19 Q Hello, Dr. Fish. Thank you --

20 MR. EGLET: Judge, I'm sorry to interrupt. Before
21 Mr. Rogers begins, could we just have the Court let the jury
22 know that we haven't rested our case but, rather, that this is
23 a witness --

24 THE COURT: Right.

25 MR. EGLET: -- we're taking out of order to accommodate

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1 the defense.

2 THE COURT: I can't remember if I mentioned that
3 yesterday, that this is a witness out of order. This is one
4 of Mr. Rogers' witness. We have to accommodate these various
5 witnesses, because some of them come from out of state. It
6 happens with both sides. But it's true, the Plaintiff has not
7 rested their case in chief yet.

8 Mr. Rogers.

9 BY MR. ROGERS:

10 Q Okay, Dr. Fish, thanks for taking time out of your
11 schedule to come here today. Now in my opening I told the
12 jury a little bit about you, and I'd like you to tell them a
13 some more of the specifics of your expertise. So to begin
14 with, if you would tell the jury where you went to medical
15 school.

16 A I went to New York Medical College in New York.

17 Q Okay. And I understand you obtained a Master's
18 Degree?

19 A Yes. At the same time I got my Doctorate in
20 medicine I had a Masters in public health.

21 Q Okay. What is public health?

22 A Public health is how, basically, the health affects
23 the community. It affects all of us. So it's the public
24 component of the healthcare, the delivery system, and the
25 administration of that system for the population and community

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1 at large.

2 Q Okay. And then, as I advised them, you served in
3 the military as well.

4 A Yes.

5 Q What'd you do there?

6 A I was in the U.S. Army. I paid for medical school
7 since it was expensive. So I spent three years in Europe.
8 One of those years I spent in Bosnia, in 1996, as a general
9 medical officer. So it was after medical school. I was able
10 to go to Europe and serve my country as a physician.

11 Q Okay. And after completing your service in the
12 military, did you return to school?

13 A Training.

14 Q Okay. What kind of training?

15 A So I -- my specialty is physical medicine and
16 rehabilitation. And I was fortunate enough to get into Johns
17 Hopkins for training for the residency program.

18 Q Okay. And I understand that you were appointed to
19 the chief resident there.

20 A Yes. One person out of each class is given the
21 opportunity to become chief resident for the residents. So
22 it's the person who interfaces between the attending staff and
23 the resident training.

24 Q Okay. And what did you do after completing your
25 residency?

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1 A I secured a fellowship in pain medicine at UCLA,
2 West LA VA, Veterans Administration in Los Angeles.

3 Q All right. What year did you complete your
4 fellowship?

5 A 2002.

6 Q Are you board certified in physical medicine?

7 A Yes.

8 Q Are you board certified in pain management?

9 A Yes, with the American Board of Anesthesia.

10 Q And to pass the boards -- the jury has heard some
11 discussion from the other doctors who've come. It's my
12 understanding that you have to take a written and an oral test
13 as well.

14 A For the physical medicine and rehab, yes, written
15 and oral. For the anesthesia board, just a written test.

16 Q And did you pass these boards on your first attempt?

17 A Yes.

18 Q All right. After you completed your service in the
19 military and you passed your boards, what did you do next?

20 A I was able to get a job at UCLA in the Department of
21 Orthopedics at the UCLA Spine Center.

22 Q What kind of work do you do there?

23 A Oh, I'm a physiatrist. So I do the non-operative
24 component, and we have five surgeons that are neurosurgery and
25 orthopedic surgery. And my job is to work up patients who

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1 come in with first-time injuries or patients who have had
2 surgery, to evaluate them for either future surgery or future
3 care, or to help with the diagnosis in terms of what kind of
4 therapy or what kind of treatment is going to be next involved
5 with their care.

6 Q You also mentioned working at the VA Hospital. What
7 do you do there?

8 A I'm a consultant for the residency program, and I
9 work in the physical medicine and rehabilitation department at
10 time with the Veterans Administration.

11 Q Okay. And describe to the jury what you do in your
12 role as a professor.

13 A Well, at UCLA we have the future of medical care.
14 So we have residents. We have medical students. We have
15 undergrads too that come to the office, and we also have
16 fellows, people who are trying to get specialty training in
17 pain medicine. And so, my role is to teach the medical
18 students as well as have them come and rotate with me and
19 teach them clinical aspects of what I do on a day-to-day
20 basis.

21 Q Okay. So in addition to your clinical practice,
22 teaching -- or pardon me -- treating patients, you are
23 teaching fellows, residents, and med students.

24 A Right. So it kind of overlaps a little bit. So if
25 a patient comes into the room and comes and sees us, and we

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1 have a resident and myself and maybe a medical student all
2 evaluate the patient. And they learn from the experience of
3 evaluating and coming up with a treatment plan.

4 Q Okay. Now in addition to your clinical and academic
5 work -- and in this case, you're doing a -- sort of a forensic
6 kind of work. If you would explain to the jury the difference
7 between those two I guess engagements.

8 A Well, as a forensic expert, I would not be treating
9 the individual. In other words, I wouldn't be seeing them on
10 a day-to-day basis or a week to month basis, or performing any
11 injections or any workup on them, but evaluating what had been
12 done and what kind of treatment has been involved and whether
13 or not that's appropriate, related to the events that may have
14 occurred.

15 Q Okay. As a treating medical provider, are there
16 things that you are, I guess, less interested in than you are
17 when you're a forensic expert?

18 A Well, I don't know if I'd be less interested in. I
19 mean I'm interested in the whole aspect around them. I think
20 the expert component is taking a person from an injury to what
21 kind of treatment was involved. The -- usually, as a treating
22 physician, you're really not as concerned with the causation
23 of that injury in terms of what caused it, but you may just
24 want to make sure that the person seems to be progressing in
25 their therapies and improving. As an expert person who's

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1 reading records, there's really no way of allowing that person
2 or influencing that person to have any improvement in their
3 therapies, because you really have no say in their therapies.

4 Q Okay. Let me phrase the question this way. When
5 you're a treating provider and you're treating a patient who
6 comes to you for any given complaint, do you do what you did
7 in this case, as a forensic examiner, and investigate all the
8 records surrounding the treatment from start to finish?

9 A Well, sometimes I don't have the luxury of having
10 all those records. In a case like this, there's a lot of
11 records that I'm given. And usually, when you're coming in
12 for an evaluation, I may not have a lot of those components of
13 the records surrounding that issue.

14 Q Okay. When were you first contacted and retained to
15 be an expert in this case?

16 A February 2008 -- 2009.

17 Q Okay. So two to three years ago?

18 A Yes, about.

19 Q How much do you charge per hour for your work in
20 this case?

21 A Seven hundred dollars per hour.

22 Q When you're working at UCLA, do you make more or
23 less than that?

24 A Well, it depends on what I'm doing. But you're
25 billing a lot more than 700 an hour.

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1 Q Okay. And we've discussed with the jury that every
2 expert who comes in is being paid for the time off. And you,
3 of course, flew in from Los Angeles to appear today for them.
4 And how much is your charge for the day?

5 A Today's charge is \$12,000 for the day.

6 Q Okay. And is that -- all that money going to you?

7 A Well, it becomes inclusion with the overall salary
8 at UCLA. So it goes to the department and then it's a part of
9 my salary.

10 Q So are you being paid anything extra today than you
11 would have earned otherwise if you weren't in this courtroom?

12 A No. I'm probably taking somewhat of a pay cut,
13 because I'm not seeing patients. I'm not evaluating them. My
14 residents and fellows are -- they have nowhere to go for
15 today. And I'm not generating income for the hospital or the
16 department today. So --

17 Q Okay. Well, naturally, the question is then why are
18 you doing that?

19 A Well, I think it's an important aspect of -- as a
20 clinician, what you do on a day-to-day basis. And it's
21 evaluating how patients are being brought from point A to
22 point B and what their therapy is, and how the community at
23 large, say, versus an academic center, may approach these
24 patients. So there's somewhat of a puzzle factor within it.
25 And understanding the whole components and putting them

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1 together is something that I think a physician does on a
2 day-to-day basis. But having the opportunity to have a
3 plethora of records and looking at a big component of a case
4 is a unique thing that you do on a day-to-day basis. And so,
5 I think it's important to have that aspect. And on top of it,
6 looking at the components of how individuals are treated,
7 bringing it back to the residents and the trainees on the
8 component of what they're learning on a day-to-day basis and
9 how other people may handle a case.

10 Q Now how did you approach your forensic review in
11 this case? You've mentioned the records. What else have you
12 done?

13 A I had the opportunity to meet Mr. Simao for about 45
14 minutes or so and examine him and discuss with him the events
15 that had taken place, as well as the treatments. And then
16 based on the -- on that discussion and a direct examination of
17 Mr. Simao, as well as looking at the records and the images
18 and looking at the treatment that had been conferred upon him,
19 came up with opinions.

20 Q And what did you do to prepare for trial today?

21 A I tried to re-review my records, my own records and
22 my summaries, relook at the imaging studies to make sure that
23 I understood what they conveyed to me, reevaluated the records
24 that were given as well as reevaluating my examination of him.

25 Q All right.

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1 MR. ROGERS: Your Honor, at this time, we offer Dr. Fish
2 as an expert in physical medicine, rehabilitation, pain
3 management, and diagnostics.

4 THE COURT: Would counsel approach, please?

5 [Bench Conference Begins]

6 MR. EGLET: I want to address at the bench there's no
7 electro diagnostic studies in this case. He didn't perform
8 any electro diagnostic studies on our client when he examined
9 him.

10 MR. ROGERS: No, there is an EMG and there is a
11 conduction study done after the surgery.

12 MR. EGLET: Okay. Well, he didn't present any opinions
13 on that in his reports, on the electro diagnostic study. He
14 did not present any opinions in his reports, and he didn't do
15 it in his deposition. So I would object to him offering any
16 opinions on electro diagnostic studies. It wasn't disclosed.
17 He may very well have expertise in that area. I'm not
18 doubting that. But it wasn't disclosed. It's not in his
19 reports, and it's not in his deposition.

20 MR. ROGERS: I think what was discussed was that -- like
21 Dr. McNulty [phonetic] mentioned yesterday, that an EMG and
22 nerve conduction study is done that show positive findings for
23 carpal tunnel. And I believe that was brought up by Dr. Fish,
24 and not in the report, in the deposition. I don't have the
25 record right in front of me, but I'm fairly confident that

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1 issue has come up, because it's been a running issue in the
2 case.

3 MR. EGLET: I've read his reports. He has four or five
4 of them. It's not in any of his reports. I can tell you
5 that. And I don't believe it's in his deposition either.

6 THE COURT: Let's defer any questions until we can
7 confirm that.

8 MR. EGLET: We think that's something to wait till the
9 end, till he's done.

10 THE COURT: Yeah, I think it's an issue we'll have to
11 discuss later.

12 MR. ROGERS: Okay. Well, I may address it, not as the
13 jury question, but my own.

14 [Bench Conference Ends]

15 THE COURT: Any objection to counsel's motion?

16 MR. EGLET: With the qualifying on the electro
17 diagnostics, that that's not included, Your Honor.

18 THE COURT: Other than that, any objection?

19 MR. EGLET: No.

20 THE COURT: Other than that, the motion is granted.

21 BY MR. ROGERS:

22 Q Doctor, I want to go back to the things that you
23 have reviewed to prepare for this case. A question has been
24 posed about what other records you have seen. Are there any
25 other records of treatment that the Plaintiff has undergone,

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1 and as presented in this case, that you have not seen?

2 A I think I've seen all the records that have been
3 made available to me.

4 Q And we'll be walking through these records as we go
5 through the examination today. But including the diagnostic
6 films and the treatment records, but it is your understanding
7 that every record the Plaintiff has produced in this case,
8 every medical record, you've seen?

9 A I believe so.

10 Q Okay. Now I want to start with your medical
11 opinions, and then we will get into the specifics of them as
12 we go. First, did this car accident of April 15, 2005 cause a
13 traumatic cervical disc injury?

14 A No, it did not.

15 Q Was the Plaintiff, Mr. Simao injured in a car
16 accident?

17 A He complained of neck pain and head pain initially.
18 But as -- when you have these gaps in care, if you look at the
19 record component, he did not really complain much of neck pain
20 and didn't really seek care consistently for the next couple
21 of months, and then there was another gap in care. So it's
22 hard for me to say that he was truly injured in this accident.

23 Q Okay. And of the care that he has undergone since
24 the car accident, what care might be related to the accident?

25 A Well, initially, he presented to the Urgent Care

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1 Clinic, and he was having a headache and some neck pain. And
2 I think they evaluated him at the time and felt that the
3 workup that was done was appropriate. But then when no other
4 treatment was rendered and there was no further follow-up,
5 anything into May -- or the end of May, anything after that
6 didn't seem to be related to the accident.

7 Q Okay. As I said, we'll get into the details on
8 that. An issue that's been brought up today is -- and through
9 this trial is occipital pain or occipital headaches. Is
10 occipital pain the same as neck pain?

11 A No, it's different.

12 Q Okay. If you would describe the difference?

13 A When you talk about occipital pain, it's basically
14 the back of the head.

15 Q You can stand up and show the jurors.

16 A And show them the back of my head. The back of the
17 head as opposed to the neck, which is more of the component
18 below the head. There is a distinct difference between the
19 two.

20 Q Okay. And can a person have occipital headaches
21 without having neck pain?

22 A Yes.

23 Q Now are there things other than the cervical spine
24 that can cause occipital pain?

25 A Well, you have the muscles that are going to attach

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1 to the head, which is a main component. Plus you have nerves
2 in the back of the skull. You have the skull itself as well
3 as the skin layers. So there may be many components that can
4 cause that type of pain.

5 Q Okay. Are there other kinds of headaches that can
6 also be experienced in the occipital region?

7 A Sure. You can have what's called a tension headache
8 or a migraine headache or a chronic daily headache. There's
9 various types of headache components that can give you
10 occipital region pain.

11 Q All right. The focus of the Plaintiff's injury
12 claim is that the car accident cause disc disruption at C3/4
13 and C4/5. Would a traumatic injury at C3/4 or C4/5 cause
14 occipital headaches?

15 A No, because the occipital nerve comes off of the
16 C2/3, or the third occipital nerve. And so, that's above the
17 level of where the C3/4 and 4/5 nerve comes out.

18 Q If you then sustained a traumatic injury at C3/4 and
19 C4/5 -- and I'll have you come down in a minute and then show
20 this to the jury in a little bit. But if you did sustain a
21 traumatic injury at those levels, would it be head pain or
22 neck pain that you would most likely experience?

23 A You'd probably get more neck pain and trapezius
24 pain, possibly a little bit of the shoulder in terms of the
25 pain region.

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1 Q Okay. Now there's been some suggestion here in this
2 proceeding, the gate theory [phonetic] explain, a delay in
3 onset of neck symptoms, that there is -- could be a headache
4 complaint, and a neck injury might not be felt at C3/4 and
5 C4/5. Is that an accurate account of what happened here?

6 A So when you say gate theory, is it the typical
7 Melzack and Walls gate theory of pain or is this a -- I'm not
8 sure I understand what gate theory that is being discussed.

9 Q You're already over my head. So --

10 A So let me try to clarify. The gate theory is what,
11 in the 50s, Melzack and Walls were the two scientists who kind
12 of came up with this idea of pain. And if you had people
13 wearing different color shirts, let's say a red shirt, blue,
14 or green shirt, and they're all trying to get through a gate
15 to the other side, if you had people all wearing blue, and
16 there's only a few of them, they're going to get through to
17 the other side, no problem. But if you flood it with red,
18 orange, yellow, and blue, and then shove them all through the
19 gate, you're not going to get that blue going through at one
20 time. You're going to get other colors. And so, it's going
21 to confuse the information on the other side. So when you
22 talk about pain and how it distributes to an area, if multiple
23 stimuli is coming in at one point, the individual may not feel
24 a component of that pain. It's -- the signals are scrambled
25 if you will.

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1 Q Okay. Can that scrambling of signals occur then in
2 a case as the Plaintiff has described, which is an immediate
3 onset of occipital pain and a five to six-month gap in onset
4 of neck pain?

5 A No, huh-uh. If you're going to have a disc problem,
6 and it's going to happen right there, you're going to feel it
7 right then and there. If someone got hit in the head with a
8 baseball or hit in the shoulder, you're going to know you got
9 hit in that shoulder. It's not going to spread to your knee
10 or other areas. Yes, they're close, because you have the
11 occiput in the neck, but it's going to be distinct. People
12 are going to know that there's a problem with the disc.

13 Q There has been some discussion with the two doctors
14 who testified so far, Doctors McNulty and Rosler, that there
15 could be a delayed onset of neck pain with traumatic disc
16 injuries, with a traumatic disc injury at C3/4 and C4/5. Now
17 you -- as you've touched on and reviewed these records, can
18 there be a delay in onset such as the Plaintiff experienced?

19 A Usually within 48 to 72 hours is probably the latest
20 I've seen. But anybody that has an immediate disc injury is
21 going to feel the pain right then and there. And it's going
22 to be obvious, completely obvious. Even if it's mild, you
23 still would have that pain component.

24 Q Now let's combine these two theories that have been
25 proposed, the gate theory and this delay in onset theory. Can

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1 this explain the gap in symptoms for the Plaintiff from the
2 date of the incident up until roughly October, five or six
3 months after the incident?

4 A I don't think that explains it.

5 Q Why not?

6 A You would expect pain right away. This delay is
7 just inconsistent with anything I've seen in the emergency
8 room, in the military M*A*S*H units that I was in in Bosnia,
9 in the care that I get from pati- -- or the people that come
10 in to see me on a day-to-day basis. It's just you're not
11 going to have a delay like that. It's just not going to
12 happen.

13 Q And do you work at a trauma center?

14 A We're a level one trauma center.

15 Q So you see people involved in car accidents --

16 A Yes.

17 Q -- as well as other type patients.

18 A We get all the patients who have major car accidents
19 get flown to our center from all over the area and southern
20 California.

21 Q I want to turn to the medical records. We'll start
22 with the date of the incident, which I believe is Exhibit 18.
23 Doctor, there's a monitor up there next to you.

24 [Counsel Confer]

25 MR. ROGERS: Okay. Now if you can pull out the

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1 assessment. Okay, or the reason for visit will do.

2 BY MR. ROGERS:

3 Q Some hours following the incident, the Plaintiff
4 complained of left elbow pain, tenderness in the back of his
5 head. And the assessment shows that he was assessed with neck
6 pain. We don't see the neck complaint right here, but he was
7 assessed with a neck sprain. Now is that a common assessment
8 following a car accident?

9 A Yes.

10 Q Okay. Dr. McNulty discussed yesterday that a neck
11 sprain, in many instances, is sort of a catch all. It's not a
12 really complete diagnosis. It's just a way of describing neck
13 pain.

14 A Right. It's -- it can encompass a lot of different
15 factors. You've got the muscle, the ligaments, the joints,
16 anything can really encompass a sprain if you will. So it's a
17 catch all term in some respects.

18 Q All right. And then we see that in this business,
19 the plan --

20 [Counsel Confer]

21 BY MR. ROGERS:

22 Q Now the plan was the Plaintiff should seek primary
23 care follow-up if not improving in the next week to 10 days.
24 If a patient has sustained a traumatic injury at C3/4 or C4/5
25 and doesn't follow up within seven to 10 days, what will

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1 happen?

2 A Well, if the injury is significant enough, you would
3 have progression of the symptoms. You could have weakness in
4 the shoulder, weakness in the components of the upper part of
5 the neck and area here. The -- you may get some numbness,
6 burning sensation in the arms. You may get some bowel and
7 bladder insufficiency if there was enough trauma to the spinal
8 cord itself, because you have the cord right underneath that
9 area of the disk. You may experience ongoing symptoms that
10 are just not getting better with just simple rest, if you
11 will.

12 Q Okay. Now as you learned from your records review,
13 the Plaintiff did not return during that seven to 10 days. He
14 returned three weeks later, on May 4, 2005.

15 [Counsel Confer]

16 BY MR. ROGERS:

17 Q All right. Now --

18 [Counsel Confer]

19 MR. ROGERS: While we're waiting, what I can do to speed
20 this up, Your Honor, can I take the trial folder up to --

21 THE COURT: Sure.

22 MR. ROGERS: Well, if we have it, we'll just go ahead
23 with it.

24 BY MR. ROGERS:

25 Q Okay. Now when the Plaintiff presents on May 4, he

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1 complained about what, Doctor?

2 A Can you pull up the ---

3 [Counsel Confer]

4 THE WITNESS: It says -- I think it says checkup on
5 headaches, MVA, 4/22/05.

6 BY MR. ROGERS:

7 Q All right. And if there were no neck complaints at
8 this visit, what would that --

9 A That the neck is not a problem. It's not bothering
10 him.

11 Q Okay. Now there's a physical exam also in this
12 visit --

13 [Counsel Confer]

14 BY MR. ROGERS:

15 Q -- that includes an examination of the neck.

16 MR. EGLET: Would that be the assessment?

17 MR. ROGERS: It might the following page. There it is.
18 Okay.

19 BY MR. ROGERS:

20 Q Okay. Now are there any abnormal findings on this
21 physical exam of the neck?

22 A Well, there's positive tenderness to palpation over
23 the occiput scalp, which is the back of the head here, scalp.
24 And there are no palpable masses or palpable defects that can
25 be felt over the skull or scalp. The pupil are equal round,

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1 reactive to light in accommodation. So the eyes look good.
2 There's no facial trauma in any area. The throat looks good.
3 The neck shows no issues. Neurological exam shows the nerves
4 are intact. And the musculoskeletal exam, there's a notation
5 of full range of motion in the extremities with strength as
6 five over five and the reflexes are normal.

7 Q Okay. Do these findings suggest or refuse a
8 traumatic injury at C3/4 and C4/5?

9 A I would have expected some kind of examination
10 component for, specifically, the neck. But, you know, with
11 full range of motion of the extremities, being able to move
12 the entire arms, it's hard to say that there was a nerve
13 damage or there was a specific shoulder injury or a joint
14 injury based on this.

15 Q Okay. Now I want you to explain to the jury where
16 the occipital scalp is -- I believe I have it as --

17 [Counsel Confer]

18 BY MR. ROGERS:

19 Q Okay. If you would come down.

20 A Sure.

21 Q If you'll just --

22 A Okay. Obviously, the ears. This line right here,
23 pretty much the line right along this top here. So the
24 occiput is going to be his upper part here or the part right
25 up here, as opposed to the neck region. And you can see that

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1 C3 is down here, and the occiput region is up here. Well,
2 it's a little bit lower. It's probably down in this area
3 here.

4 Q Okay. And you said there was some tenderness at the
5 occiput but not the neck.

6 A Right. So the -- you have the big musculature --
7 the trapezius muscle is going to come up to this point and
8 it's going to attach at the lower part of the head. But the
9 palpating area here is not tender, and the area of the pain is
10 in the upper part right here, much higher.

11 Q Okay. And if you would, explain to the jury how it
12 is that the C2/3 is what might innervate or cause headaches
13 from the occipital region but not C3/4 and 4/5?

14 A So if this is the C3, this area right here, 2/3, you
15 can see these nerves right here coming at -- I'm sorry. 2/3.
16 3/4 is just a little bit lower. So the C2/3 area nerve comes
17 up around this area here, but the C3/4 is down below, and
18 that's going to cover more of the shoulder area here.

19 Q Okay. And what of C4/5?

20 A C4/5 is going to be even lower, and that's going to
21 be the lower part down in the shoulder area that you can't
22 quite see further down.

23 Q Now with the findings that they had on the objective
24 exam three weeks after the accident, do you see that they
25 refer the Plaintiff out for a CT scan?

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1 A Of the head.

2 Q Right. And was that an appropriate recommendation
3 given his complaints on that day?

4 A Yeah, absolutely. I mean if you think someone has
5 had a head bump or a head hit, you want to make sure that
6 there's no, especially weeks out, there's a small bleed in the
7 brain. So it would be appropriate to get that test.

8 Q And on this day, May 4, 2005, was there any
9 suggestion or need of a [indiscernible] in the neck?

10 A No, there wasn't really any suggestion for that,
11 because there really wasn't pain in that area.

12 Q Okay, good. You can take your seat again. Now I
13 asked you earlier about the difference between occipital
14 tension, migraine, and then I think you mentioned another kind
15 of headache or two. And I want to get into that at this
16 point. Can a person have the same headache presentation that
17 the Plaintiff had on May 4, three weeks after the accident, if
18 it's a tension type headache?

19 A Sure, he could definitely have that.

20 Q Okay. And what about migraines?

21 A Well, migraines you -- sometimes people have nausea,
22 facial numbness, pain behind the eyes. They call it
23 photophobia, where the light really bothers you, or pressure
24 deep inside the front part of the side of your head. It's
25 maybe a little bit different, but it could still be that, but

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1 it's -- you know, it's hard to say.

2 Q All right. What do you know about the Plaintiff Mr.
3 Simao's headaches before the car accident?

4 A He was treated for a left side headache problem. I
5 think he was first evaluated at the Southwest Medical
6 Associates in 2002. So he was having pain on the left side
7 and actually some facial numbness as well. So it was a left
8 sided headache component.

9 Q And what kind of headache does that consist of?

10 A Well, it can vary. It can be a tension. It can be
11 a migraine. I think they called it a migraine. That's kind
12 of what he was treated for and even seeing a neurologist to
13 evaluate it as well. And they tried him on different migraine
14 abortive medications to see if that would help.

15 Q On the date of the incident, when he presented to
16 Southwest Medical Associates, if I recall right, he reported
17 that he was taking Butalbital.

18 A Correct.

19 Q Is that a medication for migraines or for a
20 different --

21 A Right. It's a migrainous type of medications, an
22 opiate with a caffeine component to it to try to help stop
23 some of the migraine components.

24 Q Okay. Then after he has this CT scan of the head,
25 which comes back normal, he reports again to Southwest Medical

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1 Associates the following week, and he complains of something
2 you just mentioned a moment ago, and that was facial pain and
3 numbness.

4 A Correct.

5 Q Do you recall that May 12 --

6 [Counsel Confer]

7 BY MR. ROGERS:

8 Q Okay. Now is -- are the symptoms with which he's
9 presenting on this day -- here we are nearly a month out now
10 from the car accident -- similar to the symptoms that he
11 presented with before the car accident?

12 A It says headache, numbness in the upper lip. And
13 can you blow up the -- numbness in the upper lip and nose,
14 status post-MVA. Persistent pressure/sensation in the
15 occipital head after being involved in MVCA. Pressure in the
16 scalp, radiating at time.

17 Q Okay. That describes --

18 A He doesn't have new onset of blurred vision with
19 facial field defects. So there's no pain behind the eyes
20 component. So it's possible.

21 Q Okay. It's -- I'm not --

22 A It's possible that it could be similar to the pain
23 complaints and the headache symptoms that --

24 MR. EGLET: Your Honor, I'm going to object on the
25 foundation grounds. Possibilities are not the basis for

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1 expert testimony.

2 THE COURT: Let's ask for some clarification.

3 MR. ROGERS: Yes, very good.

4 BY MR. ROGERS:

5 Q Okay. Now you have somewhat similar symptom
6 presentation and you say this -- that appears to be a
7 possibility.

8 MR. EGLET: Objection, leading.

9 THE COURT: Sustained. Ask you to rephrase the question.

10 MR. ROGERS: Okay.

11 BY MR. ROGERS:

12 Q It is possible that it's the same. Is it possible
13 that it's not? And if so, if you would explain that to the
14 jury.

15 A Well, you know, if you've been --

16 MR. EGLET: Your Honor, I'm going to object on
17 possibilities.

18 THE COURT: The Court already sustained that objection.
19 Ask you to rephrase, please.

20 MR. ROGERS: Okay.

21 BY MR. ROGERS:

22 Q What I'm trying to get, Doctor, is the Plaintiff
23 presented with the headaches you described from before the car
24 accident.

25 MR. EGLET: Objection, leading.

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1 MR. ROGERS: This is foundational, Your Honor.

2 MR. EGLET: It's leading.

3 THE COURT: Overruled.

4 BY MR. ROGERS:

5 Q And then he presented again after the accident with
6 the headaches that you see before, roughly a month after this.
7 And the question is is there a different kind of headache
8 going on?

9 A It seems the same.

10 Q Now on this visit, were there any neck complaints?

11 A No, there were no neck complaints.

12 Q And what was the diagnosis?

13 A Can you blow up AP.

14 Q Sure.

15 A Headache, tension type.

16 Q Okay. Was any testing ordered on the neck?

17 A Well, the -- they reviewed the CT scan, which was
18 negative. So there was no bleed. There wasn't an inner
19 cranial problem. And since the -- it was negative, there was
20 a referral for an MRI of the brain.

21 Q Okay. Let's pull up the findings on that MRI to see
22 what the result was.

23 [Counsel Confer]

24 BY MR. ROGERS:

25 Q Do you recall, Doctor, while you're waiting on that

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1 what the findings were?

2 A Yeah, I believe it was normal. It was unremarkable
3 and normal. There was no evidence of an inner cranial lesion.
4 There was no evidence of any component that would explain a
5 headache or a brain type problem.

6 Q Okay. Was there any evidence form the CT scan or
7 the MRI that a head injury occurred at this accident?

8 A No, there was not.

9 Q All right. The Plaintiff then was next seen on May
10 26th, again, at Southwest Medical. At that visit --

11 MR. ROGERS: This is actually page 20.

12 BY MR. ROGERS:

13 Q Were there any signs or symptoms of neck problems at
14 that time?

15 A I was there to review the results. And if you bring
16 up the bottom part, it says A, assessment. Has a history of
17 migraine headaches. Did experience a change in the headache
18 intensity and character after a motor vehicle accident. The
19 workup of the x-rays of the cervical spine, the CT of the head
20 were normal. And the results were explained and there was no
21 neck issue really discussed or complained of.

22 Q All right. And is there any note of any opinion or
23 prescription pain medication?

24 A There was none given.

25 Q What was the plan with this visit?

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1 A Follow up in six months.

2 Q All right. Now of all the records that we've
3 reviewed up until now, is there any evidence of a traumatic
4 cervical spine injury?

5 A No.

6 Q If there's been a traumatic cervical spine injury,
7 what difference would you expect to see?

8 A Pain at the neck, pain radiating down to the arm,
9 possibly bowel and bladder problems if it's a significant
10 enough injury, sensory change, weakness in the arm, depending
11 on the distribution of those nerves.

12 Q And would the gate theory or this potential delay in
13 onset explain the lack of neck symptoms here now, a month-and-
14 a-half after the accident?

15 A No, it wouldn't.

16 Q Now let's assume, hypothetically, that there will
17 come testimony that the Plaintiff was complaining of neck
18 pain, only not to his doctors at this time. If that were
19 true, would that change your position?

20 A No.

21 Q Why not?

22 A Well, he was -- his job is very active. And so,
23 given what he was doing at the time when I discussed with him
24 on my exam in February of 2009, it's possible these are just
25 aches and pains from his work.

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1 MR. EGLET: Your Honor, I object, possible. That calls
2 for speculation. Move to strike.

3 THE COURT: Sustain the objection.

4 Jury will disregard the witness' statement.

5 Ask you to clarify, Mr. Rogers.

6 MR. ROGERS: Okay.

7 BY MR. ROGERS:

8 Q I believe what the Court is looking for, so limit
9 the answer to the question, which is if there is,
10 hypothetically, any suggestion or testimony that, you know
11 what, I was experiencing neck problems, I just wasn't telling
12 my doctors, the question is would that change your opinion?

13 A If it's a significant enough neck problem, you're
14 going to tell your doctors, especially if there's a concern.

15 MR. EGLET: Your Honor, I'm going to object. That's
16 speculation. He's asking him to speculate what Mr. Simao's
17 had.

18 THE COURT: Sustain the objection.

19 Jury will disregard the witness' last statement.

20 Ask you to rephrase the question.

21 BY MR. ROGERS:

22 Q In the patients who you treat -- at UCLA and at the
23 Veterans Center, for those who do sustain a traumatically
24 induced disc injury in the cervical spine, do you see no
25 complaints for a month-and-a-half?

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1 A No.

2 MR. EGLET: Objection, vague and ambiguous. What's the
3 extent of the disc injury? He's described significant disc
4 injuries where you have bowel and bladder --

5 THE COURT: Counsel, approach, please. Counsel,
6 approach, please. Off the record.

7 [Bench Conference Begins]

8 THE COURT: I thought we agreed on no speaking
9 objections.

10 MR. EGLET: I apologize, Your Honor.

11 THE COURT: All right. Go --

12 MR. EGLET: The point is it's vague and ambiguous and
13 overbroad, because with this witness he is talking about -- in
14 all of these questions, when he asked him well, what kind of
15 symptoms would you expect, well, bowel and bladder loss, you
16 know, significant paresthesia, and stuff like that. I mean
17 there's a range of disc injuries, okay. Everybody here knows
18 that, especially this doctor. So for him to suggest if you're
19 going to have any disc injury at all in the neck, you're going
20 to have bowel and bladder loss, and all these significant
21 symptoms, it's ridiculous and it's improper. So I'd ask that
22 the question be narrowed. It's way too broad of a scope. He
23 needs to narrow it to a specific type of injury, because we're
24 not talking about somebody who has a cord compression. Nobody
25 has said that, and that's essentially what he's talking about

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1 is a major cord compression, a major nerve compression.
2 Nobody suggested that, but it was that kind of -- that amount
3 of an injury. But when he's talking about the symptoms,
4 here's what he's talking about.

5 So when he asks you, you know, [indiscernible]
6 significant [indiscernible] bowel -- loss of bowel
7 [indiscernible] start to see yeah, somewhat [indiscernible]
8 traumatic injury to the disc [indiscernible] mention that
9 [indiscernible].

10 THE COURT: Go ahead, Mr. Rogers.

11 MR. ROGERS: Yes. My answer is that [indiscernible]
12 cross-examination [indiscernible] is not proper on direct,
13 because the question is limited to cervical traumatic injuries
14 to cervical [indiscernible] bring up all the different kinds
15 there may be. But in this case, everybody knows that we're
16 talking about a claim of traumatic injuries internal disc
17 disruption.

18 MR. EGLET: Well, you have a history of it.

19 MR. ROGERS: Yeah, but he's listening to the jury --
20 we're not talking about somebody who has such a traumatic disc
21 injury that [indiscernible] compression or a such an impinging
22 on a major nerve that you're going to have significant
23 numbness, you know, immediately from the accident or even
24 shortly after. That's what this witness is implying, Your
25 Honor. This has got to -- the scope of the question has to be

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1 narrow. Otherwise, it's just painting a picture that is a
2 fantasy. It has nothing to do with this case. Nobody is
3 claiming there's any type of injury like this.

4 THE COURT: We'll, here's the thing. The Court is
5 inclined to sustained the objection. The way that you posed
6 the question I think it is pretty vague and overbroad. And
7 frankly, the way you first posed the question with respect to
8 his [indiscernible] UCLA didn't really have anything to do
9 with this particular Plaintiff. That was -- it looked like
10 the approach that you were taking. So the Court is sustaining
11 the objection.

12 But here's the other thing. This witness is giving
13 a lot of answers that offer possibilities and speculation, and
14 the jury is not to consider that. So I hope we can proceed
15 accordingly. I hope I don't have to keep striking his
16 testimony, because he offers lots of possibilities.

17 MR. EGLET: Thank you, Your Honor.

18 MR. ROGERS: Okay.

19 [Bench Conference Ends]

20 THE COURT: Sustain the objection for the record.

21 BY MR. ROGERS:

22 Q Okay. Now given the patients that you have examined
23 outside of a forensic exam, who have been involved in an
24 incident in which they sustained what the Plaintiff alleges in
25 this case, C3/4, C4/5 traumatically induced internal disc

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1 disruption, have you ever seen a delay in onset of a month-
2 and-a-half?

3 A No.

4 Q All right. That moves us then to this point where
5 the Plaintiff stops treatment, from May 26th up until October
6 26th, roughly four-and-a-half. And it's your understanding
7 that the Plaintiff wasn't treating with anyone during that
8 time?

9 A That's my understanding he wasn't being treated by
10 any providers or getting therapy or taking medications that
11 were new other than what he has been taking before.

12 Q Okay. Did -- was he undergoing any exercise there,
13 physical therapy, or chiropractics, or anything like that
14 during that time?

15 A Not a formal program. It was prescribed. He wasn't
16 seeing a therapist on a day -- a weekly basis, a physical
17 therapist.

18 Q And again, up to this point, we're now roughly six
19 months after the accident. Is there any medical evidence of a
20 traumatic injury that the Plaintiff alleges in this case?

21 A I don't see any.

22 Q Okay. Now the Plaintiff returned to treatment --

23 MR. ROGERS: And this is pages 21 and we may go to 22 as
24 well.

25 ///

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1 BY MR. ROGERS:

2 Q He returned to treatment in October.

3 MR. ROGERS: I want to pull that record up. And if you
4 can show the reason for visit.

5 BY MR. ROGERS:

6 Q The question is did the Plaintiff complain of
7 neck [audio skips] --

8 A It says checkup neck, shoulder pain.

9 Q And to your knowledge, is this the first time the
10 Plaintiff complained of neck pain since April 15, six months
11 earlier?

12 A Complained to his provider [audio skips at 2:40:44]
13 Medical Associates. It's also the first time of shoulder
14 pain.

15 Q Okay. Did the accident cause a [audio skips at
16 2:40:56]?

17 A There's no evidence of that.

18 Q [Audio skips at 2:41:00] treated for on this day?

19 A Can you go to the assessment?

20 [Counsel Confer]

21 THE WITNESS: This -- no. Oh, yeah, that's fine.

22 [Counsel Confer]

23 THE WITNESS: Tension type headache and migraine [audio
24 skips at 2:41:20].

25 ///

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1 BY MR. ROGERS:

2 Q All right. Would you agree that something changed
3 in the symptoms on this day?

4 MR. EGLET: Objection, leading.

5 THE COURT: Sustained.

6 BY MR. ROGERS:

7 Q Is there anything different in the assessment on the
8 visit compared to the assessment in the April visit?

9 A No.

10 Q And on the April visit, we don't see an entry of
11 shoulder sprain.

12 A Correct.

13 Q Okay. That's the difference I'm asking about.

14 A Oh. I guess because it's crossed off, I'm not sure
15 if that was what the intent of the notation was here. But if
16 you go down to the next section, the assessment section I
17 guess.

18 Q Okay.

19 A The summary. History of migraine started to become
20 worse in the last few months, more frequently, nausea,
21 vomiting. These are all kind of migraine components.
22 Tightness in the left shoulder and then radiating up to the
23 neck. So it's like from the shoulder up to the neck. It's
24 not the neck. And later on, will develop a migraine headache
25 with this. So it's really talking about the migraine, and

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1 they're suggesting that he goes to neurology for an evaluation
2 and a CT scan. So I think the provider thought there was some
3 kind of change, but --

4 MR. EGLET: Your Honor, I'm going to object to what he
5 thinks the provider thought. That's speculation.

6 THE COURT: Sustained.

7 MR. ROGERS: Okay.

8 BY MR. ROGERS:

9 Q Go ahead, Doctor, with what the provider
10 recommended.

11 A Provider recommended a CT scan to rule out causes
12 for the headaches. No neck issues.

13 Q Okay. There was also a recommendation there for a
14 shoulder x-ray.

15 A That must be on the next page.

16 MR. ROGERS: Okay. If you would, Dan.

17 THE WITNESS: Actually, go to A. Migraine headache with
18 a muscle contracture component, indicating a tension type
19 headache with a migraine. And --

20 BY MR. ROGERS:

21 Q I think we're on the wrong date. I'm looking -- I
22 was talking about October 12, where the x-ray is ordered. Do
23 you have that?

24 MR. EGLET: Page number?

25 MR. ROGERS: It would be the next one in order. We were

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1 just on October 6th.

2 THE WITNESS: This is October 12.

3 BY MR. ROGERS:

4 Q Yes.

5 A The assessment is nicotine dependence. I don't --
6 I'm not sure where you're pointing to the shoulder component.

7 Q I'm being terribly clumsy with this demonstration.
8 So I'll move it along. If there's a traumatic disc injury,
9 would it be shown on an x-ray?

10 A No. The x-ray is only going to show bone structure.
11 It's not going to show soft tissues like an MRI.

12 Q Okay. Now the Plaintiff returns to treatment a
13 couple months later. And at this point, in December -- I
14 believe this is pages 28 in Exhibit 18. Let's make sure I've
15 got it right this time.

16 A December --

17 MR. ROGERS: Pull up the -- it looks like the date is cut
18 off. It's right under tobacco -- is 42 -- good.

19 BY MR. ROGERS:

20 Q Okay. And here, he's complaining of what?

21 A Neck and shoulder pain for the past several months.
22 It's gotten worse in the past couple weeks. Not tried any
23 medications for it, although has some in the past, which made
24 him sleepy.

25 Q Now is there anything in this record suggesting a

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1 traumatic injury at C3/4 and C4/5?

2 A No.

3 Q Now again, do traumatic injuries go -- to C3/4 and
4 4/5 go months without any comment?

5 A No.

6 Q Now I want to turn to some testimony by Dr. McNulty.
7 The Plaintiff went to see him a few months after this visit.
8 And Dr. McNulty talked about an MRI that he ordered, that was
9 taken in April 2006. If, hypothetically, Dr. McNulty told the
10 jury that MRIs are not very reliable for determining a
11 traumatic injury to the cervical spine, would you agree or
12 disagree?

13 A I don't know how he can say that, because in our
14 spine center we have neurosurgeons and orthopedic spine
15 surgeons --

16 MR. EGLET: Your Honor, I'm going to object to this
17 question. He's commenting on a spine surgeon's opinion here.

18 THE COURT: Sustain the objection.

19 MR. ROGERS: Okay.

20 BY MR. ROGERS:

21 Q Then the question is can an MRI be used to see a
22 traumatic cervical disc injury?

23 A Yes.

24 Q And is it something you use at UCLA?

25 A Yes. All of the patients that come through that

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1 have neck issues, back issues, any kind of spine issues, the
2 standard for us is to get an MRI of the spine.

3 Q Okay. I'm sorry.

4 A No, go ahead.

5 Q Now you've reviewed the actual films, right?

6 A Yes.

7 Q Is there any evidence of a traumatic cervical disc
8 injury on this March 2006 cervical MRI?

9 A No.

10 Q Are there any abnormalities at all?

11 A Well, he has a large facet. If you have it, we can
12 look at it.

13 Q Yeah.

14 [Counsel Confer]

15 MR. EGLET: Which date?

16 MR. ROGERS: March 22, 2006.

17 BY MR. ROGERS:

18 Q If you would --

19 A Yeah. Can you go to the next one? So what we're
20 going to do is go through what -- the process for me to
21 evaluate an MRI. Okay. This is like a middle picture down
22 the middle of your nose, and you're looking sideways, kind of
23 a sideways view. Okay. You can see the jaw right here. You
24 can see the brain. You can see the spinal cord through here.
25 You can see some nice pictures of the discs in between the

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In the Supreme Court of Nevada

Case Nos. 58504, 59208 and 59423

Electronically Filed
Aug 14 2012 04:08 p.m.
Tracie K. Lindeman
Clerk of Supreme Court

JENNY RISH,

Appellant,

vs.

WILLIAM JAY SIMAO, individually, and
CHERYL ANN SIMAO, individually and as
husband and wife,

Respondents.

APPEAL

from the Eighth Judicial District Court, Clark County
The Honorable JESSIE WALSH, District Judge
District Court Case No. A539455

**APPELLANT'S APPENDIX
VOLUME 8
PAGES 1678-1928**

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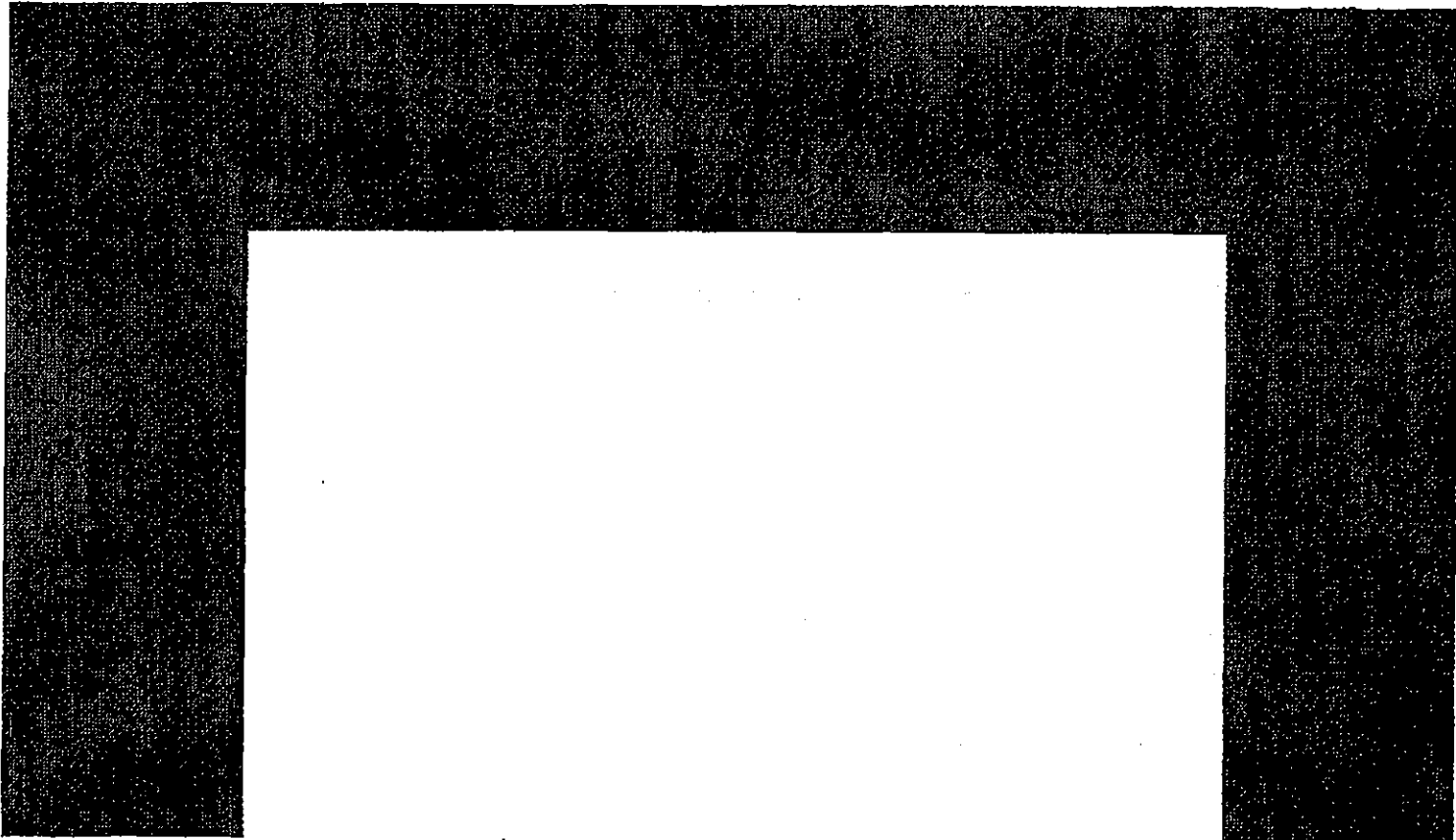
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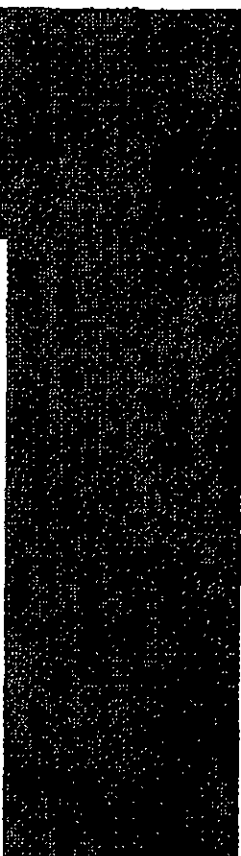
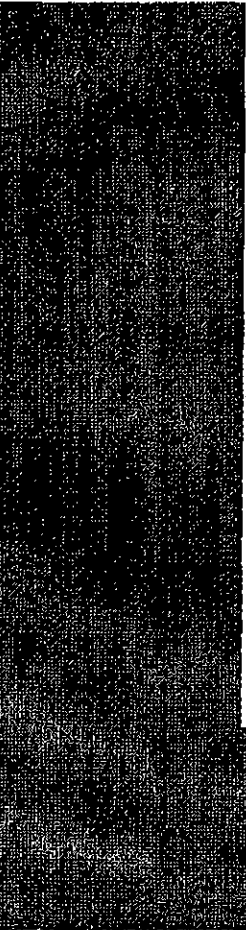
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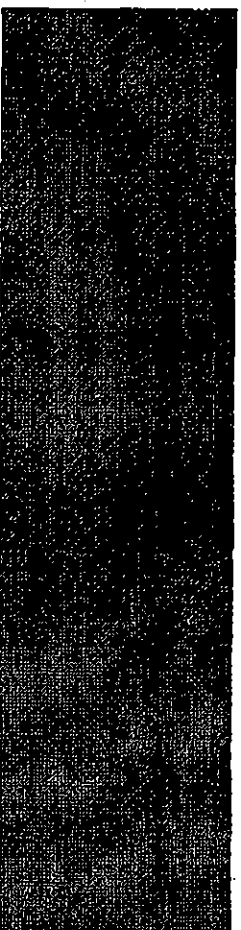
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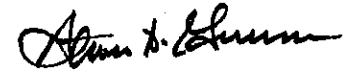


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ROC**ROBERT T. EGLET, ESQ.**

Nevada Bar No. 3402

DAVID T. WALL, ESQ.

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*Attorneys for Plaintiffs***DISTRICT COURT
CLARK COUNTY, NEVADA**WILLIAM JAY SIMAO, individually and
CHERYL ANN SIMAO, individually, and
as husband and wife,

Plaintiffs,

v.

JENNY RISH; JAMES RISH; LINDA
RISH; DOES I through V; and ROE
CORPORATIONS I through V, inclusive,

Defendants.

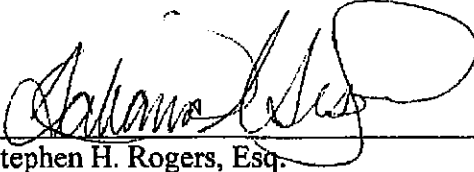
CASE NO.: A539455
DEPT. NO.: X**RECEIPT OF COPY OF PLAINTIFFS'
OPPOSITION TO DEFENDANT'S TRIAL
BRIEF IN SUPPORT OF ORAL MOTION
FOR MISTRIAL**

MAINOR EGLET

001679

RECEIPT OF COPY

RECEIPT OF A COPY OF the foregoing PLAINTIFFS' O PPOSITION TO
DEFENDANT'S TRIAL BRIEF IN SUPPORT OF ORAL MOTION FOR
MISTRIAL in the matter of SIMAO v. RISH; et al, is hereby acknowledged:

Date: 3/18/11 Time: 11am

Stephen H. Rogers, Esq.

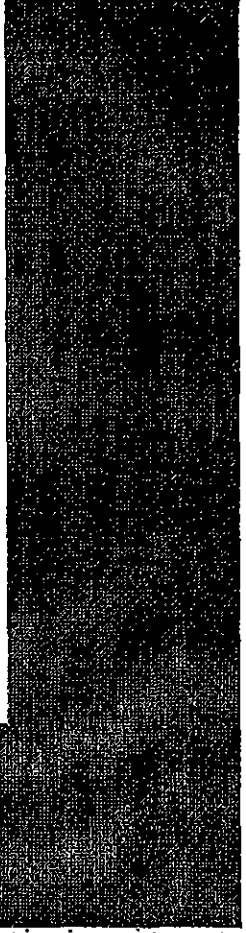
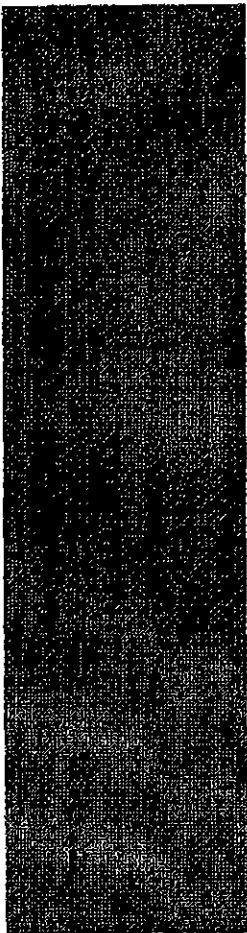
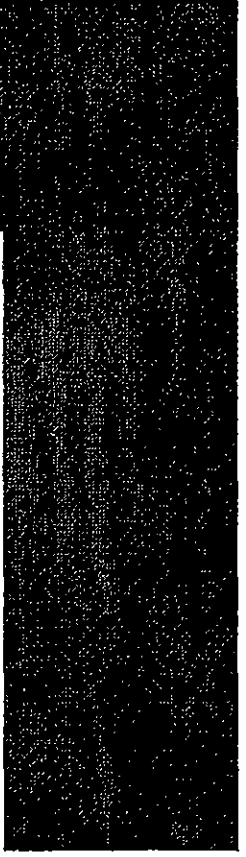
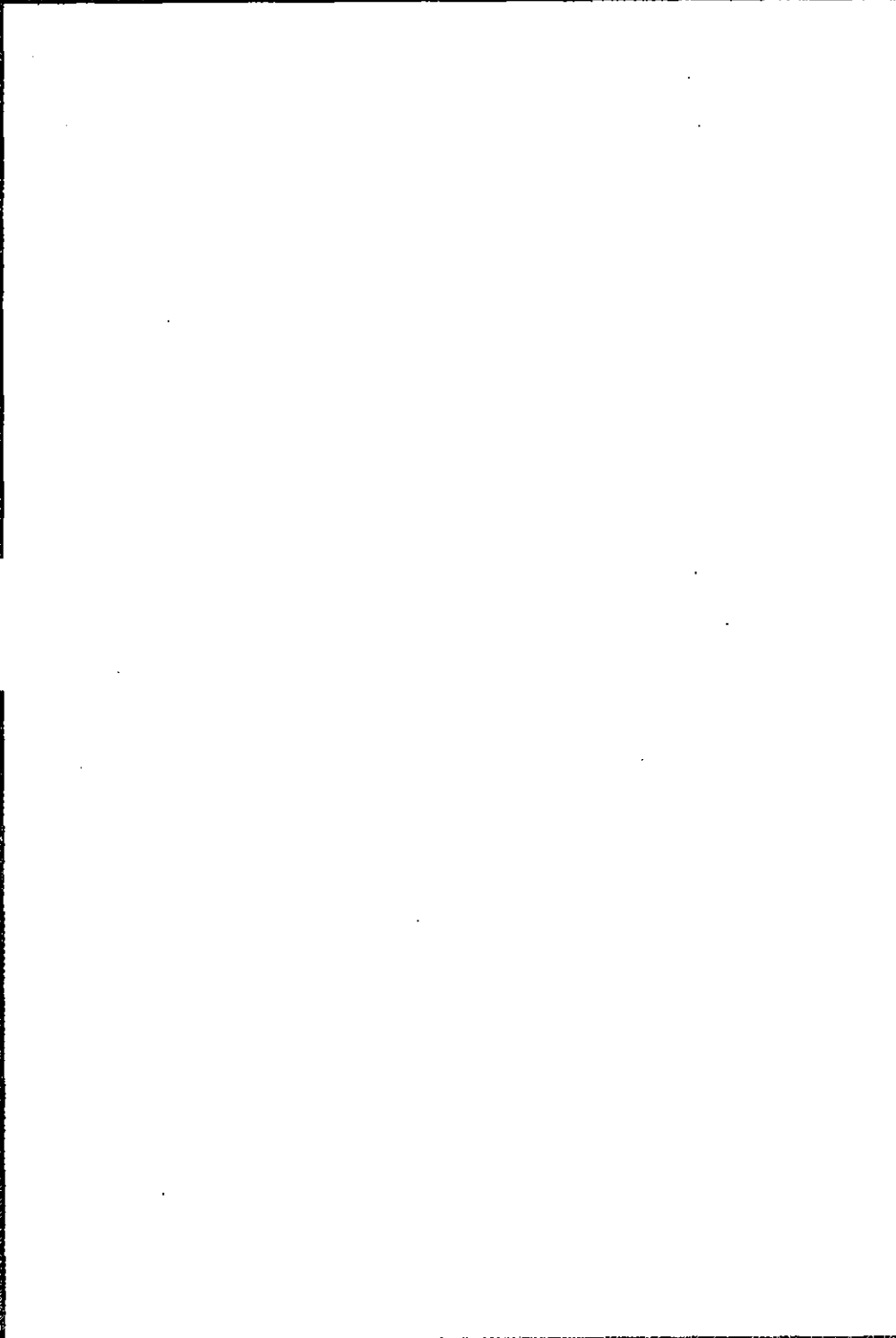
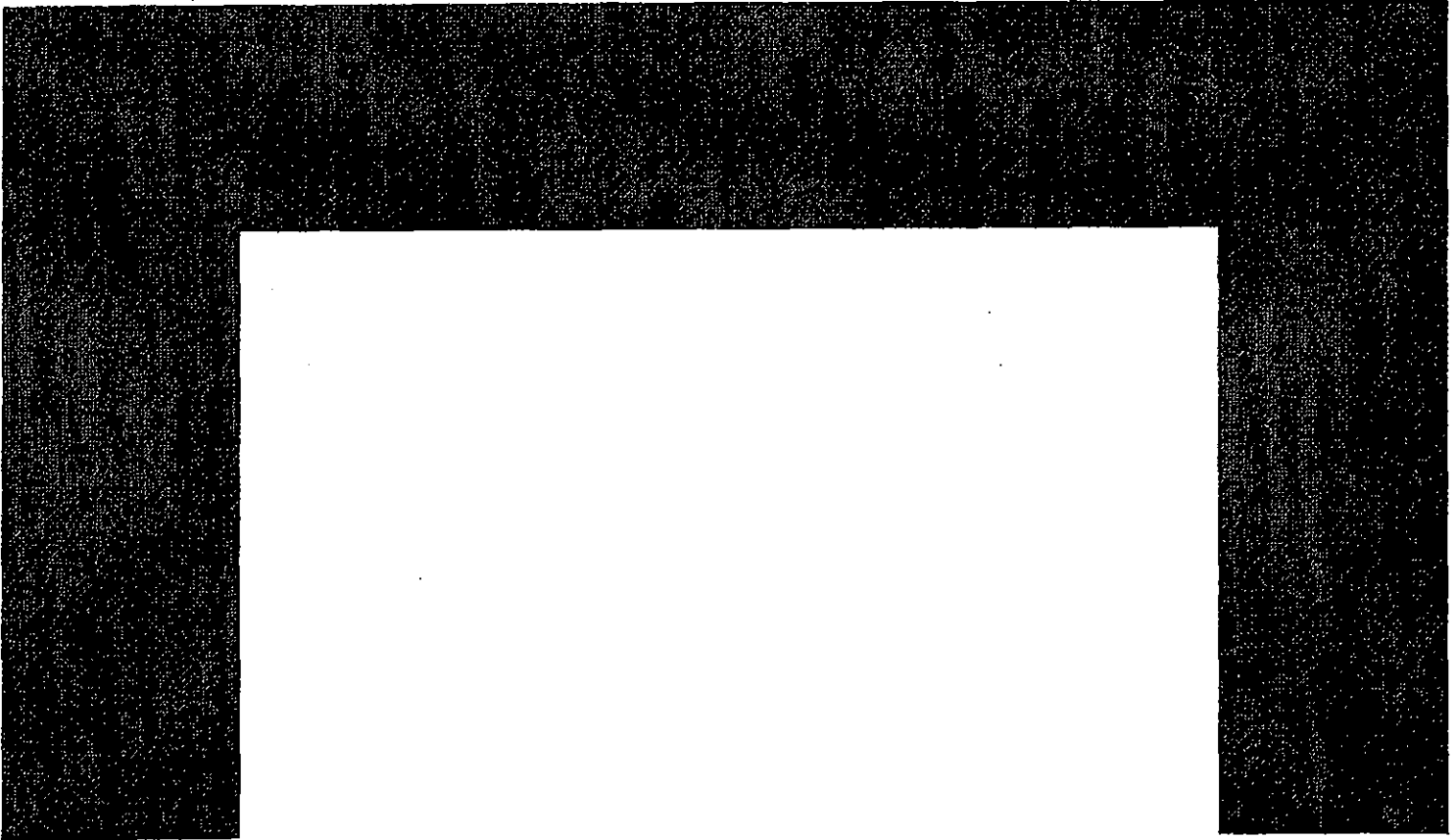
ROGERS, MASTRANGELO, CARVALHO & MITCHELL, LTD.

300 S. Fourth Street, #710

Las Vegas, NV 89101

Attorneys for Defendants

MAINOR EGLET



60

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ORIGINAL

1 **ORDR**
STEPHEN H. ROGERS, ESQ.
2 Nevada Bar No. 5755
ROGERS, MASTRANGELO, CARVALHO & MITCHELL
3 300 South Fourth Street, Suite 710
Las Vegas, Nevada 89101
4 Phone (702) 383-3400
Fax (702) 384-1460
5 *Attorneys for Defendant Jenny Rish*

Alvin D. Quinn

CLERK OF THE COURT

6
7 **DISTRICT COURT**
8 **CLARK COUNTY, NEVADA**

9 WILLIAM JAY SIMAO, individually and
10 CHERYL ANN SIMAO, individually, and as
husband and wife,
11
12 **Plaintiff,**
13 v.
14 JENNY RISH; JAMES RISH; LINDA RISH;
DOES I - V; and ROE CORPORATIONS I - V,
inclusive,
15
16 **Defendants.**

CASE NO. A539455
DEPT. NO X

17 **ORDER GRANTING MOTION TO EXCLUDE TRAFFIC ACCIDENT REPORT AND**
18 **INVESTIGATING OFFICER'S CONCLUSIONS**

19 This matter having come on regularly for hearing before the Court on February 15, 2011,
20 Stephen H. Rogers, Esq. of the law firm of Rogers, Mastrangelo, Carvalho & Mitchell appearing
21 on behalf of Defendant Jenny Rish; and David T. Wall, Esq., of the law firm of Mainor Eglet
22 appearing on behalf of Plaintiffs; and the Court having entertained the respective arguments of
23 counsel as well as being fully apprised of all the papers and pleadings on file with respect Jenny
24 Rish's Motion to Exclude Traffic Accident Report and Investigating Officer's Conclusions, and
25 good cause appearing:

26

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1 IT IS HEREBY ORDERED, ADJUDGED AND DECREED that:

2 1. Defendant Jenny Rish's Motion to Exclude Traffic Accident Report and
3 Investigating Officer's Conclusions is GRANTED.

4
5 IT IS SO ORDERED.

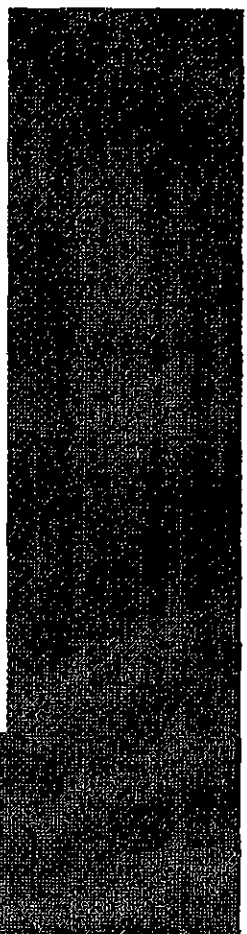
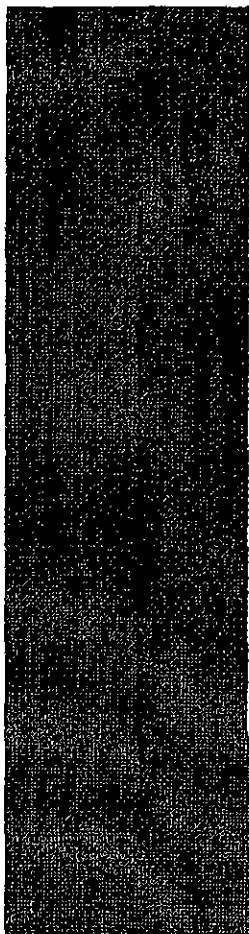
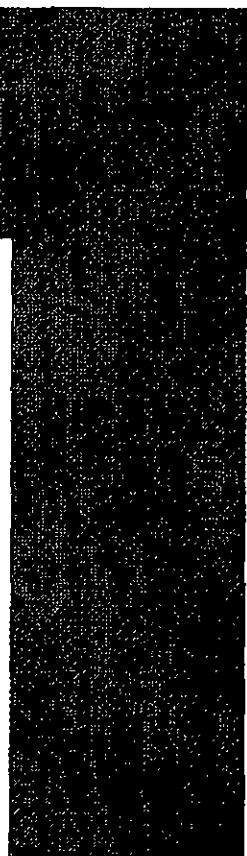
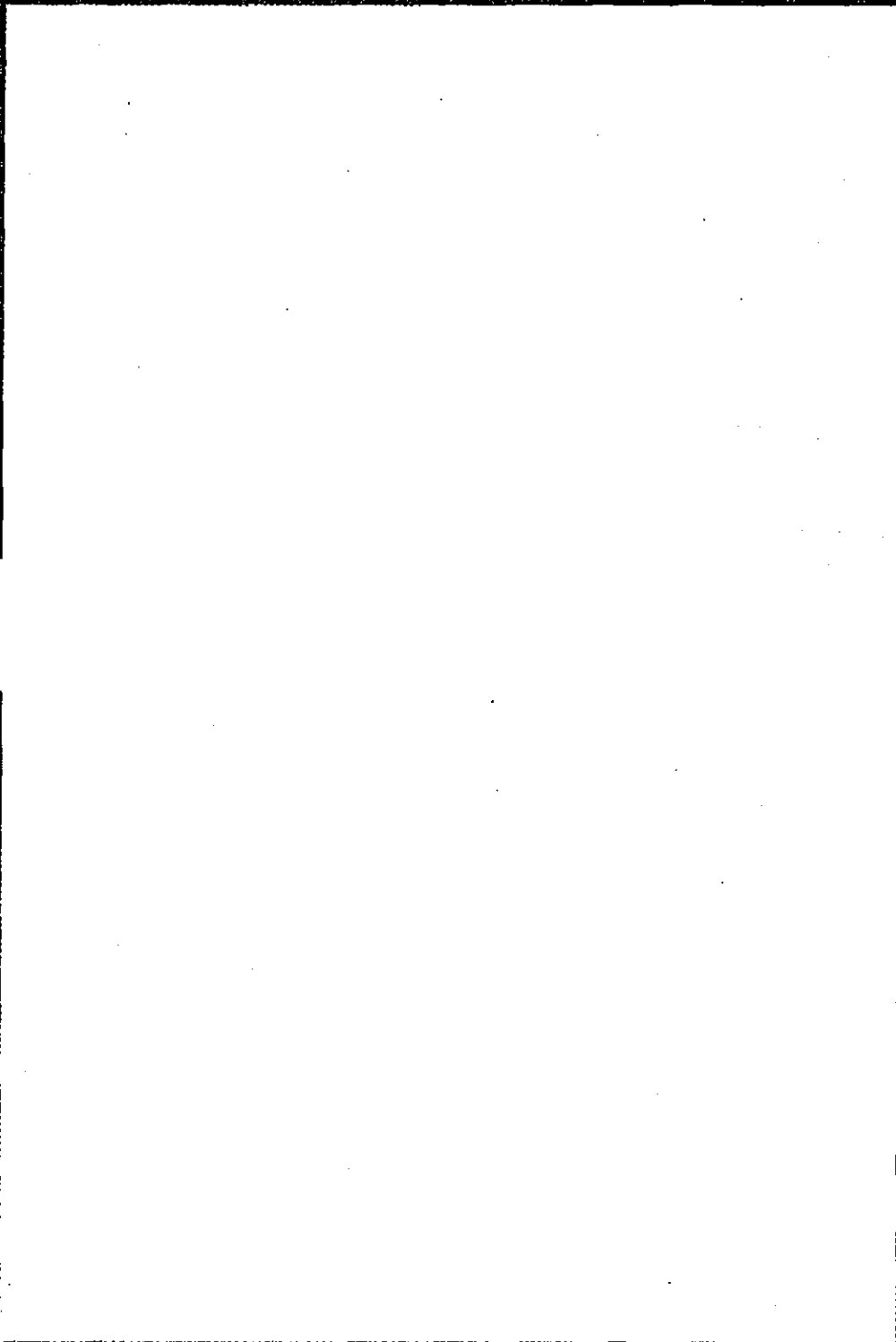
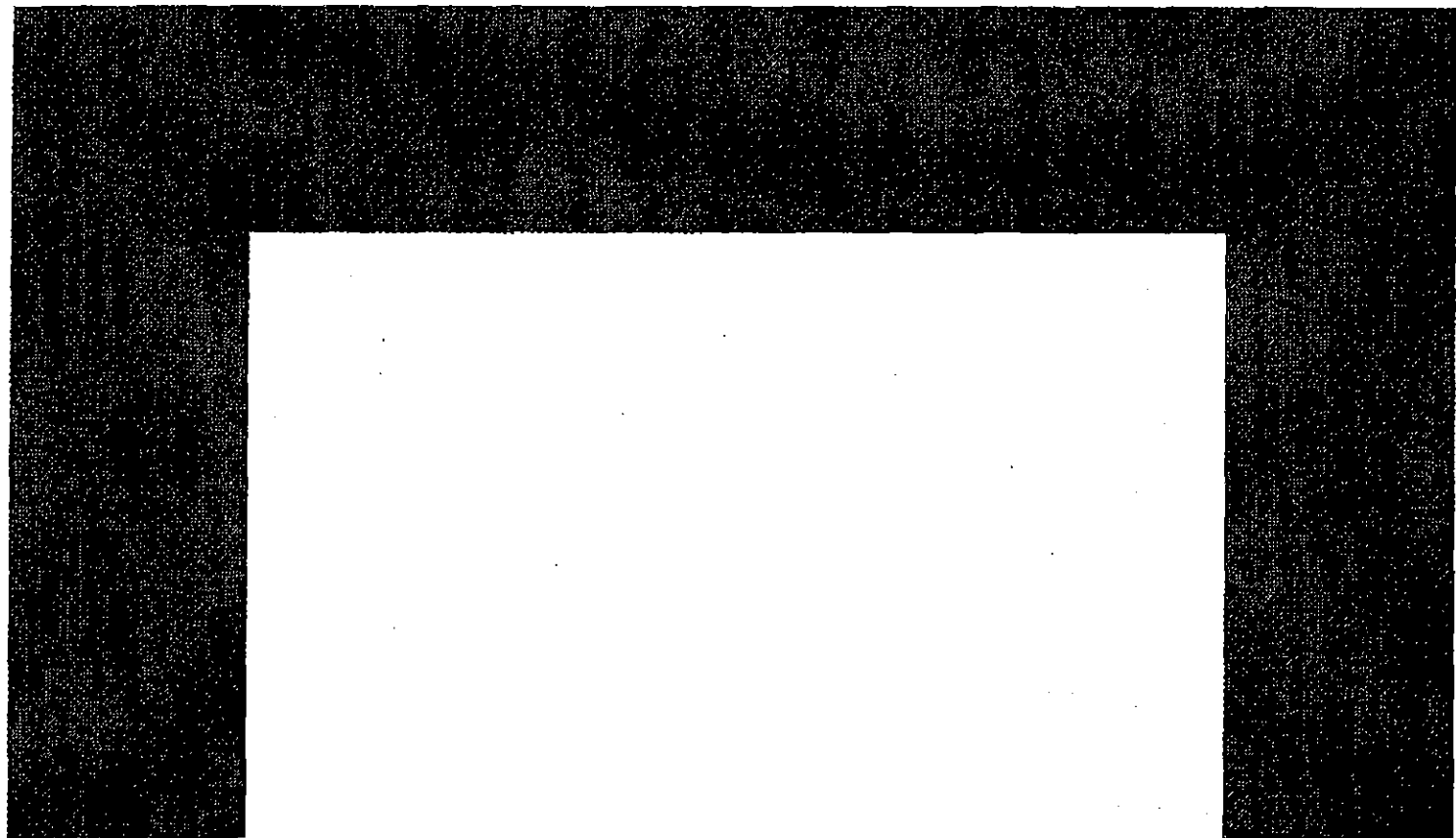
6 Dated: 16 Mar 2011

Jessie Walsh
7 The Honorable Jessie Walsh
District Court Judge

8 Submitted by:

9 ROGERS, MASTRANGELO, CARVALHO & MITCHELL
10
11

12 Stephen H. Rogers, Esq.
Nevada Bar No. 5755
13 300 South Fourth Street, Suite 710
Las Vegas, Nevada 89101
14 Telephone: (702) 383-3400
Facsimile: 702-384-1460
15 Attorneys for Defendant Jenny Rish



61

61

1 **ORDR**

2 **ROBERT T. EGLET, ESQ.**

3 Nevada Bar No. 3402

4 **DAVID T. WALL, ESQ.**

5 Nevada Bar No. 2805

6 **BRADLEY J. MYERS, ESQ.**

7 Nevada Bar No. 8857

8 **MAINOR EGLET**

9 400 South Fourth Street, Suite 600

10 Las Vegas, Nevada 89101

11 Ph: (702) 450-5400

12 Fx: (702) 450-5451

13 dwall@mainorlawyers.com

14 **MATTHEW E. AARON, ESQ.**

15 Nevada Bar No. 4900

16 **AARON & PATERNOSTER, LTD.**

17 2300 West Sahara Avenue, Ste.650

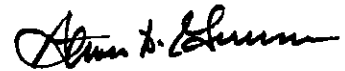
18 Las Vegas, Nevada 89102

19 Ph.: (702) 384-4111

20 Fx.: (702) 384-8222

21 *Attorneys for Plaintiffs*

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CLERK OF THE COURT

22 **DISTRICT COURT**

23 **CLARK COUNTY, NEVADA**

24 WILLIAM JAY SIMAO, individually and
25 CHERYL ANN SIMAO, individually, and as
26 husband and wife,

27 Plaintiffs,

28 v.

JENNY RISH; JAMES RISH; LINDA RISH;
DOES I through V; and ROE CORPORATIONS I
through V, inclusive,

Defendants.

CASE NO.: A539455

DEPT. NO.: X

ORDER REGARDING PLAINTIFFS'
SECOND OMNIBUS MOTION IN
LIMINE

This Honorable Court, having read the pleadings and papers on file herein regarding the

MAJOR EGLET

001685

1 Plaintiffs' Second Omnibus Motion in Limine, the parties appearing before the Court on March
2 8, 2011 for hearing, and good cause appearing therefore, the Court rules upon the Plaintiffs'
3 Motion as follows:

4 **IT IS HEREBY ORDERED** that Plaintiffs' request to exclude Plaintiffs' prior and
5 subsequent unrelated accidents, injuries and medical conditions and prior and subsequent claims
6 or lawsuits is hereby **GRANTED in part and DENIED in part**. Any and all evidence relating
7 to Plaintiffs' lawsuit concerning their home is excluded. However, William's diagnosis of a non-
8 cancerous tumor may be admitted for the limited purpose to show emotional distress.
9

10 **IT IS FURTHER ORDERED** that Plaintiffs' request to exclude hypothetical medical
11 conditions is hereby **GRANTED** as written.
12

13 **IT IS FURTHER ORDERED** that Plaintiffs' request to exclude evidence of the
14 absence of medical records for any period of time prior to the accident is hereby **GRANTED**.
15

16 **IT IS FURTHER ORDERED** that Plaintiffs' request to exclude any reference to an
17 alleged federal grand jury investigation into doctors and lawyers in Las Vegas is hereby
18 **GRANTED**.
19

20 **IT IS FURTHER ORDERED** that Plaintiffs' request to exclude reference to attorney
21 advertising is hereby **GRANTED**. However, if during voir dire members of the venire volunteer
22 information on the subject of attorney advertising based upon questions in the Jury
23

24 ///

25 ///

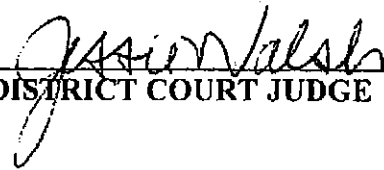
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1 Questionnaire, the subject of attorney advertising may be inquired into during voir dire.

2 DATED this 22 day of March, 2011.

3
4 
5 DISTRICT COURT JUDGE g
6

7 Respectfully submitted by:

8 **MAINOR EGLET**

9
10 
11 BRADLEY J. MYERS, ESQ.

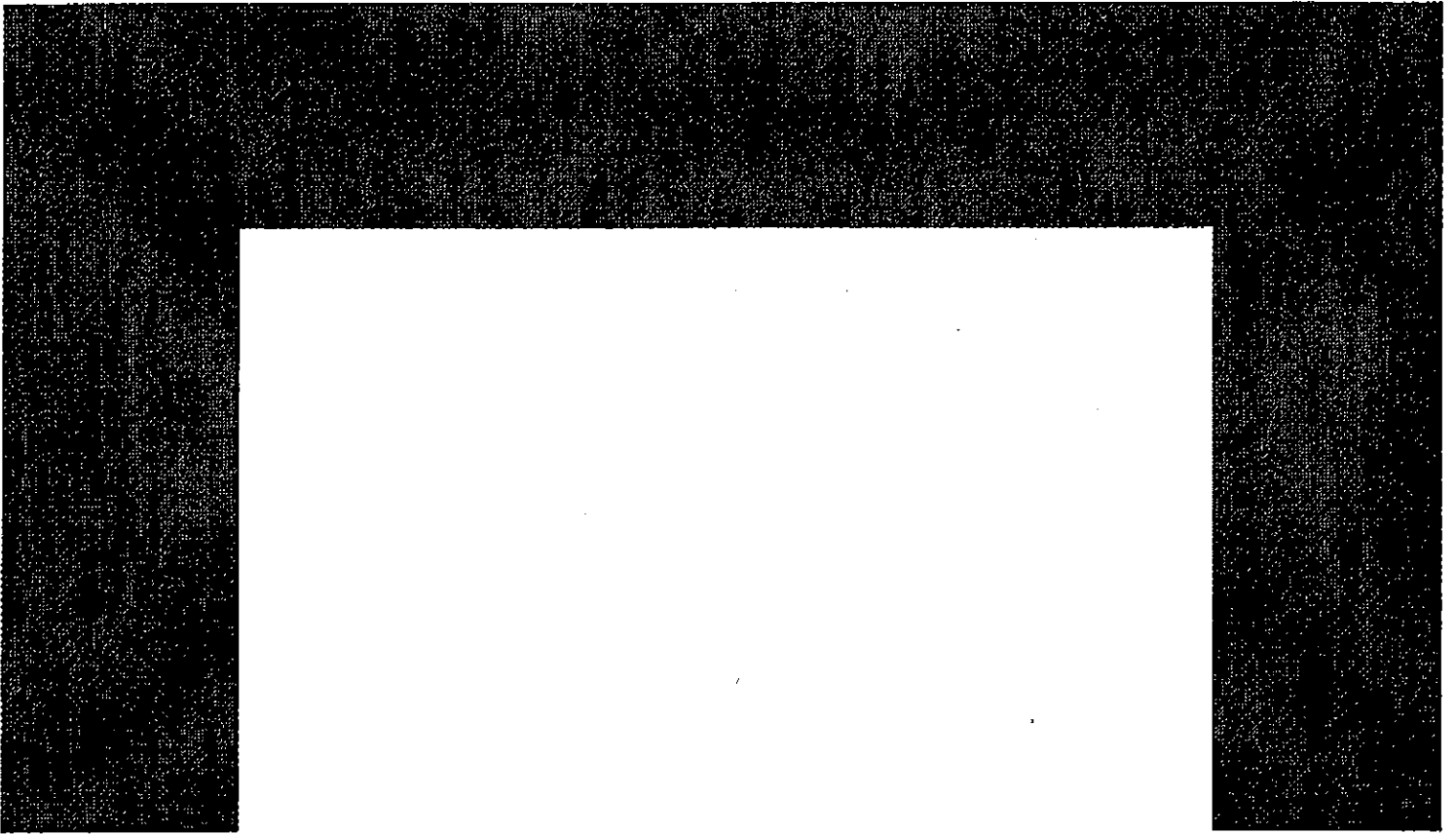
12 Nevada Bar No. 8857

13 400 South Fourth Street, Suite 600

14 Las Vegas, Nevada 89101

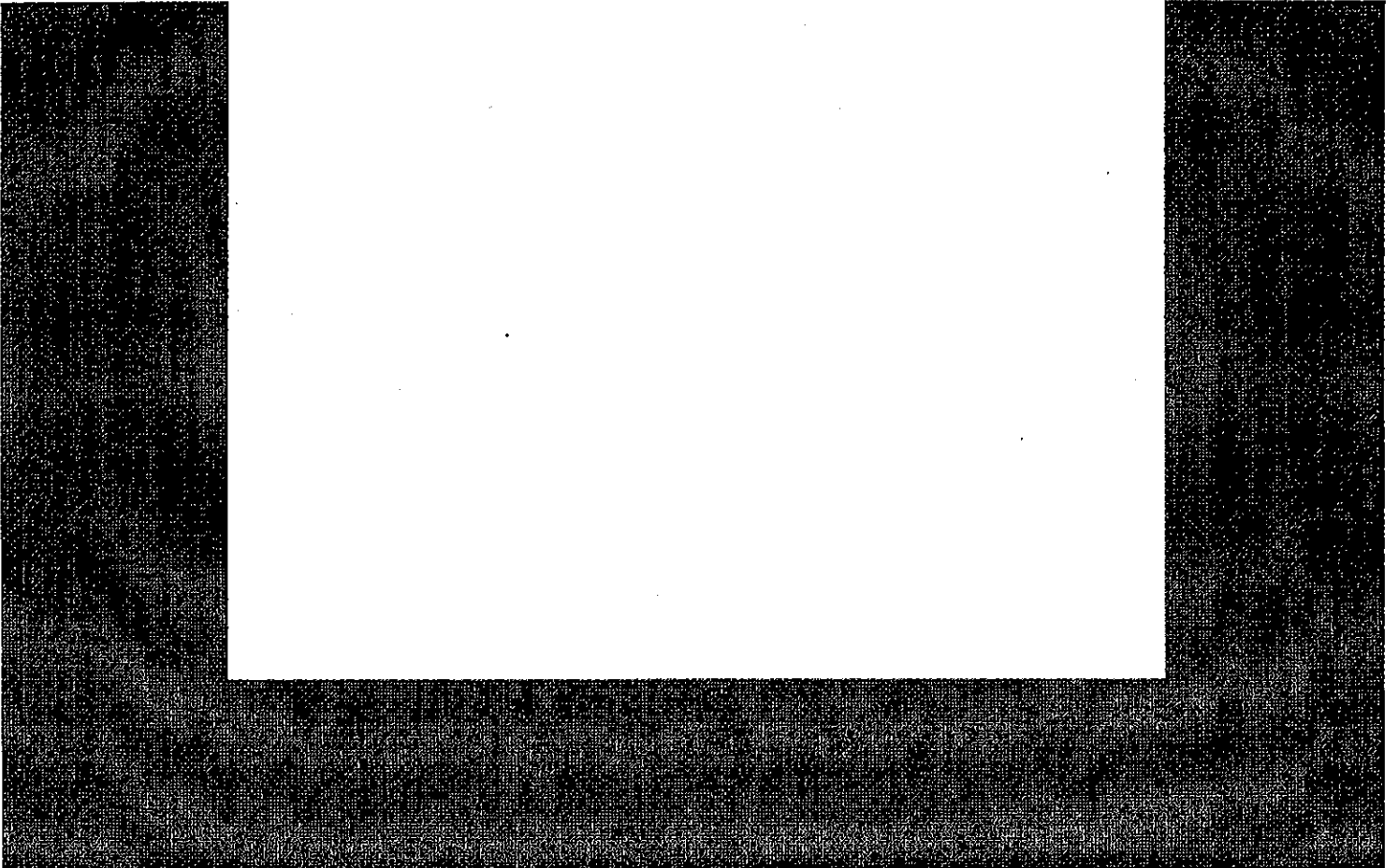
15 *Attorney for Plaintiffs*
16
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MAINOR EGLET



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ORIGINAL

Alvin D. Quinn

CLERK OF THE COURT

1 **ORDR**
2 STEPHEN H. ROGERS, ESQ.
3 Nevada Bar No. 5755
4 ROGERS, MASTRANGELO, CARVALHO & MITCHELL
5 300 South Fourth Street, Suite 710
6 Las Vegas, Nevada 89101
7 Phone (702) 383-3400
8 Fax (702) 384-1460
9 *Attorneys for Defendant Jenny Rish*

DISTRICT COURT

CLARK COUNTY, NEVADA

10 WILLIAM JAY SIMAO, individually and)
11 CHERYL ANN SIMAO, individually, and as)
12 husband and wife,)
13)
14 Plaintiff,)
15)
16 v.)
17)
18 JENNY RISH; JAMES RISH; LINDA RISH;)
19 DOES I - V; and ROE CORPORATIONS I - V,)
20 inclusive,)
21)
22 Defendants.)

CASE NO. A539455
DEPT. NO X

**ORDER GRANTING MOTION TO EXCLUDE LIFE CARE
EXPERT, KATHLEEN HARTMANN, R.N.**

23 This matter having come on regularly for hearing before the Court on February 15, 2011,
24 Stephen H. Rogers, Esq. of the law firm of Rogers, Mastrangelo, Carvalho & Mitchell appearing
25 on behalf of Defendant Jenny Rish; and David T. Wall, Esq., of the law firm of Mainor Eglet
26 appearing on behalf of Plaintiffs; and the Court having entertained the respective arguments of
27 counsel as well as being fully apprised of all the papers and pleadings on file with respect Jenny
28 Rish's Motion to Exclude Life Care Expert, Kathleen Hartmann, R.N., and good cause appearing:

25

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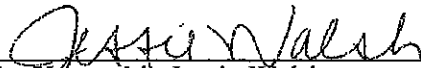
28

1 IT IS HEREBY ORDERED, ADJUDGED AND DECREED that:

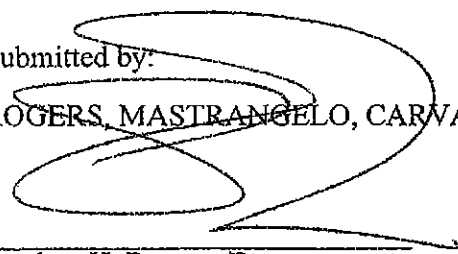
2 1. Defendant Jenny Rish's Motion to Exclude Life Care Expert, Kathleen Hartman,
3 R.N. is DENIED, but the Plaintiff must provide foundation before Ms. Hartmann will be
4 permitted to offer expert testimony

5
6 IT IS SO ORDERED.

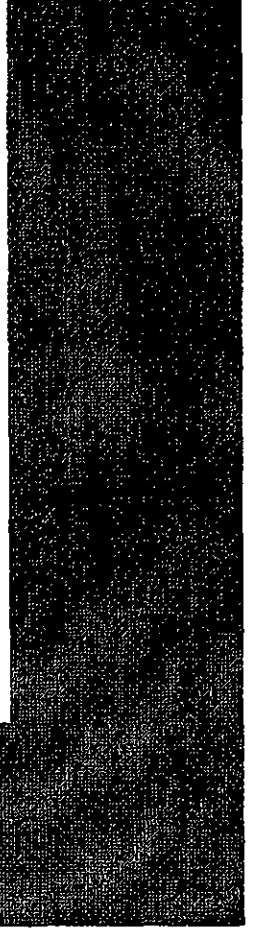
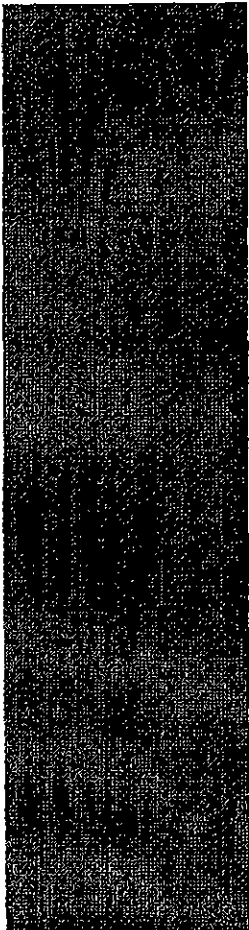
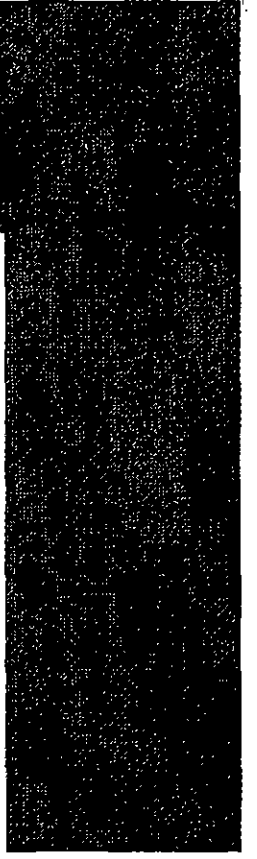
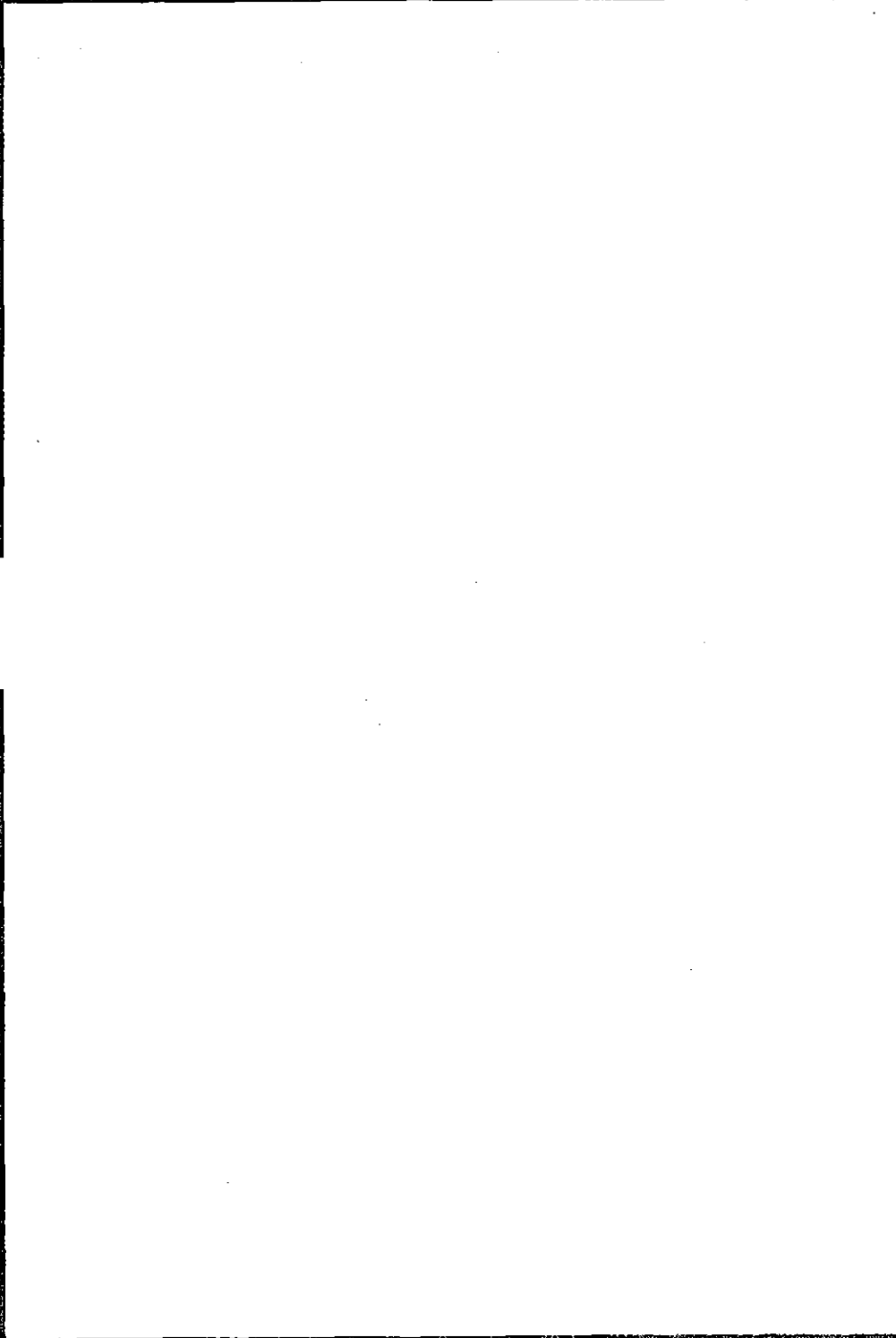
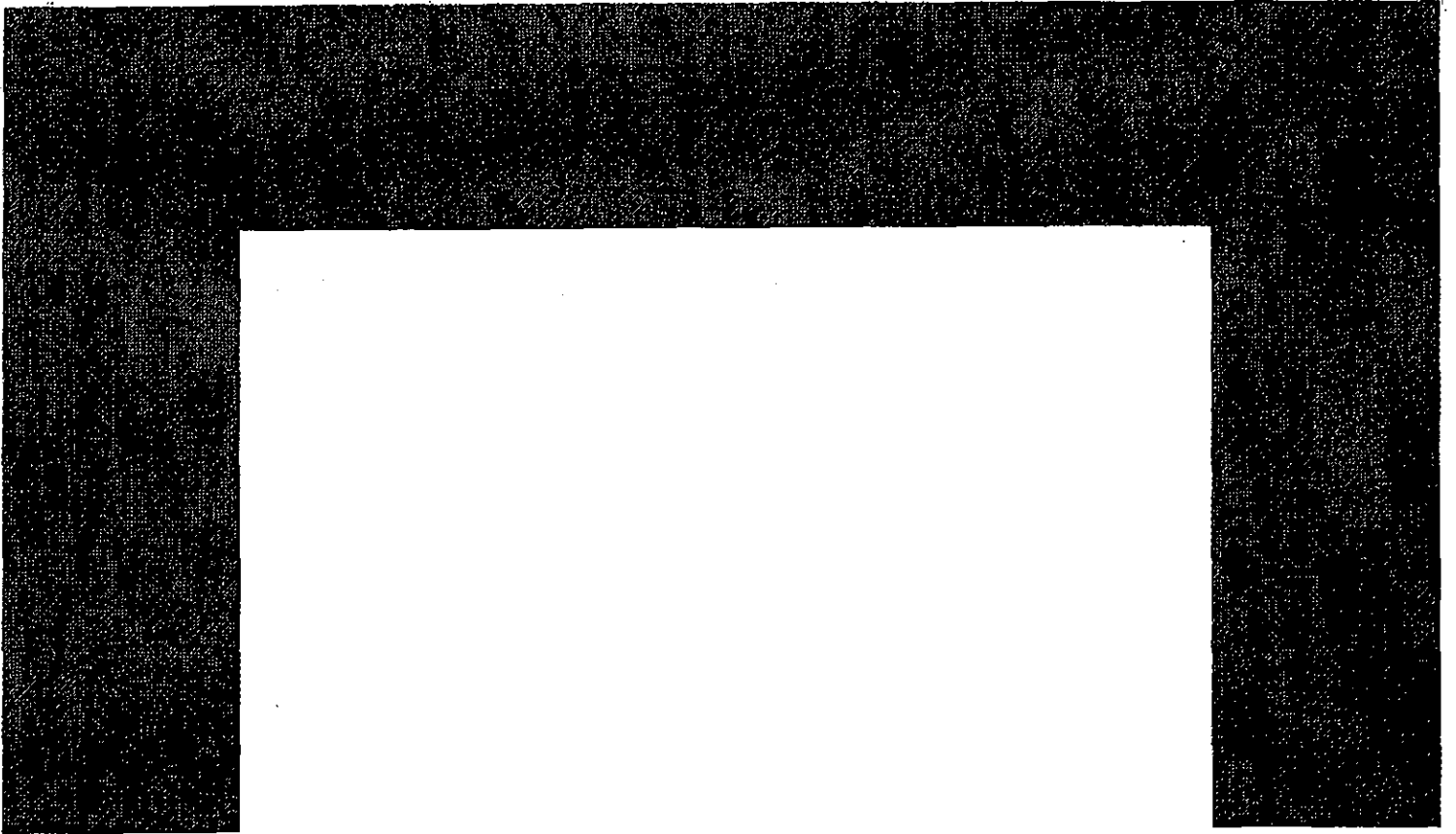
7 Dated: 21 Mar 2011


8 The Honorable Jessie Walsh
9 District Court Judge

10 Submitted by:

11 
12 ROGERS, MASTRANGELO, CARVALHO & MITCHELL

13 Stephen H. Rogers, Esq.
14 Nevada Bar No. 5755
15 300 South Fourth Street, Suite 710
16 Las Vegas, Nevada 89101
17 Telephone: (702) 383-3400
18 Facsimile: 702-384-1460
19 Attorneys for Defendant Jenny Rish



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ORIGINAL

Electronically Filed
03/22/2011 02:43:27 PM1 **ORDR**

2 STEPHEN H. ROGERS, ESQ.

3 Nevada Bar No. 5755

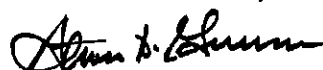
4 ROGERS, MASTRANGELO, CARVALHO & MITCHELL

5 300 South Fourth Street, Suite 710

6 Las Vegas, Nevada 89101

7 Phone (702) 383-3400

8 Fax (702) 384-1460

9 *Attorneys for Defendant Jenny Rish*

CLERK OF THE COURT

DISTRICT COURT

CLARK COUNTY, NEVADA

10 WILLIAM JAY SIMAO, individually and
11 CHERYL ANN SIMAO, individually, and as
12 husband and wife,

Plaintiff,

v.

13 JENNY RISH; JAMES RISH; LINDA RISH;
14 DOES I - V; and ROE CORPORATIONS I - V,
15 inclusive,

Defendants.

CASE NO. A539455
DEPT. NO X**ORDER GRANTING MOTION TO EXCLUDE WITNESSES FROM TESTIFYING
REGARDING THE CREDIBILITY OR VERACITY OF OTHER WITNESSES**

19 This matter having come on regularly for hearing before the Court on February 15, 2011,
20 Stephen H. Rogers, Esq. of the law firm of Rogers, Mastrangelo, Carvalho & Mitchell appearing
21 on behalf of Defendant Jenny Rish; and David T. Wall, Esq.. of the law firm of Mainor Eglet
22 appearing on behalf of Plaintiffs; and the Court having entertained the respective arguments of
23 counsel as well as being fully apprised of all the papers and pleadings on file with respect Jenny
24 Rish's Motion to Exclude Witnesses from Testifying Regarding the Credibility or Veracity of
25 Other Witnesses, and good cause appearing:

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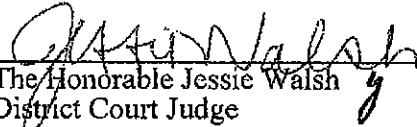
28

1 IT IS HEREBY ORDERED, ADJUDGED AND DECREED that:

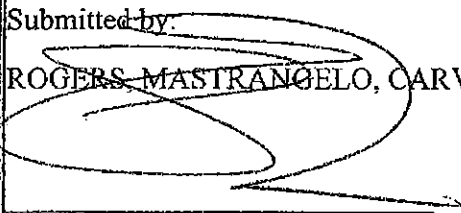
2 1. Defendant Jenny Rish's Motion to Exclude Witnesses from Testifying Regarding
3 the Credibility or Veracity of Other Witnesses is GRANTED.

4
5 IT IS SO ORDERED.

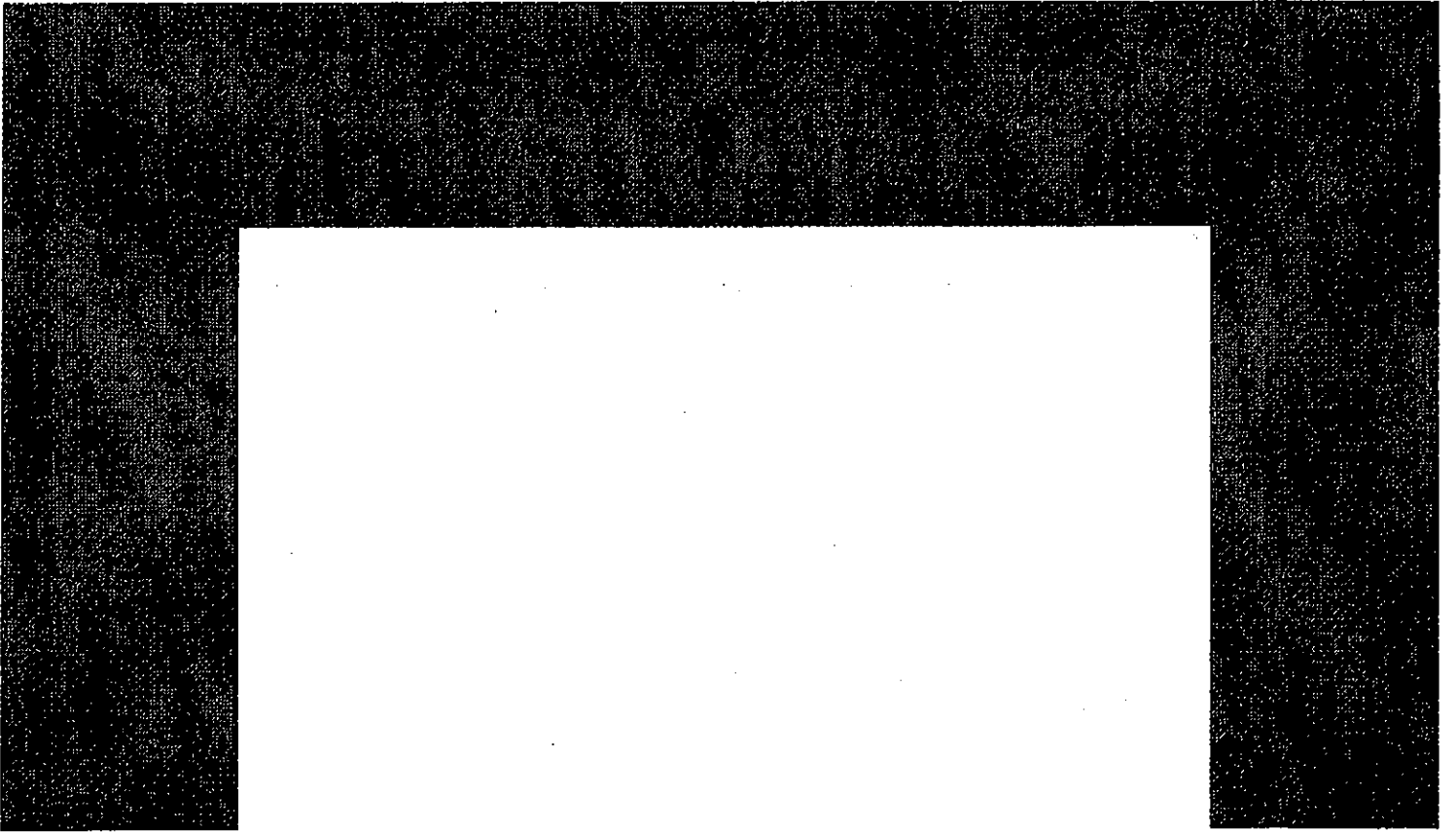
6 Dated: Mar 21, 2011


The Honorable Jessie Walsh
District Court Judge

8 Submitted by:

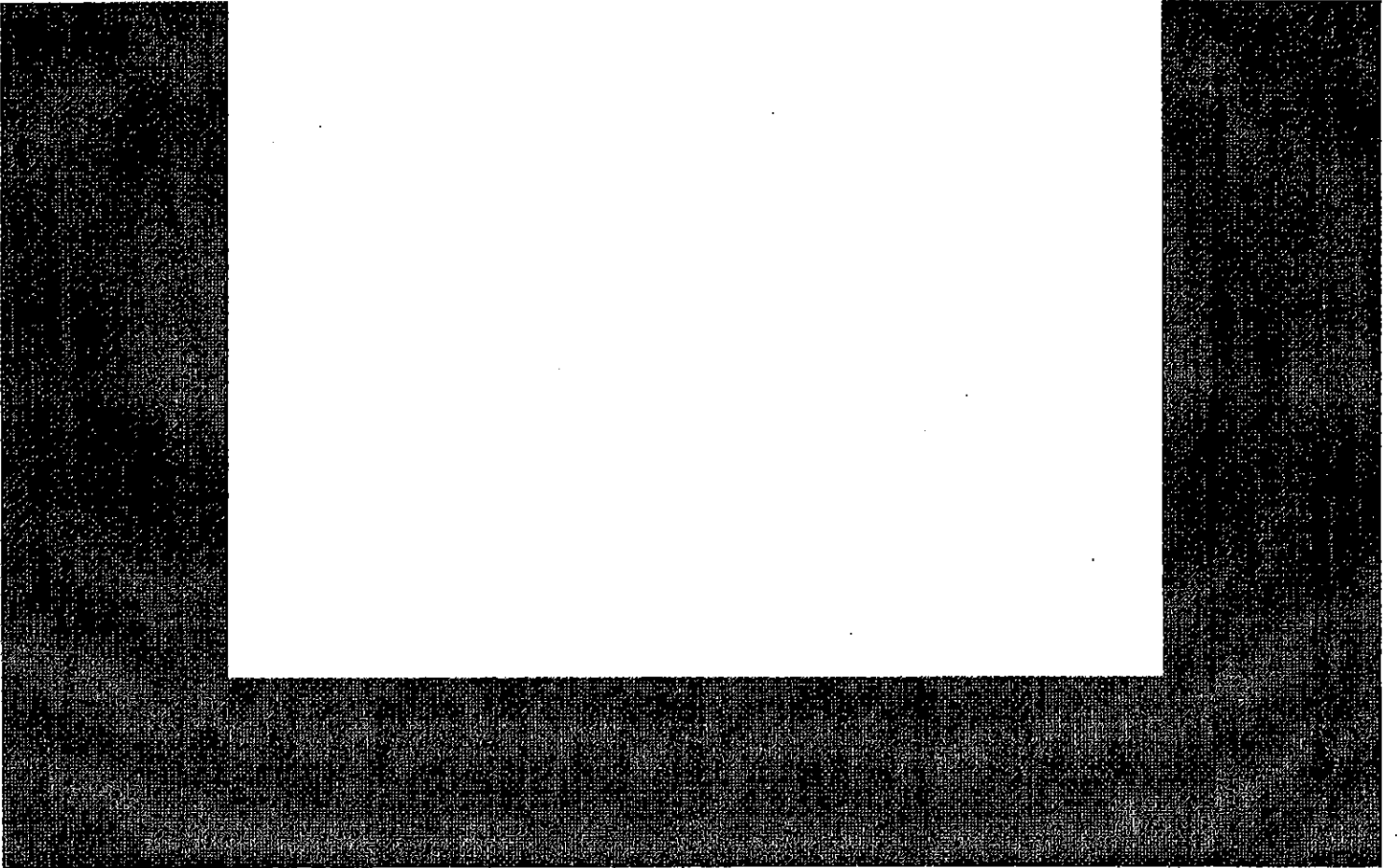
9 
10 ROGERS, MASTRANGELO, CARVALHO & MITCHELL

11
12 Stephen H. Rogers, Esq.
Nevada Bar No. 5755
13 300 South Fourth Street, Suite 710
Las Vegas, Nevada 89101
14 Telephone: (702) 383-3400
Facsimile: 702-384-1460
15 Attorneys for Defendant Jenny Rish



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ORIGINAL

Alvin D. Shuman

CLERK OF THE COURT

1 **ORDR**
2 STEPHEN H. ROGERS, ESQ.
3 Nevada Bar No. 5755
4 ROGERS, MASTRANGELO, CARVALHO & MITCHELL
5 300 South Fourth Street, Suite 710
6 Las Vegas, Nevada 89101
7 Phone (702) 383-3400
8 Fax (702) 384-1460
9 Attorneys for Defendant Jenny Rish

DISTRICT COURT

CLARK COUNTY, NEVADA

9 WILLIAM JAY SIMAO, individually and)
10 CHERYL ANN SIMAO, individually, and as)
11 husband and wife,)
12)
13 Plaintiff,)
14)
15 v.)
16)
17 JENNY RISH; JAMES RISH; LINDA RISH;)
18 DOES I - V; and ROE CORPORATIONS I - V,)
19 inclusive,)
20)
21 Defendants.)

CASE NO. A539455
DEPT. NO X

**ORDER GRANTING MOTION TO EXCLUDE GRAPHIC
AND LURID VIDEO OF SURGERY**

22 This matter having come on regularly for hearing before the Court on February 15, 2011,
23 Stephen H. Rogers, Esq. of the law firm of Rogers, Mastrangelo, Carvalho & Mitchell appearing
24 on behalf of Defendant Jenny Rish; and David T. Wall, Esq.. of the law firm of Mainor Eglet
25 appearing on behalf of Plaintiffs; and the Court having entertained the respective arguments of
26 counsel as well as being fully apprised of all the papers and pleadings on file with respect Jenny
27 Rish's Motion to Exclude Graphic and Lurid Video of Surgery, and good cause appearing:
28

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.....

1 IT IS HEREBY ORDERED, ADJUDGED AND DECREED that:

2 1. Defendant Jenny Rish's Motion to Exclude Graphic and Lurid Video of Surgery is
3 GRANTED "as to blood," but DENIED "as to non-bloody photos or animation."
4

5 IT IS SO ORDERED.

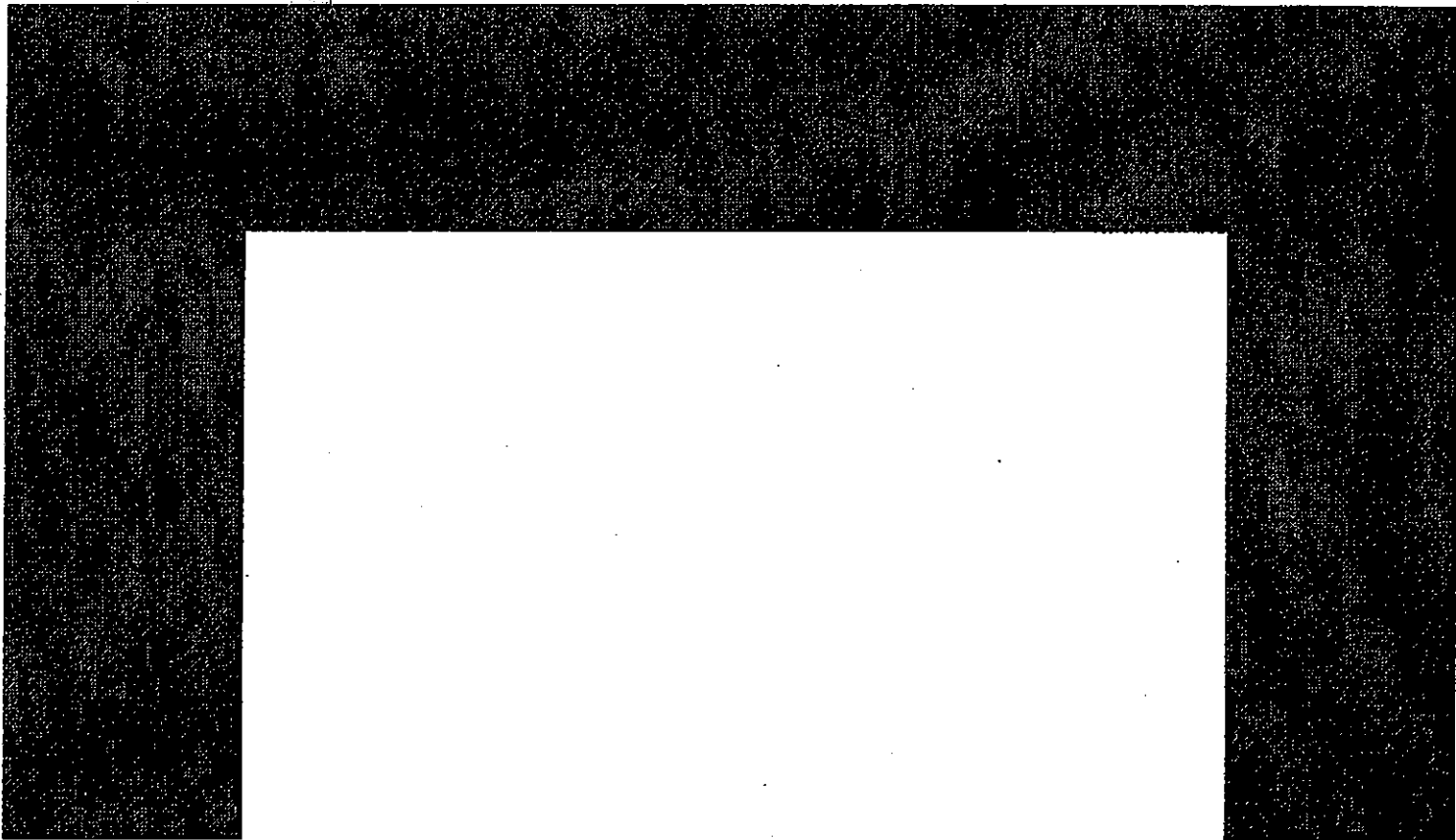
6 Dated: 22 Mar 2011

Jessie Walsh
7 The Honorable Jessie Walsh
8 District Court Judge

9 Submitted by:

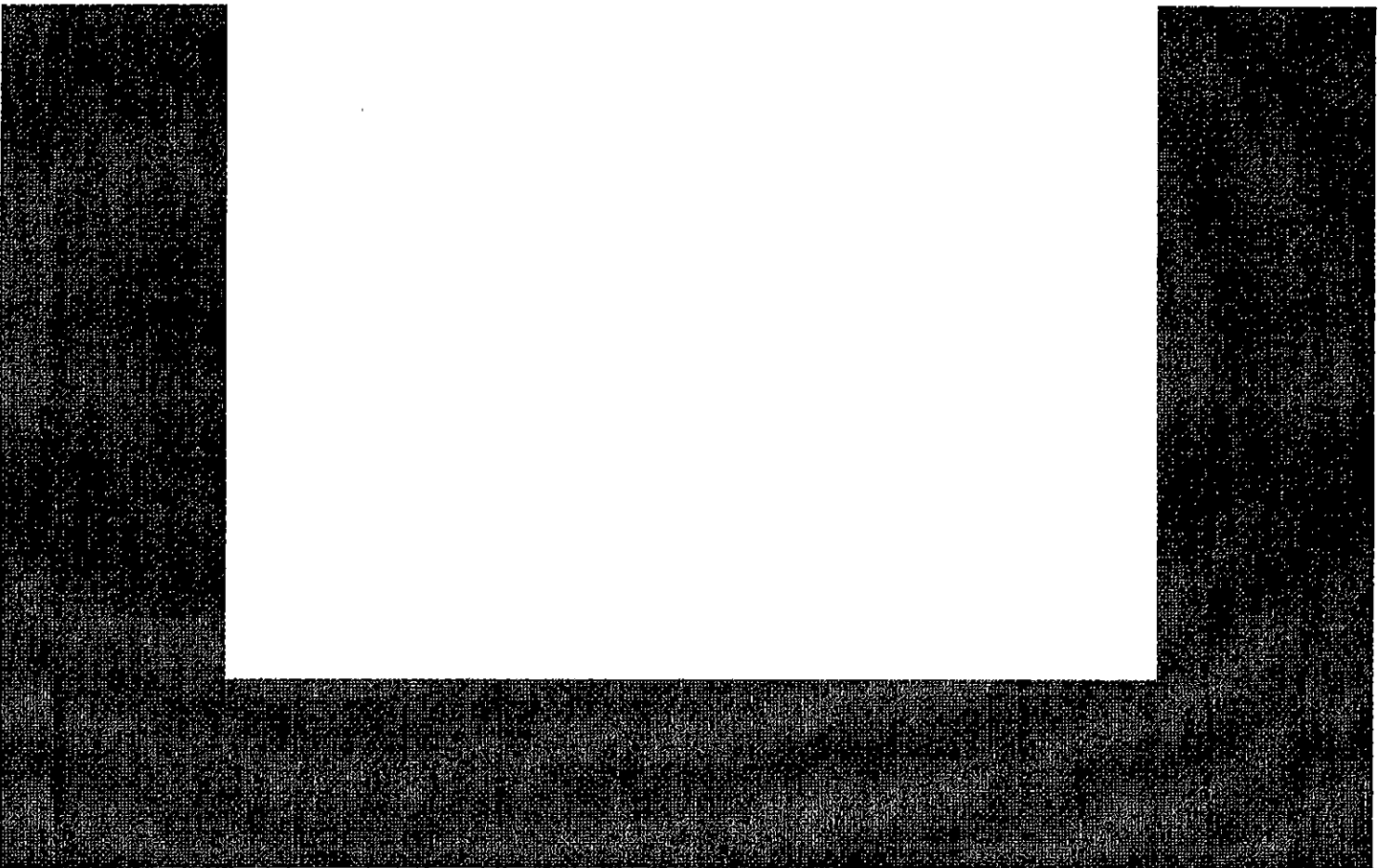
10 ROGERS, MASTRANGELO, CARVALHO & MITCHELL
11

12 Stephen H. Rogers, Esq.
13 Nevada Bar No. 5755
14 300 South Fourth Street, Suite 710
15 Las Vegas, Nevada 89101
16 Telephone: (702) 383-3400
17 Facsimile: 702-384-1460
18 Attorneys for Defendant Jenny Rish
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ORIGINAL

Alvin D. Schuman

CLERK OF THE COURT

1 **ORDER**
2 STEPHEN H. ROGERS, ESQ.
3 Nevada Bar No. 5755
4 ROGERS, MASTRANGELO, CARVALHO & MITCHELL
5 300 South Fourth Street, Suite 710
6 Las Vegas, Nevada 89101
7 Phone (702) 383-3400
8 Fax (702) 384-1460
9 *Attorneys for Defendant Jenny Rish*

DISTRICT COURT

CLARK COUNTY, NEVADA

9 WILLIAM JAY SIMAO, individually and)
10 CHERYL ANN SIMAO, individually, and as)
11 husband and wife,)
12)
13 Plaintiff,)
14 v.)
15 JENNY RISH; JAMES RISH; LINDA RISH;)
16 DOES I - V; and ROE CORPORATIONS I - V,)
17 inclusive,)
18 Defendants.)

CASE NO. A539455
DEPT. NO X

**ORDER GRANTING MOTION TO EXCLUDE DUPLICATIVE
AND CUMULATIVE TESTIMONY**

19 This matter having come on regularly for hearing before the Court on February 15, 2011,
20 Stephen H. Rogers, Esq. of the law firm of Rogers, Mastrangelo, Carvalho & Mitchell appearing
21 on behalf of Defendant Jenny Rish; and David T. Wall, Esq.. of the law firm of Mainor Eglet
22 appearing on behalf of Plaintiffs; and the Court having entertained the respective arguments of
23 counsel as well as being fully apprised of all the papers and pleadings on file with respect Jenny
24 Rish's Motion to Exclude Duplicative and Cumulative Testimony, and good cause appearing:

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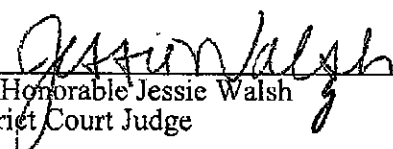
28

1 IT IS HEREBY ORDERED, ADJUDGED AND DECREED that:

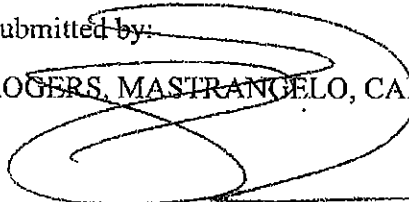
2 1. Defendant Jenny Rish's Motion to Exclude Duplicative and Cumulative Testimony
3 is DENIED "as Written," but the defense may object if the testimony becomes duplicative or
4 cumulative.

5
6 IT IS SO ORDERED.

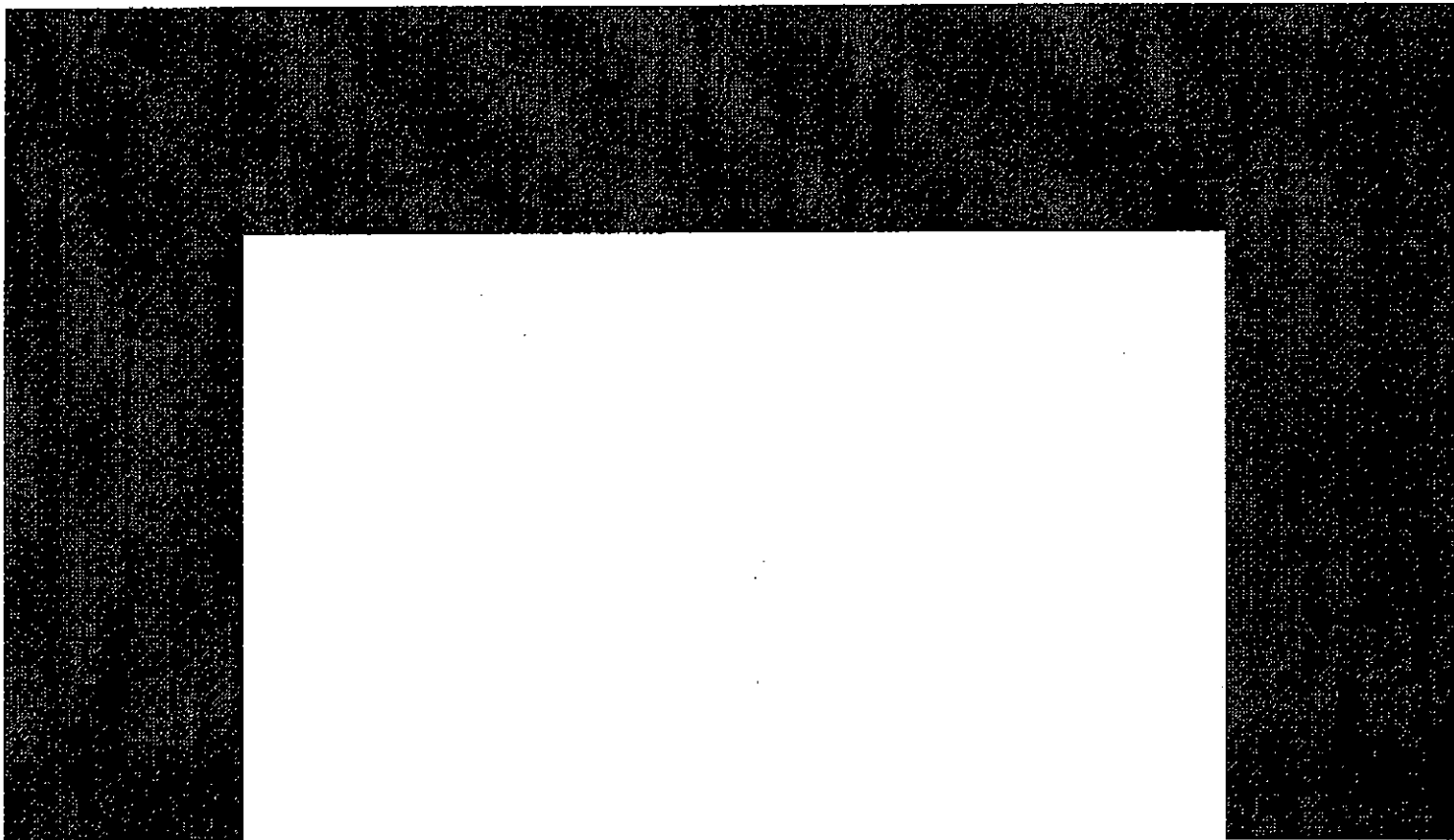
7 Dated: 22 Mar 2011


8 The Honorable Jessie Walsh
District Court Judge

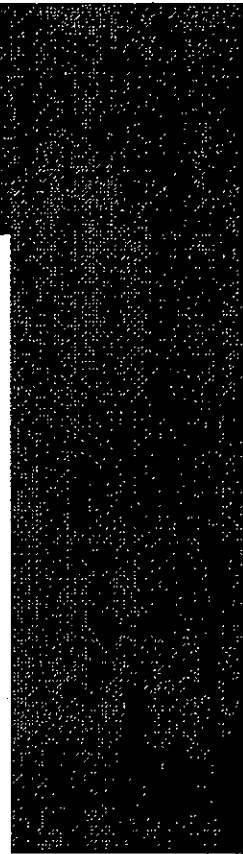
9 Submitted by:

10 
11 ROGERS, MASTRANGELO, CARVALHO & MITCHELL

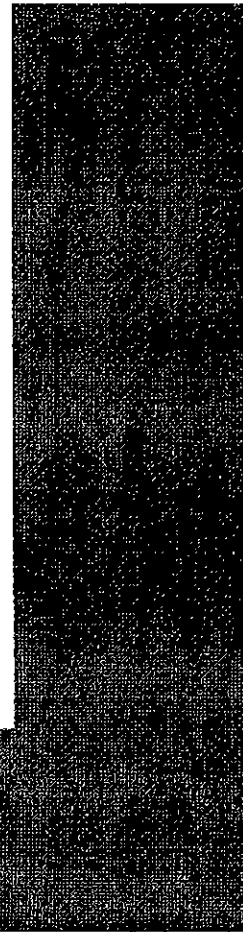
12
13 Stephen H. Rogers, Esq.
Nevada Bar No. 5755
14 300 South Fourth Street, Suite 710
Las Vegas, Nevada 89101
15 Telephone: (702) 383-3400
Facsimile: 702-384-1460
16 Attorneys for Defendant Jenny Rish



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ORIGINAL

Alvin D. Blum

CLERK OF THE COURT

1 **ORDER**
2 STEPHEN H. ROGERS, ESQ.
3 Nevada Bar No. 5755
4 ROGERS, MASTRANGELO, CARVALHO & MITCHELL
5 300 South Fourth Street, Suite 710
6 Las Vegas, Nevada 89101
7 Phone (702) 383-3400
8 Fax (702) 384-1460
9 *Attorneys for Defendant Jenny Rish*

10 **DISTRICT COURT**
11 **CLARK COUNTY, NEVADA**

12 WILLIAM JAY SIMAO, individually and)
13 CHERYL ANN SIMAO, individually, and as)
14 husband and wife,)
15)
16 Plaintiff,)
17)
18 v.)
19)
20 JENNY RISH; JAMES RISH; LINDA RISH;)
21 DOES I - V; and ROE CORPORATIONS I - V,)
22 inclusive,)
23)
24 Defendants.)
25)
26)
27)
28)

CASE NO. A539455
DEPT. NO X

17 **ORDER GRANTING MOTION TO EXCLUDE PLAINTIFF'S ACCIDENT**
18 **RECONSTRUCTIONIST/BIOMECHANICAL EXPERT DAVID INGEBRETSSEN**

19 This matter having come on regularly for hearing before the Court on February 15, 2011,
20 Stephen H. Rogers, Esq. of the law firm of Rogers, Mastrangelo, Carvalho & Mitchell appearing
21 on behalf of Defendant Jenny Rish; and David T. Wall, Esq. of the law firm of Mainor Eglet
22 appearing on behalf of Plaintiffs; and the Court having entertained the respective arguments of
23 counsel as well as being fully apprised of all the papers and pleadings on file with respect Jenny
24 Rish's Motion to Exclude Plaintiff's Accident Reconstructionist/Biomechanical Expert David
25 Ingebretsen, and good cause appearing:

26
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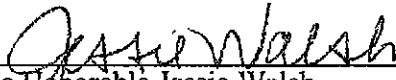
1 IT IS HEREBY ORDERED, ADJUDGED AND DECREED that:

2 1. Defendant Jenny Rish's Motion to Exclude Exclude Plaintiff's Accident
3 Reconstructionist/Biomechanical Expert David Ingebretsen is DENIED.

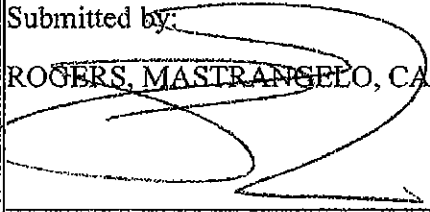
4 The defense is granted leave to conduct voir dire of the witness before he offers expert
5 opinion testimony.

6
7 IT IS SO ORDERED.

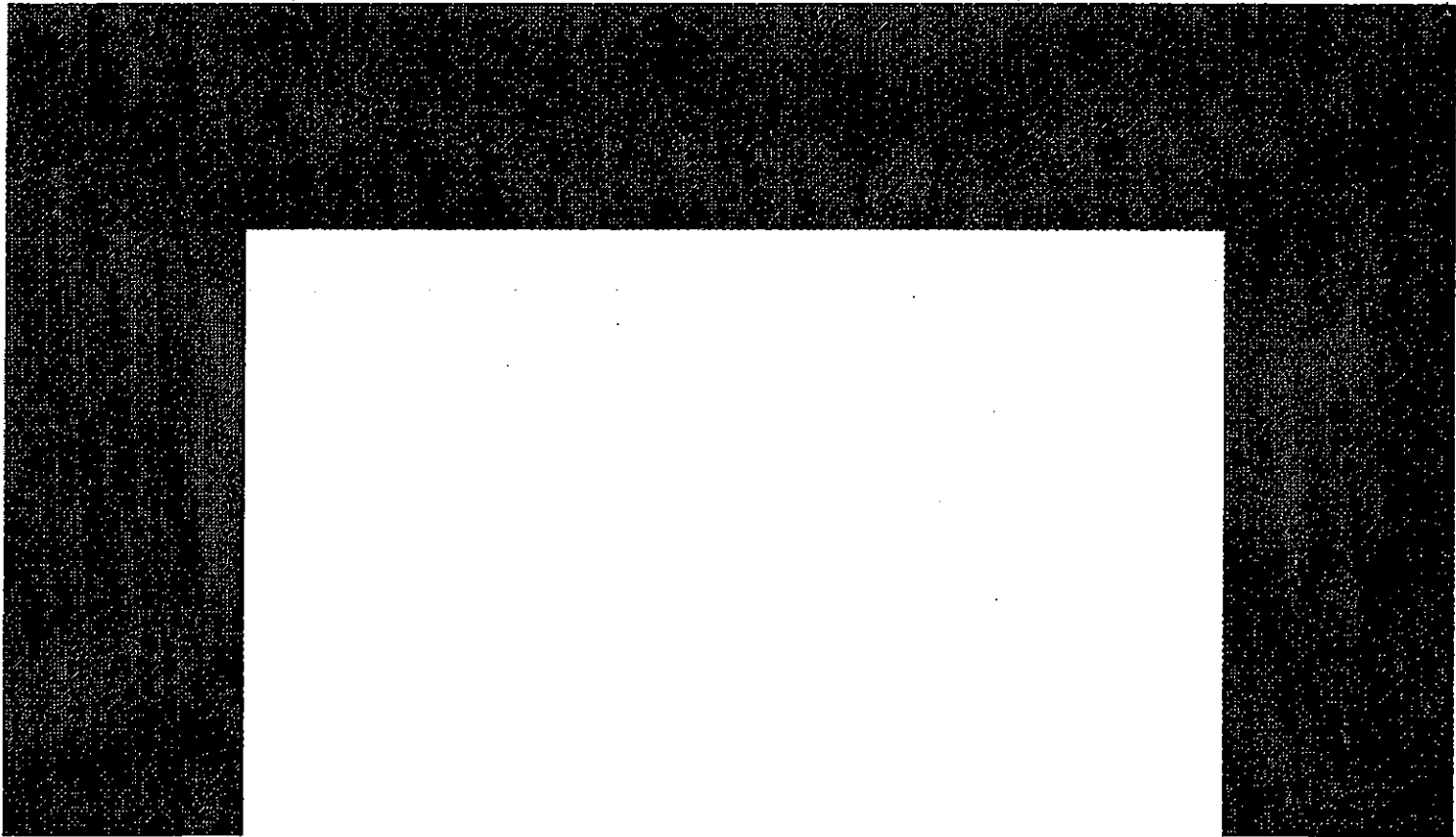
8 Dated: 22 Mar 2011


The Honorable Jessie Walsh
District Court Judge

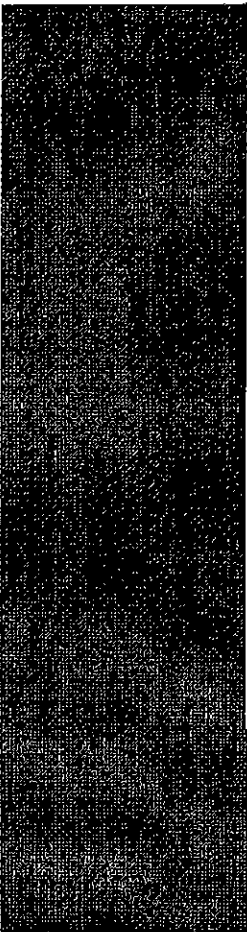
10 Submitted by:

11 
12 ROGERS, MASTRANGELO, CARVALHO & MITCHELL

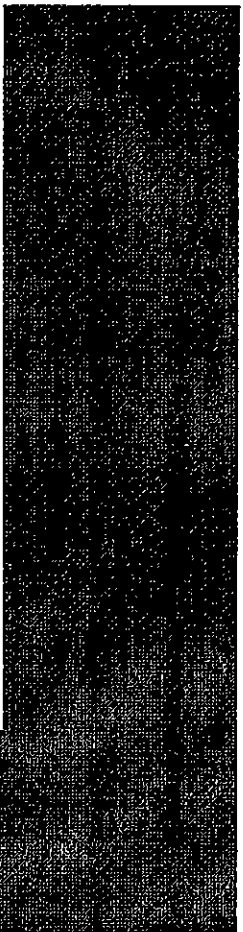
13
14 Stephen H. Rogers, Esq.
15 Nevada Bar No. 5755
16 300 South Fourth Street, Suite 710
17 Las Vegas, Nevada 89101
18 Telephone: (702) 383-3400
19 Facsimile: 702-384-1460
20 Attorneys for Defendant Jenny Rish



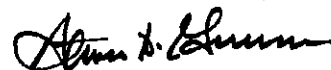
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CLERK OF THE COURT

1 **ORDR**
 2 STEPHEN H. ROGERS, ESQ.
 3 Nevada Bar No. 5755
 4 ROGERS, MASTRANGELO, CARVALHO & MITCHELL
 5 300 South Fourth Street, Suite 710
 6 Las Vegas, Nevada 89101
 7 Phone (702) 383-3400
 8 Fax (702) 384-1460
 9 *Attorneys for Defendant Jenny Rish*

7 **DISTRICT COURT**
 8 **CLARK COUNTY, NEVADA**

9 WILLIAM JAY SIMAO, individually and)
 10 CHERYL ANN SIMAO, individually, and as)
 11 husband and wife,)
 12)
 13 Plaintiff,)
 14 v.)
 15 JENNY RISH; JAMES RISH; LINDA RISH;)
 16 DOES I - V; and ROE CORPORATIONS I - V,)
 inclusive,)
 Defendants.)

CASE NO. A539455
 DEPT. NO X

17 **ORDER GRANTING MOTION TO EXCLUDE ARGUMENT OF CASE**
 18 **DURING VOIR DIRE**

19 This matter having come on regularly for hearing before the Court on February 15, 2011,
 20 Stephen H. Rogers, Esq. of the law firm of Rogers, Mastrangelo, Carvalho & Mitchell appearing
 21 on behalf of Defendant Jenny Rish; and David T. Wall, Esq.. of the law firm of Mainor Eglet
 22 appearing on behalf of Plaintiffs; and the Court having entertained the respective arguments of
 23 counsel as well as being fully apprised of all the papers and pleadings on file with respect Jenny
 24 Rish's Motion to Exclude Argument of Case during Voir Dire, and good cause appearing:

25

26

27

28

1 IT IS HEREBY ORDERED, ADJUDGED AND DECREED that:

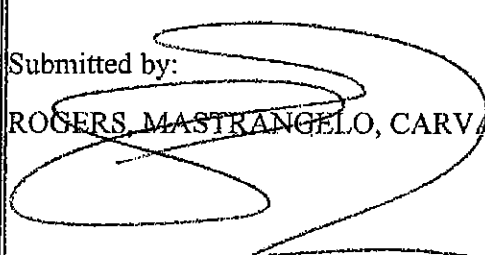
2 1. Defendant Jenny Rish's Motion to Exclude Motion to Exclude Argument of Case
3 during Voir Dire is GRANTED;

4
5 IT IS SO ORDERED.

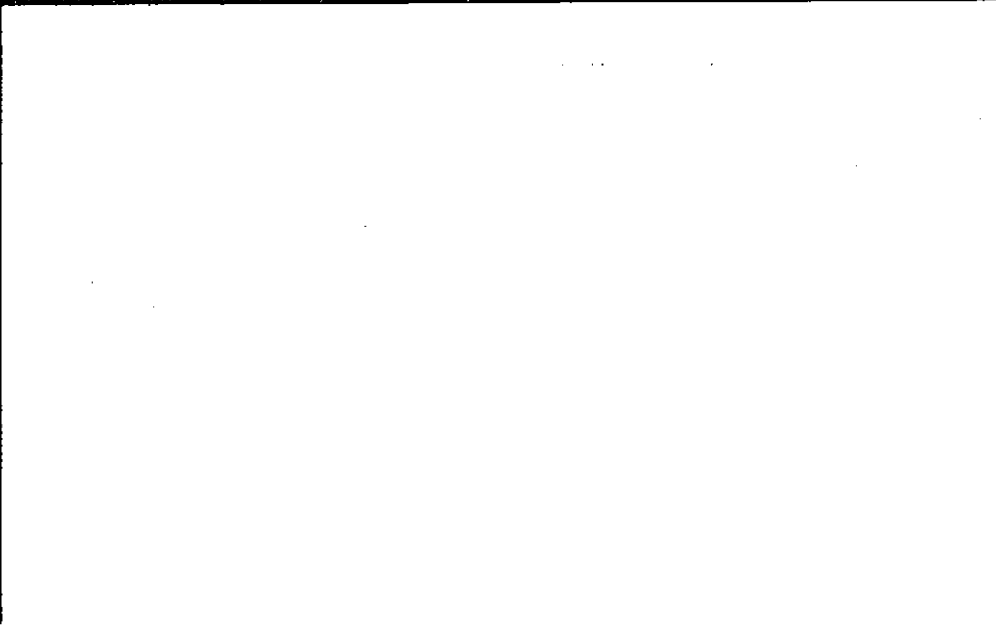
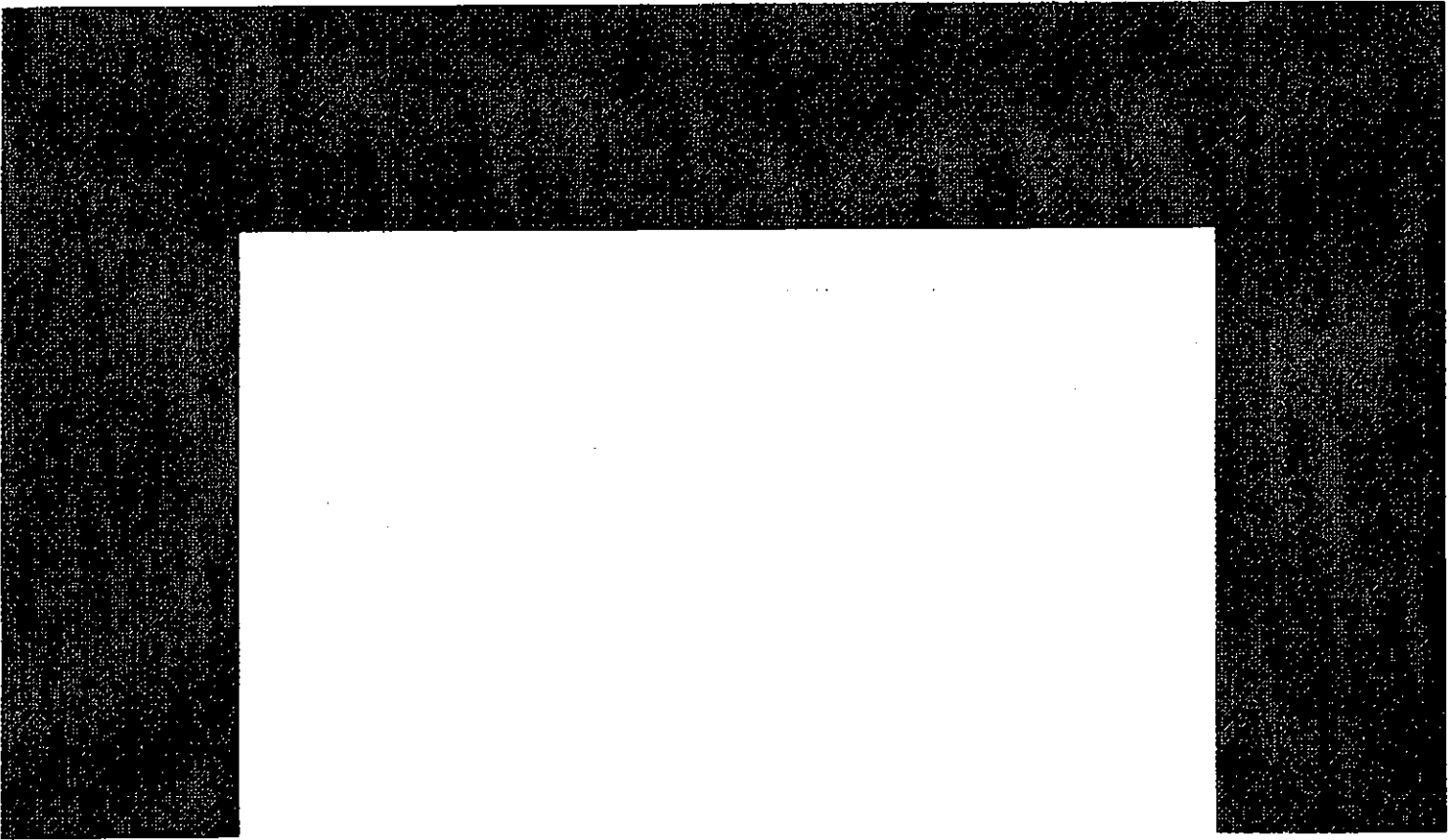
6 Dated: 22 Mar 2011

Jessie Walsh
7 The Honorable Jessie Walsh
District Court Judge

8 Submitted by:

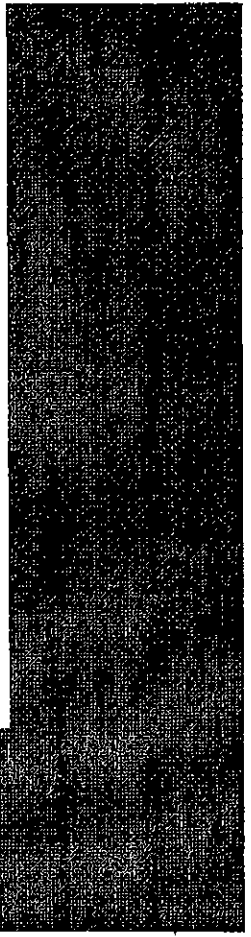
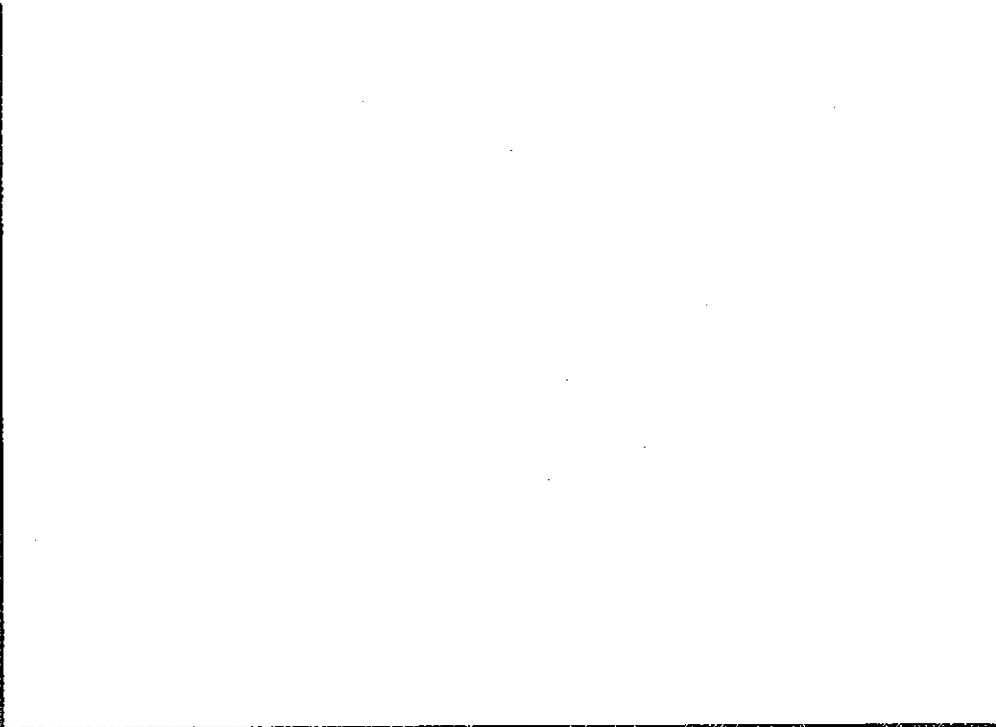
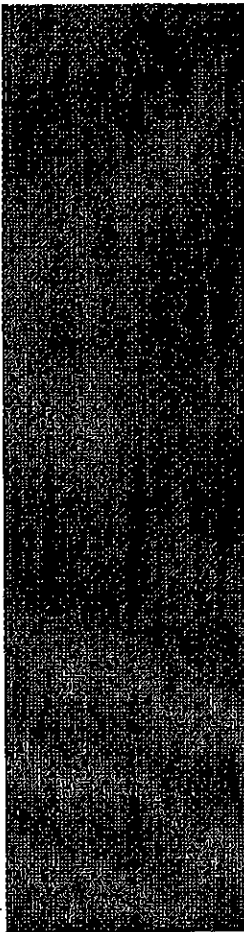
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10 ROGERS, MASTRANGELO, CARVALHO & MITCHELL

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12 Stephen H. Rogers, Esq.
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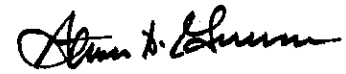
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1 **ORDR**
 2 STEPHEN H. ROGERS, ESQ.
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CLERK OF THE COURT

DISTRICT COURT
 CLARK COUNTY, NEVADA

9 WILLIAM JAY SIMAO, individually and)
 10 CHERYL ANN SIMAO, individually, and as)
 11 husband and wife,)
 12 Plaintiff,)
 13 v.)
 14 JENNY RISH; JAMES RISH; LINDA RISH;)
 15 DOES I - V; and ROE CORPORATIONS I - V,)
 16 inclusive,)
 Defendants.)

CASE NO. A539455
 DEPT. NO X

ORDER GRANTING MOTION TO EXCLUDE PLAINTIFF'S ECONOMIST, STAN SMITH, FOR LACK OF FOUNDATION TO OFFER EXPERT ECONOMIST OPINION TESTIMONY

19 This matter having come on regularly for hearing before the Court on February 15, 2011,
 20 Stephen H. Rogers, Esq. of the law firm of Rogers, Mastrangelo, Carvalho & Mitchell appearing
 21 on behalf of Defendant Jenny Rish; and David T. Wall, Esq.. of the law firm of Mainor Eglet
 22 appearing on behalf of Plaintiffs; and the Court having entertained the respective arguments of
 23 counsel as well as being fully apprised of all the papers and pleadings on file with respect Jenny
 24 Rish's Motion to Exclude Plaintiff's Economist, Stan Smith, for Lack of Foundation to Offer
 25 Expert Economic Opinion Testimony, and good cause appearing:

26
 27
 28

1 IT IS HEREBY ORDERED, ADJUDGED AND DECREED that:

2 1. Defendant Jenny Rish's Motion to Exclude Plaintiff's Economist, Stan Smith, for
3 Lack of Foundation to Offer Expert Economic Opinion Testimony is GRANTED in part; and
4 Plaintiff's economist offers opinion testimony in five (5) categories:

5 **A. Loss of business earnings**

6 Motion granted

7 **B. Household services**

8 Motion denied, but Plaintiff must lay the foundation.

9 **C. Loss of Enjoyment**

10 Motion denied, but Plaintiff must lay the foundation.

11 **D. Loss of Society and Relation**

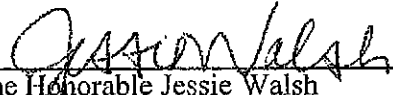
12 Motion denied, but Plaintiff must lay the foundation.

13 **E. Present Value of Future Life Care Plan**

14 The ruling will be made after the hearing on the motion to exclude the life care plan.

15 IT IS SO ORDERED.

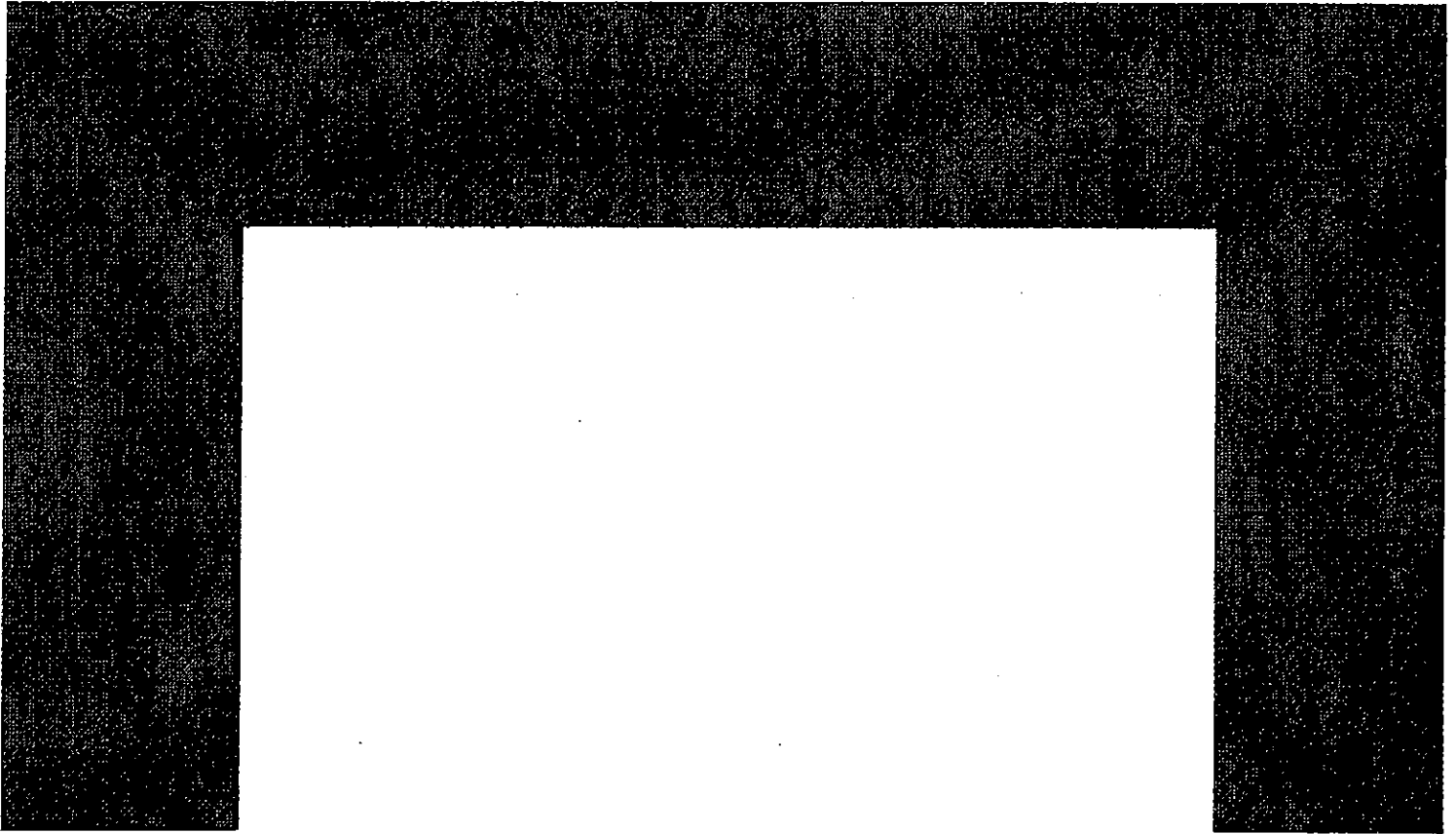
16 Dated: 22 Mar 2011

17 
The Honorable Jessie Walsh
District Court Judge

18 Submitted by:

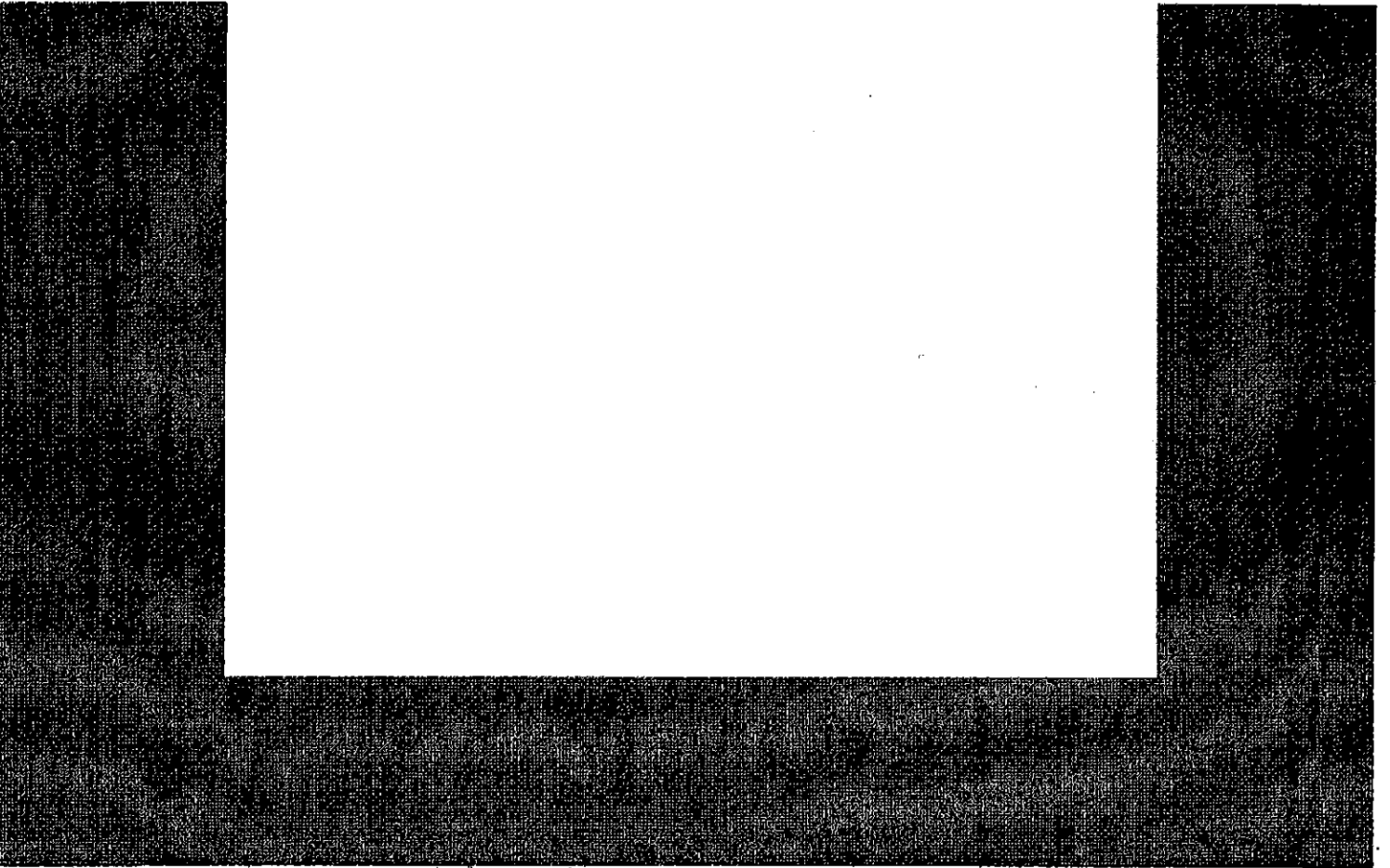
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21

22 Stephen H. Rogers, Esq.
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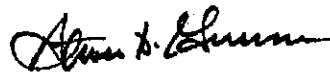
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Electronically Filed
03/29/2011 07:14:40 AMDISTRICT COURT
CLARK COUNTY, NEVADA
CLERK OF THE COURTCHERYL A. SIMAO and
WILLIAM J. SIMAO,

Plaintiffs,

v.

JAMES RISH, LINDA RISH
and JENNY RISH,

Defendants.

CASE NO. A-539455

DEPT. X

BEFORE THE HONORABLE JESSIE WALSH, DISTRICT COURT JUDGE

WEDNESDAY, MARCH 23, 2011

REPORTER'S TRANSCRIPT
TRIAL TO THE JURY
DAY 3 - VOLUME 1

APPEARANCES:

For the Plaintiffs: DAVID T. WALL, ESQ.
ROBERT M. ADAMS, ESQ.
ROBERT T. EGLET, ESQ.
Mainor EgletFor the Defendants: BRYAN W. LEWIS, ESQ.
James and Linda Rish: Lewis and Associates, LLCFor the Defendant: STEVEN M. ROGERS, ESQ.
Jenny Rish: CHARLES A. MICHALEK, ESQ.
Hutchison & Steffen, LLC

RECORDED BY: VICTORIA BOYD, COURT RECORDER

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TABLE OF CONTENTSPageMarch 23, 2011Trial to the JuryPlaintiffs' Witness(es):

Patrick Shawn McNulty, M.D..... 6

Defendants' Witness(es):

None

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EXHIBITS

Page

PLAINTIFFS':

Exhibit 65 114

DEFENDANTS':

None

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1 WEDNESDAY, MARCH 23, 2011 AT 1:00 P.M.

2 THE COURT: Please be seated. I understand there's
3 something outside of the presence of the jury, Mr. Rogers.

4 MR. MICHALEK: I want to discuss sort of the objections
5 that went on yesterday and sort of the mis-citation in the
6 record and what happened.

7 MR. EGLET: Your Honor, if I could --

8 MR. MICHALEK: There was a motion in limine --

9 MR. EGLET: Before Mr. Michalek begins, if I could
10 interrupt. I've got a doctor waiting out in the hall. I have
11 got to get him --

12 MR. MICHALEK: He's right behind you.

13 MR. EGLET: Actually, he's here. I've got to get him
14 finished today. Mr. Michalek wants to make a record and do
15 some offers of proof regarding yesterday's witness. That can
16 be done during a break or at the end of the day. Can we --
17 can get this started? It has nothing to do with this witness.

18 THE COURT: I agree. Yes.

19 MR. EGLET: Thank you.

20 MR. MICHALEK: Your Honor, it does have something to do
21 with this witness. Mr. Eglet is incorrect. What I'm
22 discussing affects the questions that Mr. Rogers will ask this
23 witness. I'm going to be very brief, but I need to go through
24 the ground --

25 THE COURT: Well, specifically, what does it have to do

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1 with this witness?

2 MR. MICHALEK: Okay. The veracity of witnesses and
3 experts, we had a motion in limine which was filed, and I'll
4 read to you the relief that we asked for. We said, "Defendant
5 asks this Court to enter an order precluding any witness,
6 including expert or medical witnesses, from vouching for the
7 veracity of credibility of another witness." Now, yesterday,
8 that's exactly what Dr. Rosler [phonetic] did. Dr. Rosler
9 commented upon the veracity of his patient. He vouched for
10 it, he said that he was trained to tell if patients are
11 exaggerating or lying, and he gave his opinion upon
12 questioning from Mr. Eglet that his patient was telling
13 essentially the truth. He vouched for that credibility. If
14 that's going to happen again with the other medical doctors, I
15 think it's important the fact that the Court granted this
16 motion in limine without objection. And I can show you in the
17 -- I got a copy of the transcript --

18 THE COURT: If that --

19 MR. MICHALEK: -- of hearing --

20 THE COURT: If that's the subject of your wanting to make
21 a record as to this witness, then it can wait, frankly,
22 because what I heard was not an expert witness or a -- or a
23 treating physician vouch for the credibility of his -- of his
24 patient. That's not what I heard. So let's move on. Let's
25 bring our jury in and --

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1 MR. MICHALEK: All right.
2 THE COURT: -- let's get going.
3 Can we have the witness come forward to the witness
4 box. Save a little time.
5 [Jury In]
6 THE COURT: Please be seated, ladies and gentlemen.
7 Counsel, stipulate to the presence of the jury.
8 MR. ROGERS: Yes, Your Honor.
9 MR. EGLET: Yes, Your Honor.
10 THE COURT: Okay. I ask the witness to raise his right
11 hand to be sworn by Madam clerk.
12 PATRICK SHAWN McNULTY, PLAINTIFFS' WITNESS, SWORN
13 THE CLERK: Thank you. Please be seated. State and
14 spell your name for the record.
15 THE WITNESS: Patrick Shawn McNulty. Patrick,
16 P-a-t-r-i-c-k, Shawn, S-h-a-w-n, McNulty, M-c-N-u-l-t-y.
17 THE COURT: Whenever you're ready, Mr. Eglet.
18 MR. EGLET: Thank you, Your Honor.
19 DIRECT EXAMINATION
20 BY MR. EGLET:
21 Q Good afternoon, Dr. McNulty.
22 A Good afternoon.
23 Q Doctor, would you please tell the jury the specialty
24 in medicine you practice.
25 A I'm a board certified orthopedic surgeon who

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1 subspecializes in spine surgery.

2 Q And can you please tell us where you attended
3 medical school.

4 A University of Miami.

5 Q And what year did you graduate?

6 A 1988.

7 Q And where did you do your internship and residency
8 training?

9 A U.T. Southwestern and Dallas, Texas, essentially
10 Parkland.

11 Q And you did your orthopedic surgery residency there
12 as well?

13 A Yes.

14 Q Okay. And did you go on to do a spine fellowship?

15 A Yes.

16 Q And what years did you do your spine fellowship?

17 A 1993 through 1994.

18 Q Where did you do your spine fellowship?

19 A Johns Hopkins.

20 Q Are you board certified?

21 A Yes.

22 Q And what does it mean to be board certified?

23 A Board certified is simply a process by which an
24 independent national entity vouches for your credentials and
25 qualifications to practice a specific specialty of medication.

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1 I've got board certification by the orth- -- American Board of
2 Orthopedic Surgery as well as the American Board of Spine
3 Surgery.

4 Q And do you belong to any professional memberships?

5 A Yes.

6 Q What memberships?

7 A Scoliosis Research Society, North American Spine
8 Society, the American Academy of Orthopedic Surgeons, also
9 members of various engineering societies because I was an
10 engineer before.

11 Q And could you detail for us the scope of your
12 practice as an orthopedic spine surgeon.

13 A Essentially my practice is focused on spine
14 problems. Occasionally I do some general orthopedics in the
15 sense it's -- a good example would be shoulders can be
16 sometimes presenting as neck problems and vice-versa since I
17 evaluate patients and then decide in a general sense what's
18 appropriate treatment. And I myself as -- primarily I'm a
19 spine surgeon.

20 Q And do you have hospital privileges?

21 A Yes.

22 Q At what hospitals do you have privileges?

23 A I have several. I primarily practice at University
24 Medical Center, but I also will practice at Valley Hospital,
25 Mountain View, Sunrise, Southern Hills. The facilities in the

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1 Valley for which I choose not to have privileges is primarily
2 North Vista and St. Rose Delima.

3 Q And have you ever worked at a military hospital?

4 A Yes.

5 Q What military hospital?

6 A I was active duty in the military. During the
7 course of my training in medical school I was at Oakland Nava
8 Hospital, Bethesda Naval Hospital, San Diego Naval Hospital,
9 as well as when I was active duty doing spine surgery,
10 teaching residents I was at Port Smith Naval Hospital.

11 Q Have you been qualified as an expert in the area of
12 orthopedic spine surgery and orthopedic surgery in the courts
13 of Clark County, Nevada?

14 A Yes.

15 MR. EGLET: Your Honor, we would offer Dr. McNulty as an
16 expert in orthopedic surgery and orthopedic spine surgery?

17 THE COURT: Any objection?

18 MR. ROGERS: No objection.

19 THE COURT: So ordered.

20 BY MR. EGLET:

21 Q Doctor, would you please describe for us the scope
22 -- strike that.

23 Now Doctor, are you one of William Simao's treating
24 orthopedic spine surgeons?

25 A Yes.

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1 Q And who referred Mr. Simao to you for orthopedic
2 spine evaluation?

3 MR. EGLET: Would you put up Exhibit 22, page 2, please.

4 THE WITNESS: I would confirm by referring to my notes,
5 but I believe it was a Southwest Medical primary care
6 provider.

7 BY MR. EGLET:

8 Q Okay. And was it a physician assistant, Brent Hill
9 [phonetic], at Southwest Medical?

10 A I can confirm that simply with my first chart note.
11 Yes, Brent Hill, physician assistant.

12 Q Okay. And what date did you first see Mr. Simao?

13 A It was 4/18/2006.

14 Q Okay.

15 MR. EGLET: Page 3, please, Brendan [phonetic].

16 BY MR. EGLET:

17 Q Did Mr. Simao complete a pain diagram before being
18 seen by you on April 18, 2006?

19 A Yes.

20 Q Would you review for us this pain diagram and
21 describe the location, character and severity of his pain.

22 A Is it possible for me to manipulate this image, or
23 do you know?

24 Q What -- you mean draw on it?

25 A No, just move it around if you want me to refer to

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1 it.

2 Q Tell us where you want it to move and Brendan can do
3 that for you.

4 A Okay. So what was your question, please?

5 Q Well, the question is can you review this diagram
6 with us and describe the location, character and severity of
7 his pain.

8 A Sure. So essentially this is a front-back figure
9 which the patient will ideally shade in the painful areas and
10 further describe whether or not it's -- in his case he checked
11 off ache, pins and needles, numbness, stabbing, pressure. So
12 you can see he's basically drawn in the back of the neck
13 extending up to the back of the head going out onto the
14 trapezius or the trapezial regions down into the upper back
15 and in between the central portion of the upper back, what we
16 call the periscapular region. There's also some extension
17 onto the front of the left chest and down the left arm.

18 Q Okay.

19 MR. EGLET: Page 5, please, Brendan.

20 BY MR. EGLET:

21 Q What history did you obtain from Mr. Simao at the
22 time of your initial evaluation of him?

23 A Is it -- can we go to the first page of the diagram
24 -- or the questionnaire as well.

25 Let me go find that.

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1 The symbol-- my history that's written in the chart note
2 reflects both reviewing the questionnaire as well as asking
3 questions, so -- that's hard for you. It'd just be simpler to
4 pull that up. Are you able to get that on or no?

5 Okay.

6 I can simply start with reading the chart note then or --
7 BY MR. EGLET:

8 Q That's fine.

9 A So he presents to me for the first time April 18th,
10 2006, stating that he has a one-year history of pain basically
11 as drawn on his pain diagram, where he divides his pain 75
12 percent axial, which means it's basically the head, neck,
13 central portion of his spine, and 25 percent arm, stating it's
14 worse 10 out of 10, meaning the worst pain he can experience,
15 and currently 6.5 out of 10. States it's worse with movement,
16 better with massage and pressure. Does not relate any
17 significant limitations with sitting, standing, riding in a
18 car or walking, and describes his symptoms as aching, pins and
19 needles, numbness, stabbing and pressure. He states he's had
20 physical therapy, he's had medications. And the symptoms
21 started after a motor vehicle accident. Also stated -- went
22 over medications. No known drug allergies. Smokes a half
23 pack of cigarettes a day, rare alcohol. Working in flooring
24 sales. No surgeries. Past medical history of high blood
25 pressure, high cholesterol. And no fever, chills or weight

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1 loss.

2 MR. EGLET: MR. EGLET: Now go to page 5, please,
3 Brendan.

4 BY MR. EGLET:

5 Q What treatment at Mr. Simao undergone before being
6 seen by you, Doctor?

7 A Stated he's had medications and physical therapy.

8 Q Okay. And when did Mr. Simao's symptoms start?

9 A He simply stated after a motor vehicle accident.
10 But if you can find that first page --

11 Q Is that on the screen?

12 A Is that the date of -- yes. Can you zoom out a
13 little bit so I can see. I'm having a little trouble with the
14 left margin.

15 MR. EGLET: Move back.

16 THE WITNESS: Okay. If you can go to the top.
17 So here he states it's been going on approximately a year.
18 Stated it was a car accident. Doesn't give a specific, but I
19 would assume April of '05.

20 BY MR. EGLET:

21 Q All right. Now, Why did you not
22 detail the nature of Mr. Simao's motor vehicle accident in
23 your initial evaluation of him?

24 A Well, the details -- from a practical sense as far
25 as treating him, he was simply in an accident. He's had

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1 conservative measures. So as far as additional details, I
2 would -- assuming like details of the accident, preexisting
3 history -- at that point in time I specifically stated he had,
4 quote, unquote, no significant medical legal issues, and
5 that's simply because I see patients occasionally who do have
6 accidents and there are entities involved who want to know
7 details so they can sort out legal issues. So at that point
8 in time I was not aware of any. Otherwise, there would have
9 been an additional line of questioning to more specifically
10 clarify any significant prior problems, when did the symptoms
11 start, did they stay consistent, did they go away, did they
12 come back, and that line of questioning is pointed to helping
13 legal parties figure out the issues they'd like to figure out.

14 Q Okay. Now, have you had your deposition taken in
15 this case by a defense attorney?

16 A Yes.

17 Q And you had it taken once in December 2008 and then
18 again in June 2009?

19 A I assume so. I know there was two separate days.

20 Q During the course of those two depositions were you
21 asked by Mr. Rogers about Mr. Simao's previous medical
22 history?

23 A I would assume so. Do you want to -- do you want me
24 to look at the depositions to confirm?

25 Q No. Just do you recall being --

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1 A Yes.

2 Q -- asked about -- okay.

3 A Yes.

4 Q And Did Mr. Rogers also ask you about the details of
5 the motor vehicle wreck that was -- that has brought you here
6 today?

7 A I assume so.

8 Q Were you also asked by Mr. Rogers to review the
9 treatment that Mr. Simao reviewed -- received by other medical
10 providers during your depositions?

11 A Yes.

12 Q Okay. So while your primary focus during your
13 evaluation of Mr. Simao was to clinically evaluate and treat
14 his chronic pain, did you also review additional medical
15 records and documents as a result of the depositions that were
16 taken of you in this matter?

17 A During the course of the deposition, yes.

18 Q What do you recall about the motor vehicle wreck Mr.
19 Simao was involved in on April 15th, 2005?

20 A Quite honestly, I have no direct recollection.

21 Q Okay. Do you -- do you recall reading other medical
22 records which documented the nature of the motor vehicle
23 accident, in other words, whether it was a rear-end or versus
24 a --

25 A I don't have independent recollection.

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1 Q All right. Fair enough. As a result of the
2 injuries Mr. Simao sustained in the April 15th, 2005 motor
3 vehicle accident, what clinical diagnosis was given to Mr.
4 Simao by his treating medical providers at Southwest Medical
5 Associates regarding his neck after his evaluation there on
6 April 15th, 2005?

7 A Well, I mean I recall them having concerns.
8 Initially they said he had a cervical sprain. It mentions
9 some occipital pain. And I think there was more focus concern
10 about issues of headaches, alteration of vision, that
11 initiated a workup that was basically focused on making sure
12 there wasn't any significant intracranial or brain problems.

13 Q Can a traumatic injury to the neck resulting in a
14 sprain or strain injury to the neck also result in disc or
15 facet injuries to the cervical spine at the same time?

16 A Well, I would make the general comment that the term
17 "sprain" by definition means a muscle is overstretched and
18 injured. The term "strain" means a ligament, a perfect
19 example would be an ankle ligament, is overstretched, ruptured
20 and injured. So those terms get used frequently when people
21 come in with neck complaints with a traumatic mechanism as a
22 history, but the reality is they're really not doing anything
23 to confirm in a general sense whether or not it's muscle
24 strain, a ligament strain, a disc injury, a facet injury. So
25 I personally prefer the term "cervical syndrome" which

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1 basically says yes, there's complaints in regards to the neck,
2 the cervical spine, but it's really not pragmatic at that
3 initial onset to really state a more defined structural cause
4 unless someone's obviously presenting with a more extreme case
5 of a fracture, paralysis. In that case, you've got other more
6 severe presenting complaints findings. But in general, the
7 more -- the less severe complaints I use cervical syndrome,
8 and I don't think you can really appropriately in the strict
9 definition of the words apply sprain and strain. I think
10 they're, in a practical sense, just used to recognize the
11 patient's having complaints of neck pain.

12 Q In your practice when you see patients -- patients
13 ultimately referred to you after a traumatic event, let's say
14 in the neck, and you -- and you go on to ultimately diagnose
15 them with a disc injury of some type, is it common that the
16 initial medical providers, whether it's emergency room police
17 or primary care providers or physical therapist of
18 chiropractors will -- the initial working diagnosis will be
19 sprain/strain to the cervical spine?

20 A Yes.

21 Q Okay. Can the symptoms of a neck sprain or strain be
22 similar to those of a traumatic cervical disc or facet injury?

23 A Yes.

24 Q Okay. In patients who have sustained traumatic
25 cervical disc or facet injuries -- strike that.

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1 Now, how do you clinically distinguish the diagnosis
2 of a neck sprain or strain from a cervical disc or facet
3 injury?

4 MR. ROGERS: Well, I --

5 THE WITNESS: I'm sorry.

6 MR. ROGERS: I'm just going to object because it's
7 compound. We're talking ligaments, muscles, facets and discs.

8 THE COURT: Ask you to rephrase, please.

9 BY MR. EGLET:

10 Q How do you clinically distinguish the diagnosis of,
11 one the one hand, the soft tissue, muscular or ligament
12 sprain/strain type injuries we talked about, versus a disc
13 injury or a facet injury?

14 A Well, the answer is, for the most part, pragmatic.
15 When you see someone initially you assess the severity of the
16 mechanism, and then once you've ruled out serious injuries
17 like significant instability or ligament disrapture to the
18 point the vertebra aren't reliably staying together, or
19 fractures, then the prognosis overall is very good. I would
20 say that in general 85 to 90 percent of people during the
21 course of the next six to twelve weeks are going to improve.
22 So at that point, just being relatively pragmatic, you
23 reassure the patient that there is not a majority structural
24 injury, and you follow them clinically, encourage them to be
25 active. Personally, if I were following them from the initial

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1 onset, which typically as a spine surgeon I am not, if they're
2 not getting better by four weeks I would potentially initiate
3 physical therapy. But the simple answer to the question is
4 you let time tell you over the course of the ensuing six to
5 twelve weeks whether or not they're going to improve. Then at
6 that point, after three to four months, if they're not
7 improving, then you can initiate a more defined, potentially
8 invasive workup that would more clearly define the ongoing
9 structural issues that are causing the pain, and that's simply
10 because at that point if you're not better, chances are
11 relatively low, less than 10 to 15 percent, that you're going
12 to improve if you've had a reasonable course of conservative
13 measures. So you're trying to be optimistic -- appropriately
14 optimistic, but at the same time if you're reaching a fork in
15 the road where you're not improving, you don't want to
16 unnecessarily drag things out because that -- that starts a
17 whole other slew of problems and then you start getting into
18 the issues of chronic pain.

19 Q Okay. If someone were to stand in front of this
20 jury and tell them that a cervical disc injury is immediately
21 described symptomatically by the patient and/or diagnosed
22 immediately by the patient's treating physicians following a
23 traumatic event, would that be an accurate statement?

24

25 MR. ROGERS: Objection, Your Honor, that's compound as

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1 well.

2 THE COURT: Overruled. You may answer --

3 THE WITNESS: Well --

4 THE COURT: -- the question.

5 THE WITNESS: -- there are extreme severe traumatic
6 episodes, but this is more along the line of someone who's had
7 a severe injury where literally their spine has been ripped
8 apart, and in that particular, very unique case, sure. The
9 patient comes in with severe pain, their neck is diffusely
10 tender, they get an x-ray where there is some shifting of the
11 vertebra. You get a confirmatory MRI because you're worried
12 about a significant ligament injury where literally all the
13 ligaments that are keeping the vertebra together are
14 potentially ripped, in that particular case you could have a
15 quote, unquote, disc injury defined by diagnostic studies, but
16 that's a severe injury in which all the surrounding structures
17 of a disc -- the disc vastly is held by tough ligamentous rim
18 -- and all that's ripped. And that is not the classic more
19 common scenario we typically talk about in these cases.

20 BY MR. EGLET:

21 Q Do you believe that the fact that there is no
22 documentation of neck pain in Mr. Simao's medical records from
23 May 2005 until October 2005 means that he was not having neck
24 pain during that time?

25 MR. ROGERS: Objection, calls for speculation.

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1 THE COURT: Overruled.

2 THE WITNESS: I reviewed those records, and again, it was
3 my opinion that the focus appeared to be mainly his complaints
4 of headache, altered vision. It appeared that they were more
5 concerned about a serious problem with his head or his brain
6 that overshadowed or diverted the attention to a potentially
7 more serious problem. So I would agree the notes themselves
8 did not reflect any complaints of neck pain, but at the same
9 time if I was treating him and someone had come in with trauma
10 and was having complaints of altered vision and headaches, you
11 know, I would be focusing my attention on the brain/head
12 problem as well.

13 BY MR. EGLET:

14 Q And do you have any reason to believe that Mr. Simao
15 was not truthful with you during your treatment of him?

16 MR. ROGERS: Objection, Your Honor. We raised this same
17 objection yesterday. If you'd like, we can approach.
18 Otherwise, it's as --

19 THE COURT: I don't know --

20 MR. ROGERS: -- stated.

21 THE COURT: I don't know that it's necessary. Noted for
22 the record. Overruled. You may answer the question.

23 THE WITNESS: I don't have any recollection either
24 through the charts or independently, of him not being
25 forthright and truthful to me.

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1 BY MR. EGLET:

2 Q Now, let's return now to your initial --

3 MR. EGLET: If we could go -- is this page 5, Brendan?

4 BY MR. EGLET:

5 Q Let's return now to your initial evaluation of Mr.
6 Simao. Did you document his history of migraine headache
7 syndrome?

8 A Well, I can tell you just by the simple fact he
9 takes Fiorinal, even though it's not clearly listed, Fiorinal
10 is typically for migraine headaches.

11 Q Did the fact that Mr. Simao had a history of chronic
12 migraine headaches at any -- strike -- at the time of his
13 presentation to you impact your clinical evaluation or
14 assessment of his chronic neck pain?

15 A No.

16 Q Why not?

17 A Well, in the simple sense, headaches -- migraine
18 headaches are typically headaches. The pain diagram obviously
19 shows a lot of other areas of his body that Mr. Simao was
20 complaining about that would not be related to headaches -- or
21 migraine headaches. Excuse me.

22 Q Could you please review for us your document physical
23 examination of Mr. Simao on April 18th, 2006.

24 A Briefly, I stated that he was alert, oriented,
25 appropriately responding, healthy. His vital signs appeared

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1 to be stable. Had a -- basically a lean, healthy body build,
2 and says that he wasn't excessively overweight at all, 6 foot
3 6, 275 pounds. I stated there was no significant difference
4 C5 to T1 dermatomes and myotomes. Specifically what that's
5 stating is while a patient is sitting there I will test
6 various muscle groups and actions side to side at the same
7 time to appreciate any subtle imbalance or asymmetry. And at
8 that point in time he really didn't have any discernible
9 significant weakness or numbness that would be classically
10 associated with any specific spinal nerves coming out of the
11 neck. Also stated he has no clonus or Babinski or Hoffman's.
12 Those are specifically exam maneuvers to elicit or see if
13 there's any problems with the function of the spinal cord.
14 Also, there was not any abnormal reflexes or increased
15 reflexes in the arms or legs.

16 Also had at that point in time a negative elbow
17 flexion test and negative Phalen's. Those are specifically
18 tests to see if there's any associated irritations of the
19 ulnar nerves at the elbow. The ulnar nerves are the layman's
20 funny bone. If you hit it, that's when you get the zinger
21 going down to your hand. Because occasionally you can have
22 pinched nerves that can present with similar symptoms as
23 problems with ulnar nerves at the elbows or the ulnar nerves
24 at the wrist or the median nerves at the wrist, and that's
25 called carpal tunnel. So that's important to also note that

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1 at that point in time there was really no clinical findings to
2 suggest he had any problems with the ulnar or median nerves as
3 they travel through his arm.

4 Q What diagnostic testing did you review at the time
5 of your initial evaluation of Mr. Simao?

6 A An MRI of the cervical spine.

7 Q And would you please --

8 MR. EGLET: Could you put up Exhibit 19, page 11 and 12,
9 please, Brendan.

10 BY MR. EGLET:

11 Q Please show and review for us the diagnostic
12 findings on this March 22nd, 2006 cervical MRI.

13 A Well, let make the first -- the qualifying
14 statement. My diagnostic testing basically reflects me
15 looking at the report, as well as reviewing the films and
16 making a summary. So, for instance, if I'm missing a report
17 or missing the films, I make such a qualifying statement. So
18 having said this, this reflects both looking at the report as
19 well as looking at the films. So I basically said that there
20 was some mild narrowing of the left C3-4 neuroforamen. That's
21 basically where the nerve is exiting from the spinal canal
22 between the third and the fourth vertebral levels on the left
23 side. And stated also there may be some contact with the left
24 C4 nerve, and looking at the report there's really no
25 significant discrepancy there. They mention facet

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1 hypertrophy. Facet hypertrophy is basically the small joint
2 in the back of the spine. At each level you have a disc and
3 two facet joints, and sometimes those facet joints can
4 enlarge. As they enlarge they can pinch the exiting nerves
5 going out of that nerve exit hole. And then also mentioned
6 that he had a small central protrusion, which is basically the
7 disc with a small bulge in the middle back towards the spinal
8 cord at C4-5. And no significant other abnormalities. So it
9 doesn't appear like there's anything I stated there that
10 wasn't stated in the report.

11 MR. EGLET: Brendan, could you put up Exhibit 39, please.

12 BY MR. EGLET:

13 Q Doctor --

14 MR. EGLET: Your Honor, may I have the doctor come out of
15 the box?

16 THE COURT: Yes.

17 BY MR. EGLET:

18 Q Could you come back out of the box here, and I'm
19 going to ask you to discuss your findings -- your findings.
20 Just tell Brendan -- I think this is page 1 of 4 -- you can
21 tell him to go to the next page or point to what --

22 THE WITNESS: Next page. Next page. Are we able to blow
23 this up and enlarge?

24 MR. EGLET: Well, tell -- point what you want to blow it
25 up.

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1 THE WITNESS: Okay. So this is starting at the top. So
2 basically this is our map. So if we pull the model here.
3 What an MRI does is basically it takes your spine and it cuts
4 it up so you can see it. So you've got pictures that are
5 looking from the side, sometimes pictures look from the front,
6 and then pictures that look down the two like cutting a piece
7 of hotdog into little round slices.

8 So these cuts are starting at the C3 vertebra which
9 is above the C3-4 disc.

10 Now, let's -- are you able to go down square by
11 square?

12 UNIDENTIFIED MALE: Yeah.

13 THE WITNESS: Okay. So let's start here, please. So --
14 can we go to the next one down.

15 Okay. So this is a good picture to start. So this
16 is the C3-4 level. So this is basically the level -- this is
17 the whole spine, but obviously we're concentrating here. So
18 this is the level starting at this disc which is between the
19 third and fourth cervical vertebra. So this is the right
20 nerve exit hole here, okay. You see how wide open that is.
21 Now, just so you know, nature gave you plenty of room, so for
22 the most part we've all got a three-car garage to get our one
23 car out. So as we get older we've got extra room to get old,
24 so -- but you can see going to the left you've got this extra
25 prominence. This is the facet joint which is narrowing this

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1 nerve exit hole. So you can obviously see where you can
2 appreciate that this left -- left is over here -- the C3-4
3 neuroforamen or nerve exit hole is narrowed.

4 If we go to the next cut down.

5 So that is definitely there and potentially it's
6 something to keep in mind as we go on.

7 So we keep going down. We'll go down to the next
8 level. Keep going. So let's see. Go back one. Can't see on
9 that. Go back one. Okay. Keep going now back the other way.
10 Keep going. Keep going.

11 So we're basically coming down the spinal canal
12 here.

13 Go back to the bigger -- the overall views. All the
14 squares. Just want to easily march down these. Okay. So
15 here, this is the square you want. Next one down.

16 And here's the C4-5 level where there is a small
17 little bulge or extra slight prominence of this disc. But
18 there's really no significant neurologic compromise or
19 pinching of that.

20 BY MR. EGLET:

21 Q Now, are the findings that you described for us on
22 this March 22nd, 2006 cervical -- thank you -- MRI caused by
23 the motor vehicle crash that Mr. Simao was involved in on
24 April 25th --

25 MR. ROGERS: Objection, foundation.

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1 Q -- 2005?

2 THE COURT: Counsel approach, please.

3 [Bench Conference Not Transcribed]

4 BY MR. EGLET:

5 Q The question, doctor, was are the findings that you
6 just described for us as shown to us on the March 22, 2006
7 cervical MRI caused by the motor vehicle crash Mr. Simao was
8 involved in in April of 2005?

9 A Well, the answer isn't simple. The answer could be
10 yes. The answer could be no. The simple reality is this MRI
11 is a year after. So then you have to start paying attention
12 to the patient's history and when the symptoms began. But
13 this MRI and an otherwise asymptomatic person with no
14 complaints could also simply be age-related changes. But this
15 MRI, in the context of a person who's presenting with ongoing
16 complaints, hypothetically, since the motor vehicle accident
17 with no significant problems to it -- or prior to it could
18 also be structurally associated to the motor vehicle accident.

19 Q Let's assume for a minute that they weren't
20 structurally caused by this motor vehicle accident. What is
21 the cause of the changes that -- that you -- what would be the
22 cause of the changes you've described for us in CV4 and C4-5?

23 A I would say simply age-related changes; meaning, as
24 we get older we all potentially have a whole plethora of
25 findings that can show up on x-rays, CT scans, MRIs, but

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1 they're okay.

2 Q And are age-related changes sometimes referred to as
3 degenerative changes?

4 A I would say they're more commonly referred to as
5 degenerate, yes.

6 Q Okay. Can patients with the changes you've just
7 described for us in Mr. Simao's C3-4 and C4-5 cervical discs
8 be asymptomatic without complaints of neck pain or upper
9 extremity symptoms?

10 A Yes.

11 Q Okay. Before his April 15th, 2005 motor vehicle
12 crash, was Mr. Simao symptomatic with neck pain or upper
13 extremity symptoms as a result of the age-appropriate changes
14 documented on this cervical MRI?

15 A No.

16 MR. ROGERS: Objection. I don't think any foundation has
17 been laid about his understanding of the Plaintiff -- or of
18 the Plaintiff's pre-accident. He's --

19 MR. EGLET: Your Honor, first of all, I object to this
20 speaking objection, okay? May we approach?

21 THE COURT: Counsel approach, please.

22 [Bench Conference Not Transcribed]

23 MR. EGLET: Objection is overruled, Your Honor?

24 THE COURT: Yes.

25 MR. EGLET: Thank you.

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1 BY MR. EGLET:

2 Q Okay. The question, doctor, is before the April
3 15th, 2005 motor vehicle crash, assuming -- I think for this
4 question that we should assume that these structural changes
5 you've described on the MRI pre-existed the motor vehicle
6 accident, that they were these age-related changes we
7 discussed, okay?

8 A Yes.

9 Q Before his April 15th, 2005 motor vehicle crash, was
10 Mr. Simao symptomatic with neck pain or upper extremity
11 symptoms as a result of the age-related changes documented in
12 this MRI?

13 A According to his history, no.

14 Q Now by way of obtaining a history from Mr. Simao and
15 reviewing the medical records and documents provided --
16 documents provided you in this case, does Mr. Simao have any
17 history of cervical spine problems or symptoms that required
18 medical evaluation and treatment before April 15th, 2005?

19 A No.

20 Q Are patients with age-related changes of their
21 cervical spine more susceptible to traumatic injury to their
22 cervical spine than patients without degenerative or age-
23 related changes in their cervical spine?

24 A I would say there's a spectrum there, but in general
25 in I would say, hypothetically with this, I would say no.

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1 Q Why not?

2 A Well, in this case the age-related changes are
3 relatively mild. An extreme example of a, quote, unquote,
4 age-related change is where someone has had degenerative
5 changes; they're more advanced, and there's actually a
6 slippage of a vertebra forward reference the vertebra below.
7 And that's a scenario where someone potentially could be more
8 susceptible to problems from a known traumatic event.

9 Q Whether the age-related changes make them more
10 susceptible or not, can the asymptomatic age-related changes
11 be caused to become symptomatic by a traumatic event such as a
12 motor vehicle crash?

13 A Yes.

14 Q Okay. Did Mr. Simao develop neck pain immediately
15 after his April 15th, 2005 motor vehicle crash?

16 A Well, by history, he says it started after the
17 crash.

18 Q Okay. Was he seen at the Southern -- at -- strike.
19 Was he seen at Southwest Medical Associates
20 approximately three hours after the motor vehicle crash
21 complaining of neck pain and diagnosed with neck sprain?

22 A Yes.

23 Q Okay. What was your --

24 MR. EGLET: Put up page 5, please, line 22.

25 ///

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1 BY MR. EGLET:

2 Q What was your clinical assessment of Mr. Simao
3 following your initial evaluation?

4 A I stated that he primarily had axial cervical pain;
5 meaning, basically, his neck hurt, which also included his
6 upper back, his head. I specifically addressed the MRI
7 finding of narrowing of that C3-4 nerve exit hole which would
8 classically affect the C4 nerve root; classically that is a
9 pattern of numbness, paresthesias tingling that goes on to the
10 front of your chest. I stated he did not have that classic
11 pattern.

12 But it was also in the context that he was
13 complaining of an entire left arm numbness, tingling,
14 parasthesias, and I felt it was important to make out the
15 clear distinction that that would not be explained by this
16 narrowing of the nerve exit hole in and of itself.

17 Q And is that because the narrowing of the nerve exit
18 hole would imply more of an impingement on a specific nerve
19 that would follow the classic pattern you talked about?

20 A Again, classically this would affect the C4 nerve,
21 and classically the C4 was here. Anything that goes down the
22 arm, classically below the elbow, potentially would be C6, C7,
23 C8, T1.

24 Q All right. And what is axial cervical pain?

25 A Axial means basically the middle. So when I say

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1 "axial", it's the middle of your body; your head, your neck,
2 thoracic spine, your low back.

3 Q And what is a dermatome?

4 A A dermatome is the pattern of innervation that is
5 classically assigned to a specific nerve.

6 Q Okay. And so what is the clinical significance of
7 the fact that Mr. Simao's dermatomal pattern of C4 did not fit
8 his clinical symptoms of left-upper extremity paresthesia?

9 A Well, the significant [sic] is, someone comes in
10 with a numb arm, that's part of their complaints, obviously
11 you're -- you are going to try to explain that, and
12 potentially do what you need to do to make it better. So,
13 basically, that was simply to establish as a point of fact for
14 further diagnosis, potential treatment; that to simply go in
15 and do something about that C4 nerve really wouldn't do
16 anything for the patient in the sense of, you know, relieving
17 upper parasthesias.

18 Q Okay. What is a sclerotome?

19 A The two terms that are classically used are
20 dermatome, which we just discussed, and sclerotome. So
21 sclerotome actually refers to the embryo, which is a fetus as
22 it's initially growing. You've got these -- sclerotomes are
23 basically the fine segments of the body coming from the head,
24 going down to the sacrum or the bottom. So what a sclerotome
25 is, is from individual sclerotomes you'll have structures that

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1 are formed. Like the heart comes from a specific sclerotome.

2 So that sclerotome pain is important because, a
3 perfect example -- or a good example would be, someone who's
4 having chest pain from heart problems, it's because of that
5 sclerotomal origin that they have pain into the arm, pain into
6 the jaw, pain into the ear. But obviously the heart
7 technically doesn't have a neurologic structure that goes to
8 the arm, per se; but because they have similar sclerotomal
9 origins, that's why chest pain or heart problems can give you
10 arm symptoms.

11 Another classic example is someone who has
12 gallbladder problems, which is here, they'll get pain going to
13 their shoulder blade. So basically what it is, is when --
14 structurally when common sclerotomal structures are irritated,
15 they will referred pain from that same sclerotome origin.

16 Q Did Mr. Simao have a sclerotomal pain when he
17 initially presented to you in April, 2006?

18 A Well, when I examine him and I go through the
19 discussion, specifically I don't think I actually discussed
20 sclerotome. But the simple concept is, is that if you have a
21 known problem, let's say a disc problem hypothetically at C3-
22 4; well, if that disc is causing a pinched nerve and it's
23 pinching the C4 nerve, you'll get classically symptoms that
24 come here. Okay? And that would be dermatomal because it's
25 causing a pinched nerve.

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1 But if you're getting a different kind of pain
2 pattern where you're getting more trapezial pain, or shoulder
3 blade pain, or pain to your neck, pain to the back of your
4 head, that would be sclerotomal; meaning it's coming because
5 the disc itself is causing pain, and causing nerve receptors
6 to send pain impulses. That's what the patient perceives, and
7 that perception is a pattern that is sclerotomal, not
8 dermatomal, making that distinction between a classic pinched-
9 nerve pain or this common, more sclerotomal pain.

10 Q And Mr. Simao had the sclerotomal --

11 A Yes.

12 Q -- presentation?

13 A As we go on, that's basically the distinction we
14 make.

15 Q And was the sclerotomal pain that Mr. Simao
16 presented with coming from his cervical spine?

17 A As we go on it appears such, as we go through the
18 follow-up charts.

19 Q Was Mr. Simao's documentation of his symptoms,
20 occipital pressure or pain radiating to the sides, in May of
21 2005 consistent with the sclerotomal pattern of radiation of
22 pain from his cervical spine?

23 A Yes.

24 Q Okay. Are there any other explanations for the
25 occipital pain other than sclerotomal radiation from Mr.

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1 Simao's cervical spine?

2 A Yes. You can have a problem with the occipital
3 nerve itself. The occipital nerve is a nerve that comes from
4 the upper levels of the cervical spine, and they go through
5 the various muscle levels on the back of your head and neck,
6 and innervate the back of your head. So those nerves
7 potentially can be susceptible either to a direct blow or they
8 can be susceptible to chronic irritation when patients are
9 having a lot of chronic spasm of the muscle layers, the
10 various layers, that can cause relative sheering of the nerve
11 as it's coming through the muscle layers and cause irritation.

12 Q What options did you discuss with Mr. Simao at the
13 time of your initial evaluation of him?

14 A Well, at that point in time we stated that -- at
15 that -- Mr. Simao did not feel surgery was something he was
16 ready to consider simply because he did not feel his pain was
17 bad enough, usually. Then -- but at the same time he also
18 wanted to better define his pain so he'd know what his options
19 are would be to potentially fix it.

20 So we discussed that injections would be helpful in
21 the sense of defining the structural cause of the pain, but
22 probably not helpful in decreasing long-term pain. That's
23 simply driven by the fact it's already been a year.

24 So with that in mind, Mr. Simao wanted to get a
25 better idea of what was going on so at least he knew where he

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1 stood, and potentially knew better options to consider. We
2 went on to, well, recommend getting some injections at the
3 C3-4 and C4-5 facets, as well as the corresponding C4 and C5
4 nerves that exited those levels.

5 Q Do -- was that the recommendation for the C4 and C5
6 selective nerve root blocks?

7 A Right. Basically I wanted to inject the facet
8 joints, which is the small joints in the back of the spine,
9 C3-4, two levels, or two, one on each side; and C4-5, another
10 two; and then also the corresponding nerves that are exiting
11 at that level.

12 Q Okay. What was your clinical rationale for making
13 those recommendations?

14 A Well, the simple goal was to at least, by level,
15 define where the pain was coming from. So the intention was,
16 the patient would get those injection, and as I stated in my
17 chart wrote, "would have the immediate post-injection pain
18 relief documented."

19 Because technically, the whole, simple idea is that
20 you've got this scenario where you know things can just show
21 up in an asymptomatic fashion due to age-related, slash,
22 degenerative processes, yet patients are doing fine. And at
23 the same time you can have a patient whose not doing fine. So
24 you need to add another layer of confirmation or validity to
25 the process.

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1 So the whole idea is, if I think you're knee hurts,
2 as a perfect example, sometimes knee pain can come from your
3 hip. So if I want to make sure it's your knee and not your
4 hip, I would simple put an anesthetic in your knee, numb it,
5 and then I would have you keep track of what happens to your
6 pain over the next four to eight hours. I say four to eight
7 hours because I personally use Marcaine, which last anywhere
8 from four to 12 hours.

9 Then that gives you chance to actually go home, do
10 the things you would normally find aggravated. I like to use
11 the analogy, gives you chance to test drive the car before you
12 put in your order. I think that's a very good way to evaluate
13 these suspect structural issues, and put them in perspective,
14 and clearly confirm whether or not they're players in the
15 pain.

16 So because of the facet changes at C3-4 and the
17 small disc bulge at C4-5, I thought that it would be
18 reasonable to evaluate those and their pain-generating status;
19 hence, the reason to order those injections.

20 Q Now at that time did you refer Mr. Simao to
21 Dr. Seibel [phonetic] -- or is it Seibel?

22 A Seibel.

23 Q -- Seibel at the Pain Management Center of
24 Southwestern Medical Associates for the cervical spine
25 injections you recommended?

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1 A Yes.

2 MR. EGLET: Could you put up page 9, please, Brennan.

3 BY MR. EGLET:

4 Q Now after you referred Mr. Simao to the pain
5 management center at Southwest Medical, when did he return to
6 see you for follow-up evaluation?

7 A Well, I have my chart. Well, it appears 9-6-07.

8 Q And what interval history did you obtain from Mr.
9 Simao at that time?

10 A Let's see. At this point, what was it, about almost
11 a year-and-a-half. So he's back essentially saying he has a
12 new problem, but the same problem. I think he filled out a
13 new -- did he fill out a new pain diagram? Let me see here.

14 Briefly stated that when he was seen by myself 4-18-
15 06, "Patient went to pain management. Pain management took
16 him on a course of various injections in order to avoid
17 surgery." And I stated that I didn't have any definitive
18 diagnostic information as clearly defining his pain. Stated,
19 "The patient has failed injections as well as pulse-radio
20 frequency. Pain has persisted."

21 Essentially it's been a year-and-a-half since his
22 MRI. I wanted to repeat the MRI to make sure there was no
23 significant changes, and then also "do injections at C3-4 and"
24 C4-5 -- that's a typographic error. It should be "C4-5", not
25 "L4-5". -- to define whether or not the previous suspect

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1 levels at C3-4 and C4-5 were significant pain generators.

2 And the patient was to come back for the injections
3 and the new MRI.

4 Q Now was it reasonable for Mr. Simao to undertake
5 this prolonged course of pain management evaluation and
6 treatment in order to try to avoid surgery to his neck?

7 A Well, the simple answer is, it's basically
8 whatever's right for that patient. I would say in general,
9 Mr. Simao, well, he tended to be a tough guy in the sense that
10 he obviously was -- he didn't come back for almost a
11 year-and-a-half. So I'm sure that pain management offered him
12 injections, and he considered it, and did what he thought was
13 reasonable. But in the end it didn't work so he came back to
14 see me.

15 Q What conclusions did you reach at the time of your
16 follow-up evaluation of Mr. Simao?

17 A On 9-6-07?

18 MR. EGLET: Go to page 9, please, Brennan.

19 BY MR. EGLET:

20 Q Was your conclusion that he had failed a course of
21 injection therapy as well as pulse-radio frequency with
22 persistent pain?

23 A Yes.

24 Q And so what did you recommend for Mr. Simao at that
25 time? And I think you indicated to repeat MRIs and the C3-4

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1 and C4-5 transforaminal epidural steroid injections?

2 A Yes.

3 Q Okay. How do transforaminal epidural steroid
4 injections define symptomatic motion segments in the cervical
5 spine?

6 A Well, the anatomy of the cervical spine is such that
7 each level is fairly well independently and autonomously
8 innervated by the exiting nerves. So you can reliably numb up
9 those exiting nerves at each level, and that essentially numbs
10 up the motions segment; primarily discogenic pain, or pain
11 from the disc, as well as potentially facet pain. But in a
12 simple sense, it just simply tells you on a segment-by-segment
13 level where the pain is coming from.

14 Also, if someone was having corresponding nerve
15 irritation pain, that would also confirm that. So you've got
16 the motion-segment pain, which is basically the spine itself,
17 at each level you have a disc in the front, two facets in the
18 back; and the potentially you've got the other pain, which is
19 the dermatomal pain from the pinched nerve. Mr. Simao, because
20 he had primarily axial pain, the main issue is sorting that
21 out, or it would sclerotomal pain.

22 So it turns out that the anatomy of the cervical
23 spine is fairly level by level independent and autonomous. So
24 you do those injections to specifically numb up each motion
25 segment, and then as long as you use a good technique, you're

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1 not putting in too much medicine so it doesn't go all over the
2 place, then you can selectively numb up each level and
3 reliably confirm the pain-generating component of each level.

4 MR. EGLET: Now page 14, please, Brennan.

5 BY MR. EGLET:

6 Q When you saw Mr. Simao in your office again on
7 November 13th, 2007, did you review the results of his updated
8 MRI with him?

9 A Yes.

10 Q Okay. And what did you review of this diagnostic
11 imaging study?

12 A Well, essentially it was the same. It showed a
13 central disc herniation at C4-5, and foraminal narrowing on
14 the left at C3-4.

15 Q And how did the radiologist, Dr. Momii, interpret
16 this September 24th, 2007 cervical spine MRI?

17 MR. EGLET: Page 17, please, Brennan.

18 THE WITNESS: Looks like he said negative.

19 BY MR. EGLET:

20 Q Okay. And how do you explain the difference between
21 your interpretation and the radiologist interpretation of Mr.
22 Simao's September 24th, 2007 cervical MRI?

23 A That can vary. I would say that most of the time,
24 usually I will get them on the phone, ask them to read it
25 again, and we agree. So in this particular case, it -- it

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1 didn't seem important enough in the sense that we weren't
2 talking about cancer or anything. I would just simply state,
3 I can't explain why he said something other than I.

4 I mean, we could actually pull up those films and
5 maybe I could point out where they're obviously not normal.
6 That's really the only way to resolve it, I would say.

7 What was the date on that, again?

8 Q September 24th, 2007.

9 A I would have to guess for some reason or another I
10 didn't have the report at that point in time, because usually
11 I'm pretty dogmatic about getting that radiologist on the
12 phone.

13 Q We're going to bring this up, doctor, and maybe you
14 can point out the area of your finding.

15 A Okay.

16 Q We've got four different --

17 A Because I wouldn't expect that narrowing of the
18 nerve foramina to go away, for sure.

19 Q If you could come back down out of the box, Brennan
20 is --

21 A Other general comments, sometimes you can have a
22 different techniques that show different types.

23 Q Tell us which sheets you want to look at, and which
24 images.

25 A I'll start with this one here. Have you got the

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1 date confirmed?

2 Q Yes.

3 MR. EGLET: And it's Exhibit 40, Your Honor.

4 THE COURT: Thank you.

5 THE WITNESS: All right. I think the jury can hear. I
6 appreciate this. So let's blowup this one right here.

7 So here it is, this is -- you can see where that
8 left one is narrow; the right one's wide open. So for some
9 reason the radiologist chose not to mention that.

10 BY MR. EGLET:

11 Q Okay.

12 A Let's go back to the composite with all the
13 different numbers, and let's blowup this right here. And you
14 can see that this is a bulging. So I would say -- I can't
15 explain why the radiologist didn't see that.

16 Q Okay. Thank you.

17 Now, Dr. McNulty, what are the risks of cervical
18 transforaminal epidural injections?

19 A On general it's very safe for people who know what
20 they're doing. But it is potentially something that can have
21 problems. In general, what I tell my patients, it's a very
22 first simple statement, is anything can happen and no
23 guarantees. And then the few details I would mention to them
24 would be allergic reaction, infection, blood clot, nerve
25 damage, spinal fluid leak; but I also add the term paralysis

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1 here, and specifically since paralysis has been associated
2 with a specific type of steroid use, which I don't use.

3 So having said that, knock on wood, I haven't had an
4 issue.

5 MR. EGLET: Page 18, please Brennan.

6 BY MR. EGLET:

7 Q And, doctor, when did you perform a left-sided C3-4
8 and a C4-5 transforaminal epidural injections on Mr. Simao?

9 A It looks like you have that up. It looks like 11-
10 16-2007.

11 Q Okay. And, doctor, if you could come back down out
12 of the box.

13 A Sure.

14 Q And if you could use the spine model here, and you
15 could demonstrate and explain to the jury exactly what you did
16 in performing this procedure.

17 A Okay. Well, just to clarify a couple details:
18 Initially I said bilateral, but when I talked to the patient
19 he said his symptoms were only on the left side. So I said,
20 fine, we'll just do the injections on the left. No sense to
21 do both sides.

22 So when we do this, the patient is actually lying on
23 his back, and we're coming in on the left side. So typical, I
24 have Mr. Simao turn his head to the right, extend his neck,
25 and then we're coming in basically here.

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1 So basically this is how the patient is. So if he's
2 -- assuming he's lying right here; he's turned his head away;
3 we're coming on the patient's left side. So what we're doing
4 is carefully, I'm bringing the needles in. This is under live
5 x-ray or fluoroscopy, and I'm carefully monitoring. These are
6 very small needles where they're technically going behind the
7 nerve, and I carefully advance that needle tip so it's
8 actually just inside the spinal canal. And that's a very
9 important distinction, because you're trying to use this
10 injection to define axial pain.

11 So it turns out the small subcategory of nerves that
12 are going off, and going to the disc [audio skips at 2:03:28],
13 a lot of those nerves inside the spinal canal, so it's a very
14 important technique. Some doctors, when they try to do this,
15 they get the nerve -- tip of the needle close, but not get it
16 into the spinal canal. So when you're using it for this
17 purpose, to clearly confirm cause of the axial pain or neck
18 pain, it's a very important technical issue that you have to
19 pay attention to.

20 So once I get that needle in, I'm -- the patient's
21 awake because I want to make sure he's telling me, "Look, I'm
22 not having any trouble with zingers going down my arm,"
23 because you want to do these awake because it adds another
24 level of [audio skips at 2:04:06].

25 And then what I do is I inject a small amount of dye

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1 to confirm that the needle position, the dye spreads around
2 [audio skips at 2:04:15], and that it's not going into an
3 artery. And then once I do that, I think, specifically, I
4 said I injected a 1/2 cc.

5 Can you scroll down a little bit on the procedure
6 note?

7 So you can see here where I'm talking about [Audio
8 skips at 2:04:33] at all. I'm getting just the [audio skips
9 at 2:04:37] neural space, which is the spinal canal, and then
10 I inject a 1/2 cc of Marcaine with a little bit of steroid,
11 make sure that we're not really injecting anything into the
12 bloodstream.

13 So the amounts very important, because you only want
14 it to spread at that level. If -- 1/2 cc is a very [audio
15 skips at 2:04:58]. If I put in 3 ccs, it could easily spread
16 up and down maybe four or five levels. We're trying to use
17 this as a very specific confirmation process; so we say, okay,
18 the pain's coming from here or it's not coming from here. So
19 we did that at C3-4 and C4-5.

20 Q Okay. Thank you.

21 MR. EGLET: And go to page 19, please, Brennan.

22 BY MR. EGLET:

23 Q Doctor, can you tell us what were the immediate
24 post-procedural -- procedure results of this cervical
25 injection you performed on Mr. Simao?

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1 A Well, what I do, my routine is, I like the patient
2 to go home. I get their phone number and call them later that
3 day. Because, again, I try to say, "Look, I want you to go
4 home, do the stuff that you would normally find aggravating,
5 and be able to tell me percentage improvement: Is it nothing;
6 is it 100 percent; is it 50 percent?"

7 So that portion of the procedure, now, basically
8 reflects me calling him later and asking him how he's doing,
9 and him telling me how much pain relief he got.

10 Q In the recovery room, did Bill note that his typical
11 symptomology was at least 80-percent improved during the
12 anesthetic phase of the injection?

13 A Yes.

14 Q Okay. What is the clinical significance of that
15 response?

16 A Well, that would reliably confirm that those two
17 levels, C3-4 and C4-5, were the primary structural causes of
18 his pain.

19 Q Okay.

20 MR. EGLET: Page 19, please, Brennan.

21 BY MR. EGLET:

22 Q What did you discuss with Mr. Simao when you
23 re-evaluated him on December 6th, 2007, about it?

24 A Let's see. He had significant pain relief. Again,
25 this is confirming what he told me, and this is a typographic

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1 error. It's "C3-4 and C4-5".

2 Q Not "L3-4 and L4-5"?

3 A No. No.

4 Q All right.

5 A And, again, just simply stating, "The patient's
6 failed reasonable concern measures as a disc herniation
7 foraminal narrowing," and the plan was to proceed with a two-
8 level anterior or front cervical reconstruction.

9 Q Did Mr. Simao proceed with the anterior cervical
10 fusion surgery you recommended for him at that time?

11 A It appears that he did not, and the next time I saw
12 him was November of 2008.

13 Q And do you know why he didn't proceed with the
14 surgery at that time?

15 A Not precisely. I think he got a second opinion,
16 or --

17 Q Subsequently you found out he wanted to get a second
18 opinion?

19 A Subsequently.

20 Q Okay.

21 MR. EGLET: And go to page 27, please, Brennan.

22 BY MR. EGLET:

23 Q When did you next have the opportunity to evaluate
24 Mr. Simao?

25 A I saw him again on November 4th, 2008.

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1 Q And what was his clinical status at that time?

2 A His pain has increased. It is posterior neck pain,
3 trapezial radiation, mainly left-sided. And, again, because
4 of a approximately a year change, I want to get an updated MRI
5 to see if there had been any change.

6 MR. EGLET: And page 22, please, Brennan.

7 BY MR. EGLET:

8 Q What were the results of the November 6th, 2008
9 repeat cervical MRI you ordered for Mr. Simao?

10 A Mr. Simao followed up on the 25th of November with
11 the MRI as we ordered, and I stated that there didn't appear
12 to be any significant changes compared to the MRI done 9-24-
13 2007. Stated the mild issue of potential left C3-4 foraminal
14 narrowing; stated that he'd been seen by Dr. Rosler and Dr.
15 Grover; also mentioned that the results of a discogram are --
16 not in the sense that -- I didn't mention the whole report,
17 but stated that he had a discogram; and at C3-4, C4-5, and C5-
18 6, there are abnormalities at all three levels.

19 And at that point in time I did not have the
20 complete information from the discogram, so I needed that
21 information. So I was to get Dr. Rosler's and Dr. Grover's
22 notes, and see the patient back.

23 Q So at that time you were informed that he, in fact,
24 had seen a -- gotten a second opinion and gone to Dr. Grover,
25 who is also an orthopedic spine surgeon; is that correct?

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1 A Yes.

2 Q And Dr. Grover had sent him to Dr Rosler, a pain
3 management physician?

4 A Yes.

5 Q Who had done some other injection diagnostic
6 studies, including a discogram?

7 A Yes.

8 Q Okay. And what was your assessment and
9 recommendation for Mr. Simao at that time?

10 A "Patient follows up on 1-6-2009. Patient's pain has
11 changed. He has posterior cervical thoracic pain, left-sided
12 component." I need to confirm the status of the pain
13 generators, and there had been a significant amount of time.
14 So I wanted to repeat the foraminal epidural injections at C3-
15 4, C4-5. I stated that the discograms were provocative
16 discograms in the sense that they showed painful concordant
17 pain, which means - briefly, the discogram is where you put a
18 small needle in the disc, and you're trying to stimulate that
19 disc by injecting dye. And that stimulating response, if it
20 causes pain, you want to know if it's concordant, which means
21 the patient is experiencing pain that's very similar or
22 exactly his typical pain; or non-painful, which means it
23 doesn't hurt, or discordant. That means it's painful but it's
24 not the typical pain he's complaining about.

25 So specifically for Mr. Simao's discograms, he had

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1 positive concordant at C3-4, C4-5; meaning that they were
2 painful and the pain was his typical pain. And he had leakage
3 of the dye at C5-6, but it was non-painful; therefore, C5-6,
4 the dye leaked out of the disc, but it wasn't painful. And a
5 simple common about that -- when you do a discogram in a
6 cervical disc, technically the cervical disc isn't surrounded
7 and enclosed by this annulus.

8 So it's not like a tight balloon. The sides,
9 there's certain little joints called uncovertebral joints, and
10 those joints can actually, in a normal state, actually leak
11 dye. So I would say in a cervical discogram, the fact that
12 the dye is, quote, unquote, leaking isn't as -- isn't as much
13 of an issue at all in a similar situation when you do a lumbar
14 or a low-back.

15 Q So did you consider the C5-6 and the discogram a
16 control level?

17 A I would consider it a control level. At the same
18 time, I also felt it was important to confirm with an
19 analgesic block.

20 Q You -- I think you mentioned that there was a change
21 in Bill -- in William's pain to posterior cervical thoracic
22 pain with a left-sided component. Recall that?

23 A I did, and the change may have been it got worse.
24 In a similar -- in a very simple sense, it's very similar. I
25 mean the true nature of pain day-to-day is it can vary.

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1 Q So with this note -- pain change you noted, the fact
2 that you now have the provocative discogram results performed
3 by Dr. Rosler showing concordant pain at the C3-4, C4-5 level,
4 and the control level at C5-6, what did you recommend for him
5 at this time?

6 A Well, my simple practice principles are that I think
7 I'm doing a better job of selecting patients for surgery if I
8 can do a confirmatory analgesic or numbing injection. I think
9 that does a better job of both confirming the pain generator
10 status, but also selecting a patient who has a better chance
11 of doing well with appropriate surgery. So I simply wanted to
12 repeat the foraminal epidural injections and again document
13 the pain relieving effect of those injections before
14 definitely embarking upon surgery.

15 Q Okay. And what is the difference between a
16 provocative study and an analgesic study when performing
17 injections in the spine to determine a pain generating site?

18 A Well, the simple concept is if you want to know if
19 something hurts -- let's say if I want to know your knee
20 hurts. I can take your knee and move it and try to grind it
21 and manipulate it and that motion makes it hurt. Okay. But
22 at the same time, again referring to the hip, that same
23 manipulative maneuvers may also move the hip or stimulate the
24 hip.

25 So another way to clearly confirm a structure's

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1 painful is to simply, in a specific controlled fashion, numb
2 up that structure. And then if the pain goes away for the
3 same provocative maneuvers then you can reliably say that
4 structure's causing the pain. So a provocative disc --
5 unfortunately, the spine is very difficult to examine. If I
6 want to make a distinction between wrist pain and elbow pain
7 there's enough physical distance to manipulate your wrist and
8 not really do anything to your elbow. But as you can see by
9 that model, the distance between C3-4 and C4-5 isn't that
10 much.

11 So I can't reliably shuck [audio skips at 2:15:30]
12 back and forth and then go down and shuck C4-5 back and forth
13 without having some effect. So that's why we have to depend
14 on these injections in order to more selectively confirm
15 various levels. So a provocative discogram is essentially
16 trying to stimulate the disc so the patient can tell whether
17 or not it's painful and what that pain is.

18 There's an analgesic discogram, which we didn't do
19 here, because we can essentially get the same effect by
20 selectively just numbing up that corresponding nerve; would
21 confirm the pain by taking the pain away.

22 Q Now hypothetically, if a physician hired by the
23 defense in this case were to criticize you as a spine surgeon
24 for performing your own diagnostic spine injections, how would
25 you respond to that?

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1 A Well, I would be open to criticism in general. But
2 in this specific case I'm not doing provocative testing,
3 meaning I'm not sitting there while I'm injecting and the
4 patient's telling me oh yeah, that's it. This is -- there's a
5 layer of transparency here in the sense that I'm putting the
6 analgesic or the anesthetic where I want it, but it's the
7 patient telling me, you know, later that day, after four to
8 eight hours, whether or not they feel any significant change
9 in their pain.

10 So -- and the other reason I think there's really
11 not an issue with that is that it also allows the patient to
12 have direct recall of that. A lot of times with these
13 provocative discograms patients are given sedatives that make
14 them amnestic, so they don't even remember the procedure.
15 This way, the patient can independently recall and say yeah, I
16 remember that afternoon. It felt great. So I, you know, I
17 don't think it really -- there's a problem with that in that
18 sense.

19 And also in general orthopedics we do that all the
20 time. Another common scenario, someone has impingement, which
21 is irritation of the rotator cuff, we do it all the time where
22 we do a injection in there under -- around the rotator cuff.
23 We use that as another predictor to tell us whether or not
24 surgery's appropriate and whether or not they'd do well. So
25 again, I think the patient telling you, I really don't think

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1 that's an issue.

2 Q [Audio skips at 2:18:10] an injection for Mr. Simao
3 when you previously performed only left-sided [audio skips at
4 2:18:23] and his symptoms were --

5 A [Audio skips at 2:18:25] the pain diagram. More
6 reliably [audio skips at 2:18:35] do we have the procedure
7 note?

8 Q Page --

9 A So if it's central portion, then you're going to
10 have confirming [audio skips at 2:19:12] the status of that
11 level by doing injections from both sides.

12 Q Okay. Now when did you perform the bilateral C3-4
13 and C4-5 transforaminal epidural injections?

14 A This appears to be 2/13/2009.

15 Q When you spoke to Mr. Simao after this procedure,
16 what was the anesthetic response to his cervical injections?

17 A Can we go to the end of the procedure note?
18 "Patient was later called and noted that during the anesthetic
19 phase, or the period that it was numb, he had 65 to 70 percent
20 relief of his typical chronic pain, confirming those as
21 significant pain generators at C3-4 and C4-5."

22 Q Okay. Now at this point in time, am I correct in
23 stating that there had been a previous selective nerve root
24 block -- a transforaminal selective nerve root block performed
25 by you which confirmed that the C3-4 and C4-5 discs were pain

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1 generators; there had been selective nerve root blocks
2 performed by Dr. Rosler, who had confirmed the C3-4 and C4-5
3 discs were pain generators; there had been discogram --
4 discography performed --

5 MR. ROGERS: Objection, Your Honor; leading.

6 THE COURT: It's pretty compound, Mr. Eglet.

7 MR. EGLET: I'm asking him an entire question. I'm
8 laying a foundation for the question, Your Honor, if I can
9 have some leeway.

10 THE COURT: All right.

11 MR. EGLET: His testimony has already occurred, so I'm
12 just laying the foundation for it.

13 BY MR. EGLET:

14 Q Dr. Rosler had performed a discogram, discography,
15 which confirmed that C3-4, C4-5 were pain generators, and now
16 you had performed an analgesic selective nerve root blocks
17 which had confirmed that the C3-4, C4-5 were pain generators
18 in this case. Is that all correct?

19 A The only slight technical point is I don't have
20 independent recollection of Dr. Rosler's selective nerve root
21 blocks.

22 Q Okay.

23 A With the exception of that little point, yes.

24 Q All right.

25 MR. EGLET: Can you give us page 43 please, Brendon, of

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1 Exhibit 22.

2 BY MR. EGLET:

3 Q Doctor, could you discuss with us the difficulty
4 that you documented in sorting out the immediate post
5 procedure pain relief when you re-evaluated Mr. Simao on
6 February 24th, 2009?

7 A Well, I simply stated "The patient had some
8 difficulty sorting out the post procedure pain relief
9 immediately after the procedure because he had some pain
10 associated placing the needle, as well as some pain removing
11 the adhesive stereo -- sterile drapes or barriers." There's a
12 typo there. Obviously Mr. Simao's a he, not a she. But he
13 was able to make that distinction about his chronic pain, so
14 he was able to separate those two issues and state clearly
15 that his chronic typical pain was 65 to 70 percent better.

16 The term this conflicts is not correct. That again
17 is a type -- it doesn't conflict. It basically confirms --

18 Q Where are you talking about in there?

19 A On the same chart note, third line from the bottom
20 of the first paragraph. Says "This conflicts."

21 Q This conflicts?

22 A Yeah, that's a typographic. Doesn't conflict, it's
23 basically consistent with the previous discograms which showed
24 painful discogenic responses at C3-4 and C4-5, as well as pain
25 relief with previous injections at those levels. So I stated

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1 that because he had pain relief with the analgesic blocks in
2 the context of a confirmatory or consistent provocative
3 discograms, that I stated that he had painful segments at C3-4
4 and C4-5, primarily discogenic.

5 Q Discogenic pain?

6 A Yes.

7 Q Okay. And page 40 -- I guess we're still on page
8 43. What did you recommend for Mr. Simao at that time,
9 Doctor?

10 A Anterior cervical reconstruction fusion, C3 to C5.

11 Q Could you please discuss for us all the clinical
12 information that you used and your thought process in
13 determining that Mr. Simao had painful motion segments at C3-4
14 and C4-5 that were primarily discogenic, for which surgical
15 reconstruction could be beneficial?

16 A Well, the simple answer is everything we've
17 previously discussed. The brief summary is the patient
18 stating that his symptoms have persisted. He's gone through
19 reasonable conservative measures which would be time,
20 medications, physical therapy. He's failed other measures
21 such as pulse radio frequency, various injections. The MRI in
22 and of itself does not definitively tell you that this is the
23 problem, but it does raise the potential structural pain
24 generators. Then we used the injections we discussed, both
25 the provocative or pain inducing discograms, as well as the

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1 confirmatory analgesic blocks that are specifically targeting
2 those levels.

3 But in the end, it's simply the statement that the
4 patient feels that their pain is significant enough on a day-
5 to-day basis, a functional status, that they're ready to do
6 something to make it better.

7 Q Now hypothetically, if someone stood in front of
8 this jury and told this jury that the C3-4 and C4-5 cervical
9 segments were not pain generators, would that be an accurate
10 statement?

11 A Well, I'm always open to different opinions. I'd
12 want to know why they say such. Is there any hypothetical
13 justification for their opinion?

14 Q Well, it's a lawyer.

15 A Oh well, okay. I would say it'd be my opinion that
16 I would disagree and I would say that I think they are painful
17 motion segments for all the reasons we've just stated.

18 Q And hypothetically, if someone stood in front of
19 this jury and told this jury that Mr. Simao did not have a
20 cervical disc injury because cervical x-rays and MRIs did not
21 show a disc injury, would that be an accurate statement?

22 A Again, as I answered previously, with the exception
23 of the severe injury where literally the spine is being ripped
24 apart, I would state that x-rays, CAT scans, MRIs by
25 themselves, without some type of injection process, with the

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1 exception of that severe injury where the disc is literally
2 ripped apart, do not reliably confirm or eliminate discogenic
3 pain.

4 MR. EGLET: And could you go to page 52 please, Brendan.

5 BY MR. EGLET:

6 Q Doctor, what was the purpose for your re-evaluation
7 of Mr. Simao on March 24, 2009?

8 A That point, we were -- it's what I call our final
9 procedure consideration visit. That's where we simply have
10 our final check off before doing surgery, make sure there
11 hasn't been any significant changes, go over pertinent issues
12 of past medical history exam, make sure the patient
13 understands the plan, review the studies. It's basically just
14 a final confirmation before embarking upon surgery.

15 Q What are the risks of anterior cervical
16 decompression, fusion, and instrumentation?

17 A Well, I can briefly just tell you the speech that I
18 give the patient.

19 Q Okay.

20 A The simple statement I state is that there's no
21 guarantees. Anything can happen. Give me permission to
22 change the plan at my discretion. If I am there and I feel
23 something else needs to be done or changed, I do it. I'll
24 mention specifics such as heart attack, stroke, pneumonia,
25 allergic reaction, infection, blood clot, death. I also

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1 mention specifics such as weakness, numbness, paralysis,
2 spinal fluid leak, altered bile and bladder function, sexual
3 function. When we do the surgery I put in cages that are
4 filled with a synthetic bone putty to fuse or glue the
5 vertebrae together, take out the disc, replace it with a
6 structural cage, and fill the -- excuse me, the inside portion
7 with a synthetic bone putty to provide a canal or conduit to
8 help the vertebrae bone to bone and then secure it internally
9 so it doesn't move with a low profile plate. It has two
10 screws that go into each vertebra. It's like gluing two
11 pieces of wood together, put the glue, put them together, and
12 then ideally put a clamp on there to hold it until it's solid.
13 So I tell them about the potential of that breaking, not
14 healing, moving, going somewhere I don't want it to go. I
15 also specifically mention typically the issues of potential
16 swallowing difficulties, hoarseness, which usually are simply
17 related to the retraction you do to get things out of the way
18 to see and then get better.

19 Q Now before proceeding to anterior cervical
20 decompression and fusion, did you send Mr. Simao to Southwest
21 Medical for preoperative clearance?

22 A To be quite honest, I don't know. Selectively, if
23 someone's relatively healthy, I'll just get all the stuff
24 myself. And if there's anything that pops up, I'll send them
25 back to their primary. Or if it's -- usually it's a matter of

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1 convenience with how the flow is going with patients to get
2 back to their primary. If it's relatively easy for them to
3 get back, then I'll let them handle it. But ultimately it's
4 me looking at the stuff and agreeing that it looks okay.

5 Q Assuming you did that, is it your understanding that
6 Mr. Simao was cleared for surgical procedure you recommended
7 to him by the medical personnel at Southwest Medical?

8 A Yes. And then one little caveat is ultimately the
9 anesthesiologist who sees the patient the day of surgery has
10 final say.

11 MR. EGLET: Page 88 please, Brendan.

12 BY MR. EGLET:

13 Q In your dictated preoperative history and physical
14 at University Medical Center, what did you document regarding
15 Mr. Simao's employment history?

16 A Do you have that up? Okay, perfect. Let's see,
17 works in flooring sales.

18 Q Okay. Hypothetically, if someone told this jury
19 that Mr. Simao did not have a -- or could not have had a
20 cervical spine injury because he returned to work after the
21 April 2005 motor vehicle crash, would that be accurate?

22 A I would disagree. I'd say no.

23 Q And why?

24 A I would say it's my opinion, generally Mr. Simao's a
25 tough guy who doesn't let things slow him down.

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1 MR. EGLET: Page 90 please, Brendan.

2 BY MR. EGLET:

3 Q Doctor, what procedure did you perform on Mr. Simao
4 on March 25th, 2009 at University Medical Center?

5 A Well, briefly I've already talked about what we do,
6 but I --

7 Q Well, if you could come out of the box using the
8 spine and demonstrate for the jury with the spine model the
9 procedure you did, the surgery you did that time.

10 A So the goal of the surgery is to eliminate these
11 disks that are potentially contributing to the pain. But also
12 when you do that you're fusing the vertebra together. So
13 hypothetically, if there is any component of facet pain, which
14 are the small joints in the back, you would be addressing that
15 because it would stop moving. In the old days before we had
16 hip replacements, the treatment for hip arthritis was fusion.
17 So essentially it's applying old school technology and
18 principles to the cervical spine. And also -- and again, my
19 simple goal with surgery is to do as much as I can to take
20 care of any potential problem.

21 So we have Mr. Simao lying down again, he was on his
22 back. We slightly extend his neck, rotate his head to the
23 right, and we come in from the left side, classically make an
24 incision that's cosmetic and transverse here. And when we
25 just scoot the voice box and the swallowing tube over to get

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1 to the front of the spine and put retractors in that are
2 gently holding things out of the way. We also go right next
3 to the carotid artery, expose the spine.

4 Typically I'll put pins into the actual vertebra to
5 confirm we're at the right level, we'll take an x-ray, say
6 okay, everything looks good. First thing I like to do that
7 because that way if you are not at the correct level you're
8 not putting a needle in the disc per se. So you wouldn't want
9 to ideally stick a needle in a disc that doesn't need the
10 surgery. Then what we do is we use those pins to spread apart
11 the vertebra.

12 We take out the disc, I go ahead and make sure that
13 there's no pressure into the front of the spinal canal. And
14 also the process of taking out the disc, what you do is you,
15 when you -- you have to fill that space up with something.
16 After you take out the disc you make sure the bone is good and
17 what we call raw, meaning it's nice and exposed and it's got
18 some bleeding to it so that way it's going to heal to other
19 bone. So you put in these structural cages. These cages
20 specifically are made of the plastic called PEEK, which stands
21 for polyether ether ketone.

22 And in the center portion of these cages we put a
23 synthetic bone putty, so that way avoids the pain. In the old
24 days we used to take bone off their hip, cut it to size and
25 put it in there, but there's a certain incidence of pain from

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1 that procedure. And in the process of jacking open the disc
2 space, also would theoretically evaluate the potential, if
3 there is any component of this nerve at C3-4 exit hole, that
4 process also relieves that. Okay?

5 So again, the idea is if I'm going to do this, I'm
6 going to try to maximize every potential benefit to it. So if
7 he's got -- if we think he's got discogenic pain, but maybe
8 he's also got facet pain, the fusion should take care of that.
9 If you think he mainly has discogenic pain but he may actually
10 have some component of this nerve getting pinched, jacking up
11 on that disc and fusion, it should take care of that too. So
12 from a general perspective, I thought this would be the best
13 thing to potentially take care of the major players in
14 Mr. Simao's problem.

15 So we do that and then we put a low profile plate,
16 and it has screws that go into each vertebra to lock it all
17 down. The other important thing while we're doing this, we
18 have spinal cord monitoring, which is a separate technician
19 who's looking at a laptop. We have various needles and pads
20 that are constantly monitoring the traveling electrical
21 impulses up and down through the spinal cord. So that way if
22 anything's going on that's starting to affect it, we get a
23 early warning and we can intervene and do whatever we can. So
24 that's helpful for spinal cord. And that's good, but the
25 technology really doesn't protect or tell you anything about

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1 the nerves themselves, but the spinal cord does. He had no
2 problems with that, but that's just a standard precaution that
3 we do.

4 After that we go ahead and make every -- make sure
5 everything looks good with an x-ray, and then I'll close him
6 up cosmetically, put a small drain in. Then typically they're
7 in the hospital for a day or two depending how long it takes
8 for them to get their swallowing back to a reasonable degree
9 where at least they can swallow liquids, their pills, and have
10 good pain control.

11 Q Were there any complications of the surgical
12 procedure you performed on Mr. Simao?

13 A No.

14 Q Okay. You can sit back --

15 [Pause]

16 MR. EGLET: And page 92 please, Brendan.

17 BY MR. EGLET:

18 Q When was Mr. Simao discharged to home from
19 University Medical Center?

20 A Looks like we had surgery on the 25th of March, and
21 then he was discharged two days later on the 27th.

22 Q Okay.

23 MR. EGLET: Page 56 please, Brendan.

24 BY MR. EGLET:

25 Q What was Mr. Simao's clinical status when you

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1 evaluated him for his first postoperative visit on April 14th,
2 2009?

3 A Let's see. At that point, typically I'll see my
4 patients two weeks or a little over two weeks. Generally he
5 was doing well, already noticing significant improvement. X-
6 rays taken showed good maintenance of the reconstruction and
7 plan was to follow up in six weeks.

8 Q Did you obtain postoperative cervical spine x-rays
9 at that time?

10 A I did. They showed everything looked good.

11 MR. EGLET: Could you put up both images from Exhibit 61
12 please, Brendan.

13 BY MR. EGLET:

14 Q And could you please review this, study with us
15 these x-rays and tell us what they show?

16 A Okay. So this basically shows where -- this is the
17 cage we put. So this is normal disc, so these are the discs
18 we've operated on. So the discs are removed. These are
19 plastic cages that are placed in the space. These are little
20 localizer titanium bars so we know where the plastic is; it
21 doesn't show up on x-ray. These are little clips we use.
22 That space between the voice box and the carotid artery
23 there's crossing blood vessels you have to snip and clip. And
24 then this is the plate that's on the front with the screws
25 going into the vertebra locking everything down. So

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1 everything looks good.

2 Q Okay, thank you.

3 MR. EGLET: Now page 58 please, Brendan.

4 BY MR. EGLET:

5 Q What was Mr. Simao's clinical status when you
6 evaluated him two months postoperatively on May 26th, 2009?

7 A Two months.

8 "Doing well. X-rays showed good maintenance of
9 reconstruction. Plan: discontinue collar, start
10 physical therapy, may resume work as tolerated, come
11 back in four months."

12 MR. EGLET: Page 61 please, Brendan.

13 BY MR. EGLET:

14 Q What was Mr. Simao's clinical status when you saw
15 him on July 14, 2009, approximately three and a half months
16 postoperatively?

17 A "Has had left upper extremity paresthesias and
18 pain down to the hand for approximately a week. A
19 neurological exam shows no significant weakness or
20 numbness in the arms or hand. C5 to T1 dermatomes
21 and monotonies. X-rays again taken, show good
22 maintenance of reconstruction. Make a note, please
23 note prior to surgery upper extremities did not go
24 distal, which means past or below the elbow.
25 Concern for potential C6 radiculopathy. Plan: MRI

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1 cervical spine and CT cervical spine, see patient
2 back after above."

3 Q Why were you concerned about a possible C6
4 radiculopathy at that time?

5 A Well, in general when you have problems present like
6 this, there's always a chance that a disc above or below is
7 causing problems. So there's typically more stress or
8 typically the disc that may be more suspect would be the disc
9 below the fusion. So that would be C5-6, lastly C5-6 would
10 affect the C6 nerve root.

11 Q So you ordered an MRI with -- of the cervical spine
12 with contrast and a CT of the cervical spine?

13 A Yes.

14 Q Why did you recommend those two diagnostic studies
15 at that time?

16 A Well, in general, the MRI does a good job of
17 assessing whether or not there's any disc herniation or bone
18 spur, pinching a nerve or a spinal cord. And the CAT scan
19 does a good job of telling me what the status is of the bony
20 elements, the fusion, the hardware, where the screws are, how
21 the fusion looks.

22 MR. EGLET: And page 31 please, Brendan.

23 BY MR. EGLET:

24 Q What were the results of the MRI of Mr. Simao's
25 spine that you ordered and was performed on August 11, 2009?

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