BY MR. JAFFE:

Q. Dr. Gross told me the other day that the only people who consider it controversial are the people I hired.

Are you -- what is your general understanding within our medical community beyond the people that I've hired in this case --

MR. CLOWARD: Your Honor, I'm going to --

BY MR. JAFFE:

Q. -- like Dr. Siegler?

MR. CLOWARD: -- I'm going to object and ask to approach about this opinion.

THE COURT: Come on up.

(Whereupon a brief discussion was held at the bench.)

THE COURT: Overruled.

MR. JAFFE: Thank you.

BY MR. JAFFE:

Q. Dr. Schifini, do you remember the question or do you need it restated?

A. No, I remember the question.

Q. Go ahead.

A. The diskograms themselves are controversial procedures. Depending on the way that they're performed, certain physicians in our community and

other communities around the country consider them to be controversial tests or tests that should be used in conjunction with other tests, kind of as a piece of the puzzle rather than the entire puzzle.

Q. Now, you were critical of the manner in which Dr. Belsky performed the diskogram in this case; is that correct?

A. That's correct.

Q. Now, she actually did two; isn't that right?

A. Three.

Q. Three?

A. Three levels. Is that you are -- what you're referring to?

Q. No, no, no, no. At two different times did diskograms, or did she do it just the one time?

A. Just the one time.

Q. And that was immediately prior to the plasma disk decompression?

A. Yes.

Q. Now, you don't do plasma disk decompressions, right?

A. No.

Q. Are you aware of anybody in the community other than Dr. Muir who does them?

A. No.

Q. And we -- we've heard that a positive diskography is an essential finding to warrant a plasma disk decompression being performed.

Do you -- I'm just telling you that as a preparatory statement. Okay?

A. That's my understanding, yes.

Q. Now, that would mean, obviously, if there was a negative diskography, you would have to question whether plasma disk decompression is necessary or appropriate.

A. Yes.

Q. Sir -- and by the way, have you reviewed other cases than this one involving plasma disk decompression and -- performed by Dr. Muir and diskography?

MR. CLOWARD: Your Honor, I'm going to object and ask to approach.

THE COURT: Come on up.

(Whereupon a brief discussion was held at the bench.)

MR. JAFFE: Thank you, Your Honor.

THE COURT: Overruled.

BY MR. JAFFE:

Q. Have you reviewed other cases, sir, involving plasma disk decompression performed by Dr. Muir?

A. After Dr. Belsky performed the diskogram, yes.

Q. Do you routinely see Dr. Belsky as the one performing the diskogram in those circumstances?

A. I see them as a team that performs these, with Dr. Belsky performing the diskogram while Dr. Muir waits in what he described as the doctor's lounge at a particular surgery center that they utilize, awaiting the word that he can come in and put the probe through the --

Q. We're not talking about the surgery itself. Okay, sir?

A. It's not really a surgery.

Q. Okay. Sir, let's just -- let's just leave it at that. I just wanted to ask you about whether these two work as a team.

A. Yes.

MR. CLOWARD: Your Honor, I just move to strike that last comment.

MR. JAFFE: I don't --

THE COURT: About the probe, yes. Dr. Schifini is not here to talk about the probe and the surgery, so that part of it will be stricken.

BY MR. JAFFE:

Q. Okay. We're not talking about that

procedure. Okay, sir?
A. Okay.
Q. Now, again, given the fact that the positive diskography is necessary, do you have concerns about the way this diskography was performed to then allow for a positive finding?
A. Yes.
Q. Okay. How is diskography performed -- let me withdraw.
You familiar with -- with ISIS?
A. I am, yes.
Q. And ISIS is the International Society of --
A. Interventional spine physicians.
Q. Okay. And does ISIS set forth guidelines by which diskography is to be performed?
A. They do.
Q. Do you believe that Dr. Belsky complied with the ISIS guidelines?
A. No.
Q. Why?
A. Well, first of all, the ISIS guidelines strongly discourage the use of general anesthetic agents during the performance of procedures which require patient feedback or input. Propofol, the general anesthetic agent or one of the agents that was

used in this particular case, has been discussed at ISIS conferences, the most recent one being last June or July here in Las Vegas, as not being recommended for use due to its propensity to induce unconsciousness at any dose.

Diskography requires a few different kind of components to -- to be accurate and valid. One is that you measure pressures during the performance of the diskography. The other is that you describe the anatomy of the inside of the disk as you're performing it. As you put dye in there, you're basically describing where the dye went or didn't go and things of that nature.

But the most important component of diskography is patient response during the performance of the procedures so that they can tell you whether or not the pain that they may or may not be experiencing is like their pain is different than their pain is in a different location than their usual pain. The performance of the procedure with this type of sedation is unusual is the nicest word I can think of.

The other unusual thing about the performance of these procedures is the manner in which Dr. Belsky placed the needles. If you look at her procedure note, her needle placement is a particular size when she puts

it in a disk that she considers to be a negative or a normal disk. But it's a much larger size needle to -- to be placed in the disk that she knows somehow is going to be positive.

As I've stated before, I've reviewed lots of these cases involving plasma disk decompression preceded by the diskography, and it always seems that the larger needle placements in the disks is always associated with a positive disk, whereas the smaller needles placement is always associated with a negative disk. It's almost as if Dr. Belsky was able to predict the future. The future should be unknown when you're performing diskography.

Q. Given the medication used and the larger needle -- well, first off, is the larger needle likely to -- more likely to produce a positive pain response?

A. Well, you -- you can imagine placing a larger needle into any structure in your body would produce more pain than putting a smaller structure in your body. So the -- my assumption is, yes. I don't have any study to prove that, but just general knowledge of placing needles in patients, larger ones tend to cause more pain.

Q. Do you do diskography?

A. I do.

Q. Is that part of your practice?
A. To put the same size needles in each of the disks that I'm testing, yes. I'm not going to put different size needles in each of the disks.
Q. Now, as part of a diskography, is it critical to elicit a pain response consistent with the type of pain that the patient typically experiences?
A. Should be exactly like the pain that the patient typically experiences in a very specific pressure range. So measuring pressures during the diskography is very important. Pressures in a particular range validate the study. Pressures outside that range can cause pain in a disk that don't mean anything, because you could cause the pain even in a normal disk at particular pressures.
Q. So if we're using a general anesthetic and we're using larger needles, what does that say about the ability to obtain a proper response in order to have an accurate diskography?
A. It's questionable, at best.
Q. If that's the case, does it raise questions about whether the plaintiff actually did have a positive diskography before undergoing this plasma disk decompression?
A. It raises questions in my mind, yes.

Q. Is that consistent with the type of -- the manner in which you've seen Dr. Belsky perform this procedure in the other cases?

A. Every other time.

Q. Every other time?

A. Yes.

Q. And had it not been positive, then it would raise questions as to the propriety of the plasma disk decompression?

A. It would become unnecessary.

Q. Okay. Doctor, are there any other issues that you have evaluated and that you have addressed at our request?

A. There was some billing issues associated with that office as well.

Q. Okay. What are your concerns about billing?

A. Dr. Belsky's billing tends to be approximately 50 percent higher than the community standard. Assuming that the procedures she performed were reasonable and related, they -- they would have been 50 percent higher.

So I'm not making any judgments as to the reasonableness of those or the necessity of those particular procedures that were performed by her and the bills generated at the time. I was critical of the

billing that she performed. She's an anesthesiologist, as I am, and there's a society called the American Society of Anesthesiologists which is associated with something called the ASA is the initials for that. And they set forth billing standards as far as what should be billed and what shouldn't be billed.

There are a couple of procedures that she performed in which you use live X ray, and that's why we do them at a surgery center so that we can identify the particular area. It's -- it's perfectly acceptable to bill for that, but billing for the injection of dye associated with that is what we call unbundling. You assume you're going to inject some dye when you perform these. So there was some unnecessary billing associated with -- with that particular portion of the procedures.

And then there was an anesthesiologist involved in every single procedure performed by Dr. Belsky who happens to be her husband that is present which if propofol, the general anesthetic agent, wasn't used, that billing would become unnecessary as well.

Q. How many times have you heard of a wife accusing their husband of not doing their job right? Other than taking out the trash and emptying the

dishwasher.

A. Outside of the home, never.

Q. Doctor, let's -- let's turn to another area.

Did you also address an issue called "secondary gain"?

A. I did, yes.

Q. As a doctor, is secondary gain something that you're concerned about when people have a case that's in litigation?

A. It is.

Q. Okay. What is the concept of secondary gain generally?

A. Secondary gain, in general, is a person who receives some perceived benefit from acting or portraying themselves in a particular way or they evade or avoid something that would be considered to be bad for them. So you're basically gaining something good or avoiding something bad by acting a particular way or portraying yourself in a particular way. And that may be a conscious thing or it may be unconscious. Sometimes you have no way of telling the difference between the two, whether it's conscious or unconscious.

Q. Is secondary gain something that you are concerned about when treating patients involved in litigation?

A. I'm concerned about that with -- with a lot of the patients that I see. But until they demonstrate that they actually have some factors associated with it, I don't necessarily label people as having that.

But, you know, let's face it, people come to me oftentimes for medication, for injections, for time off work, for things of that nature. So I always have to kind of keep that in the back of my mind, but I don't really label somebody as having concerns for secondary gain until they have demonstrated that there is a potential for that behavior.

Q. Do you have any opinions regarding secondary gain in this case?

A. I do.

Q. What are those?

A. I believe there are factors associated with secondary gain other than the medical-legal context of this claim. I mean, that could be said of anybody that files a lawsuit, so I don't necessarily hold that against Ms. Seastrand. But there is that sort of factor associated with secondary gain that is associated with anybody who files a lawsuit.

But besides that, the complaints of hers, what we call the subjective complaints, outweighed the objective findings or the testing that was done. She

appeared to have minimized or omitted some of the facts regarding her long history of neck and back pain in the past, although she did fill that out on one particular form from a radiology facility, that she'd had back pain for 26 years. She told the police officer that she had a history of neck and back pain from prior accidents. She commented to the chiropractor that a couple of times a week or a month, I think two to four times a month, that she would have neck or back symptoms. But she didn't relay that information to all of the providers involved so that they could take that into consideration when they were offering her treatment.

And so for those reasons, I -- I feel she has some secondary gain behavior that was exhibited during my review of the records that I have had the opportunity to explore over the past year or so.

Q. Are you in any way implying whether that was intentional or an involuntary act?

A. I assume it was an unconscious act, but I don't have any other way. If I knew that it was a conscious act and that there was intent, I would use the word "malingering," but I don't think that applies here because I don't think that intention has been exhibited or documented.

Q. Okay. Doctor, have all the opinions you've stated today been to a reasonable degree of medical probability as a board-certified anesthesiologist subspecializing in pain management?

A. Yes.

Q. Thank you.

MR. JAFFE: I have no further questions, Your Honor.

THE COURT: Folks, we're going to take a little bit of a late lunch today so we can try to get through Dr. Schifini's testimony. So I'll still give you a lunch. Don't worry about that. Just take it a little bit later.

Go ahead and cross, Mr. Cloward.

MR. CLOWARD: Judge, same thing, can I have a minute to set up?

THE COURT: Yep.

CROSS-EXAMINATION

BY MR. CLOWARD:

Q. How you doing today, Doctor?

A. I'm doing well. How are you doing?

Q. Nice to see you.

A. Nice to see you as well.

Q. Now, I just want to point out when you wrote

your report, you weren't given the records from Dr. Muir -- or, excuse me, Dr. Lurie and Primary Care Consultants, correct?

A. Yes, initially I was not given those.

Q. And you -- you still authored a report, though, right?

A. I did, yes.

Q. Okay. And you had no control over what records you were given, correct?

A. That's correct.

Q. All right. And when Mr. Jaffe was talking about the disks and things changing after a surgery, you in fact examine people even after surgeries, right?

A. I do, yes.

Q. Okay. And that's helpful to you, right?

A. It can be, yes.

Q. Sure. Okay. Now, I just want to get a couple of things real quick.

MR. CLOWARD: Judge, can we turn on the TV?

THE COURT: You want the ELMO? What do you want?

MR. CLOWARD: The ELMO, yes, please.

BY MR. CLOWARD:

Q. Just want to see if we can agree on a couple of things, Doctor --

A. Okay.
Q. -- based on your prior testimony. We're just going to go through these.
MR. JAFFE: Your Honor, I think it's inappropriate to show this before the doctor's testified.
MR. CLOWARD: The objection was -- last time, it was that I showed it to him after.
THE COURT: I'm going to allow it. It's demonstrative. Go ahead.
BY MR. CLOWARD:
Q. Doctor, you've previously testified that people can get hurt from some things like picking up a pencil, correct?
A. Yes. I've had workers' comp patients, like school teachers picking up a pencil, that have gotten injured.
Q. Okay. You previously testified that people get hurt from low-speed crashes, correct?
A. They can, yes.
Q. You previously testified that knowing the speed of the vehicles at the time of the impact means nothing to you because injuries can occur at any speed as you have learned, correct?
A. I have testified to that earlier or

previously, yes.

Q. And you agree that property damage does not determine whether a person is injured, true?

A. True.

Q. You agree that when there's minor property damage, someone can still be hurt, true?

A. Yes.

Q. You agree that you can have major property damage and no injury, true?

A. Yes.

Q. You agree that you can have minor property damage and major injury, true?

A. Yes.

Q. Regarding MRIs, you previously testified that an MRI will only show trauma when it's serious, true?

A. Yes, like broken bones and blood I think is what I've said in the past.

Q. Right. So we'll just mark those ones off.

A. I wasn't reading ahead.

Q. No. Doctor, I appreciate it. Thank you. Because that's basically -- you know, you have testified to that, right?

A. Yes.

Q. Okay. You also testified that the neck -- the neck is complex and small findings can cause large

problems.

A. Yeah. I think I was speaking in a case that I -- I think I recall where a small disk protrusion may cause a larger issue in a particular area because of the whole or the -- the canal in the spine -- in the cervical spine is smaller.

Q. Sure. And like when people do surgeries, doctors do surgeries, you know, even a little mistake can have serious consequences, right?

A. Sure.

Q. Okay. Doctor, you've previously testified that spine surgery is beyond your level of expertise, true?

A. The actual performance of spine surgery, yes.

Q. And, Doctor, you have previously testified that it's bad science to pick and choose one or two records and only focus on those, true?

A. True.

Q. Doctor, and this is a -- the definition that you just gave is basically the same thing. Secondary gain is -- is that people do certain things for a secondary benefit, right?

A. Yes.

Q. Like drugs?

A. Yes. Attention, money.

Q. You agree with those?
A. Yes.
Q. Okay. And you've previously testified that you never once called a biomechanical engineer to tell you whether someone was really hurt, correct?
A. That's correct.
Q. And you previously testified that if the injury is just a sprain or strain, physical therapy should fix it.
A. It should, yes.
Q. Okay. Now, Doctor, I want to just go over a couple things, and then I'm going to get to this illustration here.
I saw before the deposition, you were meeting with Mr. Jaffe in the conference room, correct?
A. Yes.
Q. Did Mr. Jaffe tell you what Dr. Siegler testified to?
A. He did not.
Q. Did he tell you what Dr. Smith testified to?
A. Is Dr. Smith the --
Q. Biomechanical --
A. -- biomechanical guy?
Q. Correct.
A. He said he had testified yesterday or earlier

in the week or something like that and that Dr. Siegler had just got done, and I saw Dr. Siegler outside. I know him.

Q. Did he tell you what Dr. Smith specifically said?

A. No. He said something -- not specific, but said something about a disk herniation, and what's my definition of a disk herniation. He kind of wanted to know that.

Q. Wanted to make sure you guys were on the same page?

A. I guess.

Q. Let me show you this spine model here, Doctor, if I may.

MR. CLOWARD: Your Honor, may I grab this?

THE COURT: Sure.

MR. CLOWARD: Thanks. May I approach the witness?

THE COURT: You may.

BY MR. CLOWARD:

Q. Actually, Dr. Siegler -- or I mean Dr. Schifini, would you mind coming down for just a moment?

A. Sure.

Q. Could you just tell the jurors, just briefly,

what is the anatomy here?

A. Okay. Just in the low back?

Q. Just -- well, yeah, and let's focus on the low back.

A. All right. So basically just a little anatomy lesson. The white things here are the bones or the vertebras. The rubbery things in between them that kind of function as a shock absorber or a cushion are the disks. The structures behind the disks that you see sticking out here are the nerve. Now, nerves are about 3 or 4 feet long. We just cut them off here for convenience sake so they don't have a whole bunch of spaghetti stuff hanging around.

On the back of the spine, you will have these little sort of spaces in between the bones here and here, and you got them on the other side. Those are your facet joints that I was trying to describe.

Q. Those are like the knuckle joints?

A. Yeah. That was what I was trying to describe earlier. It allows you to twist your spine and get in all sorts of weird pretzel-type positions.

The red thing over here is supposed to represent a large disk herniation. It's red to represent that it's inflamed. It's also red so that you can see it from across the room or from space if

you wanted.

So then we get down into the pelvis. So once you get into the pelvis, you have the tailbone here which is this triangular-shaped bone, and then you have these bones here that a lot of people call their hip bones, kind of your waist area. And then you have your actual hip bones that come out here and go down into your legs.

Q. Thank you. I appreciate it.

A. Sure.

Q. Now, just one question while I've got you here: Which one is harder, you know, like, you know, harder, this disk right here or the vertebrae generally speaking?

A. Well, in general, the disks are softer than the bones are, but they are attached to each other, kind of there's some connective tissue, kind of like a super glue, but they're connected to each other. So oftentimes if one of these gets seriously injured, you can actually injure or damage a bone as well. But in general, the bone is harder, much harder than the disk.

Q. Much harder.

A. Much harder.

Q. Thank you, Doctor. Appreciate it.

Doctor, if you rupture a disk in a car crash,

do you also have to fracture the adjacent bone?

A. You may have some microfractures in that bone. It may not be an acute fracture. But in order to see that, you would have to obtain an MRI much earlier in order to have a disk herniation to see that fracture in the bone with the -- the serious things that we talked about on your list there with the bony fracture or blood we were talking about being serious. But that's -- it can be associated with a disk herniation, but very rarely are MRIs ordered in that first 72 hours where you would see evidence of that.

Q. Okay. But the question is: If you rupture a disk from a car crash, do you also have to have fracture at the adjacent bone? Every time.

A. I would have to know what you meant by "rupture." Are you talking about a disk herniation or -- or is it --

Q. Internal disk disruption.

A. You don't have to fracture a bone with internal disk disruption.

Q. Okay. Now, Doctor, you were asked a little bit about your opinions of, you know, what -- what treatments you felt were reasonable in this case.

A. Yes.

Q. And which ones were related to the automobile

crash, which ones were maybe just because of her age, right?

A. Right.

Q. So the first thing is: Does degeneration occur in every human being?

A. Every human being. The way I describe it to my patients in the office, it's sort of like getting gray hair or wrinkles. It happens as you get older. It doesn't necessarily hurt.

Q. Kind of like my hair falls out?

A. I didn't want to mention that. Yes.

Q. I appreciate it, Doctor. My four year old reminds me of it all the time.

A. Okay.

Q. So, Doctor, I do have a question, though: You know, some other folks have testified that most people around 50 have degenerative findings in their spine. About 85 percent is what was testified to.

A. I think that's a reasonable number. I mean, you can see it much earlier than that. But I think if you pick the age of 50, the great majority of people, that would be about five out of the six people would have some degenerative findings in their spine.

Q. And do five or six of those folks end up having fusions?

A. No.
Q. Okay. What percentage of -- of people with degenerative findings actually have to have a fusion?
A. Well, if they're over 50, 85 percent of the people who have fusions have degenerative findings. But I don't know the percentage of that subset of the population that actually go on to have fusions.
Q. So do you think it's high, over 50 percent?
A. No.
Q. So it's less likely that someone with degenerative findings just because they have them are going to have to have a fusion.
A. It's kind of a strange question, but yes, I would agree with that.
Q. Thank you.
So, Doctor, go with me, for her -- what this is, just so you can see -- I don't know if you can see this or not. But I am interested to know what you were provided regarding Ms. Seastrand's playing field, if you would, or her baseline before the crash. Okay? So, you know, what restrictions she had, what activities of daily living, things of that nature.
So based just on the records before, what are you aware of her restrictions?
A. I'm not aware of any.

Q. Okay. What about problems with activities of daily living?

A. Well, she reported some chest pain associated with some activity, ultimately had a test by her cardiologist. So I would assume she had some exercise tolerance issues, but that was more related to her heart than her spine.

Q. Sure. So you -- your opinion on that is that those -- that was related to her heart not to her spine.

A. That seemed to be the conclusion of the cardiologist.

Q. Seemed to be a reasonable conclusion, right?

A. Sure.

Q. And I want to -- I'm sorry. That was kind of a bad first question segue into that.

So the question that I have is just relating to the spine, to her cervical spine and her lumbar spine because that's really kind of why we're here.

So what activities of daily living were impacted based on her spine, you know, her cervical spine and lumbar spine?

A. And we're specifically talking about before the --

Q. Correct.

A. -- the March 19th or March 13th, 2009, crash?
Q. Correct.
A. I'm not aware of any.
Q. Okay. Doctor, do you know what her -- and, again, focused just on the neck and the low back, do you know what her pain levels were and the frequency of the pain for her neck and her back before the crash? Based on records you reviewed before the crash.
A. Before, I don't know.
Q. Okay. And when you authored your initial report, you were not provided with Dr. Lurie, his report for neck and back, correct?
A. That is correct.
Q. Okay. Now, this question here, the third one is: What -- what is your understanding of the medical treatment that Ms. Seastrand received where the chief complaint prior to the crash was for her neck or her back?
A. I'm not aware of any that her chief complaint was for the neck or for the back.
Q. Okay. Now, Doctor, are you aware of what her restrictions were or her activities of daily living were after the crash?
A. She claimed that they were limited, and, again, because of what we referred to earlier with the

cardiologist, some of the exercise tolerance was probably due to some cardiac condition. But she had decreased level of activity following the accident.

Q. Okay. So decreased activity. Anything else, Doctor, that you're aware of?

A. Nothing specific that jumps out at me. I know she claimed that her activity level was affected in a negative fashion by the motor vehicle accident.

Q. Sure. Are you aware that Ms. Seastrand as part of this case identified about 100 witnesses to talk about her condition before and after? And I believe of those, I think 12 or 15 were actually deposed. Were you aware of that?

A. I know I read a couple of depositions I believe from what appeared to be witnesses. But I don't -- I didn't know there were 12 or 15 that were deposed, no.

Q. So you weren't provided those, were you, Doctor?

A. Not all of them, no.

Q. Sure. And you probably would have liked to have seen those, hadn't you?

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

THE COURT: Sure.

(Whereupon a brief discussion was held at the bench.)

THE COURT: Overruled.

BY MR. CLOWARD:

Q. Doctor, you talked about how your role kind of expanded as the case progressed, right?

A. Yes.

Q. And you gave some causation opinions as you sit there on the stand, right?

A. Yes.

Q. Okay. You would agree with me that the opinions that you gave were not based on all of the evidence.

MR. JAFFE: Objection. Misstates testimony, Your Honor. It's --

MR. CLOWARD: I asked him to -- I asked the doctor to agree whether that was a true statement or not.

THE COURT: I don't know that anybody knows what all of the evidence is, so ...

MR. CLOWARD: Okay. I'll lay some foundation.

THE COURT: You better just ask it a different way.

MR. CLOWARD: No problem.

BY MR. CLOWARD:

Q. How many of these before-and-after depositions have you actually reviewed?

A. I want to say 1 or 2 of the -- what you've totaled 12 or 15.

Q. Okay. So you haven't seen maybe 11 or 14, whatever the numbers are, of the depositions, right?

A. Yes, I think that's a fair statement.

Q. Okay. You -- you never met with Ms. Seastrand.

A. I have not.

Q. As a matter of fact, you've never even talked to her.

A. Not that I -- I'm aware of. Not on purpose.

Q. Sure. Never examined her.

A. No.

Q. Okay. So there's -- there's some evidence that you have not had a chance to evaluate.

You agree with me?

A. I think that's fair.

Q. Okay. So it's just a simple question: You agree that your causation opinion is not based on the entirety of the evidence in the case.

A. Yes.

Q. Thank you.

Okay. So, Doctor, on the restrictions and the activities of daily living, fair to say you're only aware of decreased activity.

A. Yes.

Q. Okay. Did you -- did you get any information from the depositions that you actually did review, the two that were -- the only two that were provided to you?

A. I believe that there was some corroboration of a decreased level of activity in reference to Ms. Seastrand as it related to her accident and the injuries following the accident.

Q. So the before-and-after witnesses actually corroborated what Ms. Seastrand -- what the records showed.

A. Yes. But I will have to qualify that. I don't know or recall if they were referring to specifically immediately following the accident or following her surgeries.

Q. Okay. But they noted differences?

A. Yeah, I believe there were differences noted is my recollection.

Q. Sure. Would those folks who gave that testimony, would they also have secondary gain?

A. Depending on their relationship with her,

they could.

Q. What kind of relationship would they -- would they have? Like, would it be like maybe her neighbor or --

A. If they're friend or family, they may want to see her do well. I don't know what their motivations are. I don't know those people.

Q. Okay. Do you have any indication that the -- that the two people that you reviewed their deposition were lying?

A. Well, I mean, if we're referring to people who know Ms. Seastrand, we have to refer to people who know the people who know Ms. Seastrand, and I don't know where it would actually end up. And to -- to say that the person who is -- is testifying on her behalf is credible, we'd have to interview people who know them and then interview people who know them, and I don't know where that would end.

Q. Sure. Based on your review of the deposition itself, was there any evidence that that person was lying?

A. No.

Q. Okay. And did you review Ms. Seastrand's deposition?

A. Yes.

Q. Based on her deposition, is it your testimony that she lied during the deposition?

MR. JAFFE: Your Honor, objection. Calls for -- it's argumentative. It's outside the scope.

THE COURT: Overruled.

THE WITNESS: I'm not aware that she was lying during her deposition testimony, no.

BY MR. CLOWARD:

Q. Okay. So this secondary gain that you've talked about, do you believe that it was intentional?

A. No.

Q. So it was unintentional behavior on her part.

A. Unintentional, unconscious, something of that nature, yes.

Q. Okay. So unconscious, meaning she's not -- if there is some sort of sinister behavior, it's -- she's not meaning to do it.

A. Or that she's unaware that she's doing it, yes, I would agree.

Q. Okay. Thanks, Doctor.

Now, can you tell me what the average pain level and frequency for her neck and back were after the crash.

A. I don't know the specific numbers without referring to the records. I didn't memorize those.

Q. And I'm not asking for a specific one in particular. I'm asking for like an average.

A. The numbers I -- I saw were most commonly described as 8 out of 10.

Q. Okay. Doctor, do you know how many visits that she had after the March 2009 MVA, just an approximate number, for her neck and for her low back?

A. With one provider or --

Q. All of them.

A. -- just the totality of them?

I'm assuming there were 50 to 100.

Q. That you were provided.

A. There may have been more. I've never really looked at them in that fashion to total them up. But there was -- there was lots of visits.

Q. Okay. Thank you, Doctor.

Now, can you state to a reasonable degree of medical probabilty on a more likely than not standard that without this crash, Ms. Seastrand would have gone on to have a neck and a low back fusion?

A. I can't say that to a reasonable degree of medical probability.

Q. Thank you. Appreciate that.

Doctor, Ms. Seastrand did well after the surgeries, right?

A. Yes.
Q. And I understand that you disagree with the way that Ms. -- or that Dr. Belsky -- I understand, Doctor, that you disagree with the way that -- that Dr. Belsky performed the injections, right?
A. Correct.
Q. That's kind of the main reason why you're here. Would you agree with that? One of the main reasons?
A. I guess one of the main reasons.
Q. The question that I have is: Are you saying that you must have injections in order to diagnose a pain generator?
A. I don't know if I would say "must have." Some pain generators are very obvious and you can diagnose them without injections. But more often than not, injections are required to diagnose a pain generator in the spine.
Q. It's quite helpful, isn't it?
A. It is.
Q. But it's not required.
A. Required I don't think applies.
Q. Okay. And, Doctor, you would agree with me that a physician who treats Ms. Seastrand has information available to them that is not available to

you.

A. Well, that's an opinion that has evolved over time, and I would say that the reverse could be said, that somebody who does a forensic review has information that the treating physician doesn't have. So I would say that's true in general, but it's also true in the opposite fashion.

Q. Kind of a qualified response. In some circumstances, yes; in some circumstances, no.

A. I think that's fair, yes.

Q. Okay. And you would agree with me that in Ms. Seastrand's case, at least, her doctors were able to physically examine her where as you were not.

A. I think that's fair, yes.

Q. Okay. Now, Mr. Jaffe talked to the folks about injections that are given to -- to people who are pregnant, women who are pregnant. And can you just tell us the amount of medication that is injected for that type of an epidural versus the amount that's injected in a facet injection.

A. So you want me to compare a labor epidural with a facet injection or a labor epidural with an epidural that was performed in this particular case?

Q. Just a facet injection in general.

A. Typically -- and, again, I don't know the

specific volumes that Dr. Belsky used, but typically a lumbar facet -- I'll be more specific because that's the area of the body that it was performed, so low back facet injection. The amount of volume would be less than 2 cc's or 2 milliliters. The amount of volume used in a typical labor epidural is somewhere between 10 and 20 cc's. So it's about five to ten times more depending on where the woman is in the process of her labor.

Q. So it's a lot more medication.

A. It is a lot more, yes.

Q. Thank you.

And, Doctor, you -- you perform diskograms yourself, right?

A. I do, yes.

Q. So if performed properly, there's no controversy.

A. Well, there's still going to be controversy, but you want to minimize the controversy by performing them based on standard guidelines.

Q. Okay. But you agree that you perform them yourself.

A. I do, yes.

Q. Let me ask a question: Did Dr. Belsky commit malpractice?

A. No.
Q. Did Dr. Muir commit malpractice?
A. No.
Q. Do you believe that Dr. Belsky intentionally put things into the records for the purposes of this lawsuit?
A. No.
Q. And you certainly -- after reviewing this case, you didn't report her to the board, did you?
A. No.
Q. You didn't -- you didn't call ISIS and -- and tell them about her, did you?
A. No.
Q. Okay. Now, Doctor, you and I have been on numerous cases.
A. Yes.
Q. You agree with me, Doctor, that you have been critical of Dr. Lanzkowsky.
A. Yes.
Q. Dr. Prater.
A. Yes.
Q. Dr. Rosler.
A. Yes.
Q. Dr. Kidwell.
A. Yes.

Q. Dr. Sharma.
A. Yes.
Q. Dr. Leon.
A. Yes.
Q. Dr. Lemper.
A. Yes.
Q. Dr. McKenna.
A. Yes.
Q. Dr. Ghuman.
A. Yes.
Q. Dr. Siegler.
A. Yes.
Q. Dr. Tarquino.
A. Yes.
Q. Thank you.
MR. CLOWARD: No further questions.
THE COURT: Redirect.

REDIRECT EXAMINATION

BY MR. JAFFE:

Q. Were you critical of all those doctors in everything they do or just specific isolated incidents?
A. No, specific isolated incidents similar to what I have been critical of in this case.
Q. Okay. Now, counsel asked you if you could

say that she would have had this surgery irrespective to a reasonable degree of medical probability.

Do you remember that, sir?

A. Yes.

Q. Do you believe that this accident caused the need for that surgery?

A. No.

Q. Do you believe that this accident caused any more than a sprain or a strain?

A. No.

Q. Is that to a reasonable degree of medical probability?

A. Yes.

Q. When looking at secondary gain, while it may be intentional, unintentional, whatever, is it still misinformation?

A. It's still secondary gain behavior regardless of if it's intentional or unintentional.

Q. With respect to before-and-after witnesses, sir, were they necessary for you to evaluate the performance of work done by Dr. Belsky?

A. No.

Q. That's what you were hired for originally, right?

A. Yes.

Q. That turned into whether -- the nature and extent of her injury; is that right?
A. Yes.
Q. Anything beyond that?
A. No.
Q. The records that you saw, were there any that you didn't see that you believe would have been beneficial or helpful for you to evaluate those issues?
A. No.
Q. Have you been provided with the other records since so that you had that opportunity?
A. Yes. And your office was kind enough to provide those to me when that became necessary, when my focus expanded based on the reports that were generated by some of the other experts in this case.
Q. Okay. And when you first wrote your report on -- dealing with Dr. Belsky's issue, was Dr. Lurie's record necessary for that?
A. No.
Q. When you became further involved, then were you provided with it?
A. I was, yes.
Q. And then for the expanded issues, you relied on it and reviewed it?
A. Yes.

Q. Okay. Let's talk for a minute about disk and bone injuries from a car accident. Okay?

A. Yes.

Q. Now, if you were going to be inclined to determine whether a disk injury in a car accident, such as a rupture which was -- or a herniation which was discussed yesterday, would involve bony -- include bony involvement, what would be necessary to make that determination?

A. Well, first of all, you would have to have an MRI and/or a CAT scan obtained within the first 72 hours of the actual injury. So you would have to see that injury in the window of -- of opportunity that you would have to see that. And if you saw it, you would know that particular accident had caused that particular injury on a more likely than not basis.

Q. Okay. And even if there were microscopic fractures of that nature, that's what you would need is the CAT scan or the MRI to show that?

A. Yes.

Q. Now, can we agree that a -- an MRI is an expensive procedure?

A. It is, yes.

Q. Do you jump right into taking MRIs when patients have been involved in a car accident?

A. Not usually, unless there's something worrisome or concerning to the physician evaluating the patient, meaning that there's some neurological sort of deficit, meaning your arm doesn't work, you have, you know, shooting pain down your leg, or something of that nature. If there's no sort of signs of impending doom, there's really no reason to order an MRI early on in the course.

Q. Typically is it several months down the line when you see MRIs?

A. Typically I see MRIs ordered somewhere between about four and seven months following an onset of an injury. Because before then, you're trying to see if more conservative sort of treatment will help. So it becomes unnecessary.

I mean, there was just a big study done regarding family practitioners, that they're the biggest offenders of ordering -- early ordering of MRI studies and -- and how that -- that raises the cost of medicine unnecessarily.

Q. Okay. Now, would you agree with me that there are research institutes and groups that have in the past studied the effects of car accidents on the various aspects of the spine?

A. Yes. I mean, that's how we get safety

factors built into cars from people studying these sorts of things.

Q. Such as a biomechanical engineer who also has training in medicine and -- and is board certified in -- in medical fields.

A. Sure. That would be an ideal person to do that study.

Q. And if they're going to be doing that kind of a study, they're likely going to be having those sorts of tests done immediately afterwards, like the MRI or the CAT scan, to see what is done -- what happens to the spine, right?

A. Yeah. They do them much earlier than people who are not involved in research involving those particular, I guess, findings.

Q. So if you're just examining somebody, you can't tell if they've had a microfracture in the spine; is that right?

A. No.

Q. In fact, the disk is connected to the actual vertebral bodies, that bone, right?

A. That's correct, the disk is connected to the bone. And so if you have some sort of herniation or disk disruption, you may actually have some microfractures that show up. You may have what most

people refer to as kind of a bone bruise or something called Modic changes, which is a sign of chronic inflammation or it can be acute inflammation in the surface of the bone.

Q. If you have a microfracture in a bone, typically how long does that take to heal?

A. Somewhere between probably a few weeks to maybe six weeks.

Q. Well before you would likely get an MRI after a car accident.

A. Yes.

MR. JAFFE: Nothing further. Thank you.

THE COURT: Mr. Cloward.

RECROSS-EXAMINATION

BY MR. CLOWARD:

Q. Doctor, if you were going to rely on a study or an expert, you know, board-certified expert, would you want the research, his experience to be recent?

MR. JAFFE: Objection, Your Honor. It's broad, scope, very vague.

THE COURT: It was vague, but I think he can answer it. Overruled.

THE WITNESS: I suppose you'd want it to be as recent -- depends on the situation. But recent

experience is probably preferrable. But there's also some benefit in -- in time and wisdom that comes along with time and participation in particular activities. So it's kind of hard to answer that.

BY MR. CLOWARD:

Q. Sure. Things have certainly changed since 1993, haven't they?

A. I would say yes.

Q. And you would want opinions that were relied on to not be biased, right?

A. Yes.

Q. All of those doctors that I listed off before -- Dr. Lanzkowsky, Dr. Prater, Dr. Rosler, Dr. Kidwell, Dr. Sharma, Dr. Leon, Dr. Lemper, Dr. McKenna, Dr. Ghuman, Dr. Siegler, Dr. Tarquino -- those are all pain management doctors like you, right?

A. Yes.

Q. Those are your competitors, right?

A. I guess.

Q. Doctor, you gave -- you gave causation opinions in your very first report, right?

A. Yes.

Q. And that was without the additional records before you were asked to expand your opinions, right?

A. Yes. I gave opinions on what I had but

outlined what I was missing. So it wasn't like I recognized that -- that I wasn't missing something. So I -- I outlined what I had and what I wasn't provided with.

Q. Sure. But you did give causation opinions.

A. Yes.

Q. Let me ask a question about the secondary gain. Final question I have.

A. Okay.

MR. JAFFE: Objection. Beyond the scope of -- oh, no, that's not -- I did go into it on redirect. I apologize.

BY MR. CLOWARD:

Q. Does Mr. Khoury have secondary gain?

A. I guess it could be said that he'd like to keep his insurance rates down, I suppose.

MR. CLOWARD: Thanks.

FURTHER REDIRECT EXAMINATION

BY MR. JAFFE:

Q. Is Dr. Michael Modic's study still considered good medicine?

A. Yes.

Q. That was in 1985, right?

A. Well, when you name something after someone,

it was good medicine.

Q. That was a 1985 study, right?

A. I believe so.

MR. JAFFE: Nothing further.

THE COURT: You done, Mr. Jaffe?

MR. JAFFE: Yes, sir.

THE COURT: Mr. Cloward. Mr. Cloward. Sorry.

MR. CLOWARD: No, Judge. Or yes, I'm done.

THE COURT: Yes, you're done?

Ladies and gentlemen, any questions? I don't see any hands.

Thank you, Doctor.

THE WITNESS: Thank you.

THE COURT: All right. Folks, let's go ahead and take our lunch break. We're a half-hour late, but I'll still give you an hour.

During our break, you're instructed not to talk with each other or with anyone else, about any subject or issue connected with this trial. You are not to read, watch, or listen to any report of or commentary on the trial by any person connected with this case or by any medium of information, including, without limitation, newspapers, television, the Internet, or radio. You are not to conduct any

research on your own, which means you cannot talk with others, Tweet others, text others, Google issues, or conduct any other kind of book or computer research with regard to any issue, party, witness, or attorney, involved in this case. You're not to form or express any opinion on any subject connected with this trial until the case is finally submitted to you.

Go ahead and take an hour. We'll see you back about 1:30.

THE BAILIFF: All rise.

(Whereupon jury exited the courtroom.)

THE COURT: Anything outside the presence, Counsel?

MR. JAFFE: Nothing, sir.

You know, one thing. Yesterday, I did say I was going to have a Rule 50(B) motion. I don't believe I'm going to, sir.

THE COURT: Okay.

Mr. Cloward, anything?

MR. CLOWARD: No.

THE COURT: All right. Off the record.

(A lunch recess was taken.)

THE COURT: All right. Back on the record, Case No. 636515. We're outside the presence of the jury.

Mr. Cloward, go ahead.

MR. CLOWARD: During the deposition of Dr. Villablanca, it was asked what records he reviewed in preparation for his opinions that he testified to because his -- his report, initial report and supplemental report did not list the records, just listed some films. And so the question was asked by Ms. Brasier as to:

"Doctor, what did you review? We'd like to know specifically. Will you get us a list of everything that you reviewed?"

And there was some dialogue between Ms. Brasier, Mr. Jaffe and Ms. -- and Dr. Villablanca regarding that, and it was suggested that a list would be forthcoming and be attached as Exhibit D to his deposition -- I'm sorry, Exhibit 4 to his deposition.

That list has never been provided. We've never been given an opportunity to inquire as to what records he reviewed, specific records. We don't have a problem with him talking about films, but regarding the records before and after, we feel that we haven't been given an opportunity to discuss that.

During his deposition, it was made known that we wanted to see that. We asked him specifically for a list. Mr. Jaffe and Dr. Villablanca represented that

one would be forthcoming. No supplement was ever made.

THE COURT: Okay.

MR. JAFFE: Candidly, sir, I don't even remember that being an issue, and this is the first I've even heard. At no point did anybody ever send me a letter saying, hey, when are we getting the list from Dr. Villablanca? There was no motion in limine filed, what about the list from Dr. Villablanca. And now we're in the eighth day of trial and I'm hearing about the list from Dr. Villablanca.

MR. CLOWARD: Your Honor, may I --

MR. JAFFE: So, Your Honor --

THE COURT: I believe it was discussed in the deposition.

MR. JAFFE: I have no doubt that it was discussed. I just -- you know, if -- if -- I think it's -- I think it's improper to now start raising this as a limitation issue when this was apparently known and realized when Dr. Villablanca was deposed back in February, and nothing's been done since.

Now, is he going to run off and start spouting about everything? No. He's going to testify consistent with what's in his report. But I believe he has -- he may have to look at some additional medical records. I just don't honestly remember.

Dr. Villablanca is here. We can bring him in, and he can state for the record right now what he looked at.

THE COURT: Well, I guess, here's the issue, Mr. Cloward: Even if he had subsequently provided you with a list of items that he had reviewed, I don't know how that would change his ability to come in and testify here today as to what he reviewed as long as his opinions and conclusions are consistent with his report.

MR. CLOWARD: Well, I think it's -- it's very significant because it goes to correlation. There was no list of anything he reviewed, so we couldn't go into it, Well, hey, Doctor, did you see this record, did you see that record? What records did you see? What records didn't you see?

And it was -- it was Mr. Jaffe that actually made the affirmative representation that he would provide us with a list. It's not my burden, not my duty to, you know, write him a letter or follow-up letter saying, hey, you know, remember the deposition when you promised to give me a list, can you give me the list you promised to send.

I admit that it does -- it does have a feeling of trial by ambush. I will admit that openly to the Court. It's something that we discussed that we

realized in preparation for his trial testimony. Within the last day or two, this is something that we discovered, hey, we never got that list. Because we wanted to go through the -- the same things with -- with Dr. Schifini and Dr. Siegler and realized, well, hey, we don't even know what he went through. We don't know what he did review, what he didn't review.

So how can I even question him on those things? I don't have a list. I don't know what he reviewed and what he didn't review.

THE COURT: So you want me to exclude him altogether?

MR. CLOWARD: No. No. I think that would be too over the top.

THE COURT: I agree.

MR. CLOWARD: But I want it limited to the films and -- just the films, MRI, CTs. That's what he's here for. But I think if he gets to sit and talk about, you know, correlation of prior problems through the prior records, correlation of subsequent records, then that's unfair to us.

THE COURT: Well here's the deal: If there's a discovery issue, like somebody needs something in discovery that doesn't happen, that usually goes in front of Commissioner Bulla. It's definitely something

that has to be done prior to trial.

I'm going to let him testify. You can ask him while he's testifying what he reviewed, what he didn't. As long as his opinions are consistent and stay based upon the opinions and conclusions that he has in his report, I'm going to allow them.

MR. CLOWARD: Just -- I respect your -- the Court's ruling. Just one thing for the record. We did ask him during his deposition what he had reviewed, and he could not tell us.

THE COURT: I understand.

MR. JAFFE: Okay. And, Your Honor, I mean, obviously I need to point out the fact that Dr. Villablanca is not simply a radiologist, but he's an interventional spine neuroradiologist. And -- and he doesn't just review films. And his reports, I believe, do reflect general review of records. And that's why I said, if you want, I'll bring Dr. Villablanca -- he's in the other room, I'll bring him in right now. He can state for the record and tell everybody what he looked at.

THE COURT: Is that going to help you?

MR. CLOWARD: Well, no, it doesn't help to give me 15 minutes before I cross-examine a neuroradiologist on -- an interventional

neuroradiologist on clinical correlation when I don't even know what he reviewed in preparation for his first report.

THE COURT: I don't know that there's a way that we can parse out what his opinions are based only on the films as opposed to what his opinions are based on records that he reviewed when I think it's pretty clear that he at least had reviewed some records. He just couldn't tell you what they were. So I think we have to allow it.

Anything else?

MR. CLOWARD: No, Judge. Thanks.

THE COURT: All right.

MR. JAFFE: Nothing right now, sir.

THE COURT: Let's bring the jury back.

THE BAILIFF: All rise.

(Whereupon jury entered the courtroom.)

THE COURT: Go ahead and be seated. Welcome back, folks. We're back on the record, Case No. 636515.

Do the parties stipulate to the presence of the jury?

MR. JAFFE: Yes, sir.

MR. CLOWARD: Yes, Judge, we do.

THE COURT: We're still in the defendant's

case.

Mr. Jaffe, who's your next witness?

Mr. Smith.

MR. SMITH: Your Honor, defendant calls Raymond Khoury.

THE COURT: Mr. Khoury.

THE WITNESS: Yes, sir.

THE COURT: Come on up. You know the drill. Come on up next to the chair, stay there, if you would, and raise your right hand.

THE CLERK: You do solemnly swear the testimony you're about to give in this action shall be the truth, the whole truth, and nothing but the truth, so help you God.

THE WITNESS: I do.

THE CLERK: Please state your full name and spell it for the record, please.

THE WITNESS: My name is Raymond Khoury, R-a-y-m-o-n-d K-h-o-u-y.

THE CLERK: Thank you.

THE COURT: Go ahead and be seated. Thank you, sir. Talk into the microphone for us, if you would.

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DIRECT EXAMINATION

BY MR. SMITH:

Q. All right, Mr. Khoury, will you tell us how long you've lived in Las Vegas.

A. I moved to Las Vegas in 1986.

Q. And what first brought you to the United States?

A. To go to college.

Q. Where did you go to college?

A. I went to LSU in Baton Rouge, Louisiana.

Q. And did you graduate from LSU?

A. I did my undergraduate and graduated in 1980.

Q. Following your undergraduate education at LSU, did you get any other education?

A. I moved to New Orleans, and I lived there for five years, and I worked and went to Tulane for my master's degree.

Q. Okay. And what was your -- let me back up.

What was your undergraduate degree in?

A. In civil engineering.

Q. And then you said you were studying in Tulane University. What were you studying at Tulane?

A. Master's of science in -- in civil engineering.

Q. Okay. And when did you graduate from Tulane?

A. 1983.
Q. And you graduated with a master's in civil engineering?
A. It's a -- it's -- the field is civil engineering, but then I specialized in structures.
Q. In structures. And what -- what -- what's your current employment or where are you currently employed?
A. Currently I am self-employed. I own my own company.
Q. And what does your company do?
A. We provide structural services for architects and owners and contractors and -- mostly in the building construction field.
Q. And prior -- when did you start your own company?
A. In 2006.
Q. Prior to 2006, where were you employed? Or what was your employment doing?
A. When I moved here in '86, I came in as an employee of a structural firm here in town, and I stayed there for 20 years. And in 2006, I branched out on my own.
Q. Okay. Explain to me, if you will, and for the benefit of the jury, what exactly is it that a

structural engineer does?

A. A structural engineer is part of a design team that works -- we work with architects, with electrical engineers, mechanical engineers, civil engineers, and other consultants to design a building like this one or like hotel and casinos, like high-rise condominiums. It takes many different disciplines to come in and design a building.

My field is to make the structure of the building, whether it's concrete or steel or masonry or wood, we use these -- mostly these four building materials, to make sure that the building stands.

Q. Now, where were you when you first learned that a lawsuit had been filed against you?

A. I was out of the country on an assignment. I was in Abu Dhabi, and I learned through Skyping my wife one night. And that's when I learned that she has been served with papers.

Q. Okay. And how long were you in Abu Dhabi?

A. I was there since -- in January -- from January 2011 to July 2011.

Q. And what was it that you were doing for work in Abu Dhabi?

A. Well, the municipality of Abu Dhabi wanted to -- since they have building boom there between Dubai

and Abu Dhabi, they wanted to adopt a similar building code like the one we're using in the United States which is the International Building Code. And the -- the ICC, the International Code Council, asked me if I would go there and help train the engineers in Abu Dhabi on the application of the code, and that's what I did.

Q. Now, during that six-month period -- six- or seven-month period when you were in Abu Dhabi, did that create any problems communicating with friends and family back here in the United States?

A. It's not a major problem, except that the time -- the time frame was almost 11- to 12-hour difference in time. So during daytime over there, it's nighttime over here and vice versa. And so -- so the window gets -- of communication gets a little bit narrow.

Q. Okay. And now you said it was July of 2011 that you first returned to the United States?

A. July 18th, 2011, yes.

Q. And once you returned, was that the first opportunity you had to meet with counsel and discuss the case that had been filed against you?

A. Yes.

Q. Now, Mr. Khoury, do you deny that this

accident was your fault?

A. No.

Q. Have you ever personally denied that this accident was your fault?

A. Never.

Q. Now, is that something that has recently changed?

A. Not to my knowledge.

Q. Okay. And I just want to walk through a few certain instances that have been discussed in opening statements and throughout the course of the trial.

At the scene of the accident, did you deny that this accident was your fault?

A. No. I told the officer when he came to me, I told him, It's my fault.

Q. Okay. Now, do you remember back in 2011, you were served some interrogatories, some written questions that plaintiffs served on you, and you provided answers.

In your answers, did you deny that you were at fault for this accident?

A. No.

Q. And same thing, you were given some requests for admissions. Did you admit or deny that you were responsible for this accident?

A. I don't remember a request for admissions, but if I did, I didn't deny.

Q. In 2012, last year when you were deposed, do you recall that, sir?

A. Yes.

Q. When you were asked about whether this accident was your fault, did you deny that it was your fault?

A. No. I admit fault, yes.

Q. Okay. Now, in Mr. Cloward's opening, he made it very clear that you had filed this answer that said you denied this. And now, just recently, on the very first day of this trial, you admitted that it was your fault.

Explain to me your role in filing that answer.

A. Like I said, I was still in Abu Dhabi when my wife was served with paper, and after that, with referrals to Mr. Jaffe's, Hall Jaffe and Company. And you -- there was a time frame where you had to file for the papers, and I was not in the country. We could not get really on a phone conversation to discuss this. So without any discussion between me and -- and you, I -- the papers were filed as a caution -- as a -- just a cautionary measure that I did not admit guilt. That

was just a tactical.

Q. And so that date on June 21st when that answer was filed, you were still out of the country; is that correct?

A. Yes.

Q. That was before you had had an opportunity to meet with your attorneys and discuss the case?

A. Yes.

Q. Mr. Khoury, tell me, would you want your attorneys to admit that you were at fault without first discussing the case with you?

A. I don't think so.

Q. Now, moving along to the accident itself, March 13th, 2009, tell me what happened that morning as you were driving.

A. Well, I was on my way to my office. My office was on Rancho. Started late that day, you know, so it wasn't -- I wasn't that busy. So it was a Friday, Friday the 13th. And I -- traveling east on Craig Road, coming to the intersection with Rancho was a red light. So I came to a complete stop about 10, 15 feet from Mrs. Seastrand's car and waited for the light to change.

In the meantime, I was turning to -- trying to make a -- anticipating that I will try to make a

right turn, I looked to the left to see the oncoming traffic on Rancho, and I inadvertently took my foot off the brake and rolled -- apparently I rolled too close to be able to stop my car before I ran into Mrs. Seastrand's car.

Q. Okay. So after you hit into Ms. Seastrand's car, what did you do next?

A. You know, I was surprised, you know, myself. And I put my car in park, and I went down to inspect the damage. When I saw that the damage was minimal, I -- then I proceeded to go to Mrs. Seastrand's window to ask her if she was okay and that I'm sorry for bumping into her.

But she was in a little -- like a little panic, like she didn't know what -- know what to do next or she was in pain. I didn't know at the time because the window was rolled up.

Q. What did you say to her when you approached the window?

A. Like I said, I'm sorry, I shouldn't -- I didn't mean to hit you, but are you okay? And --

Q. What was her response?

A. She said she was in a little pain, and she told me she can't talk to me right now.

Q. Did she say --

A. Then I asked if we need to exchange any information to resolve this issue. She said, I can't talk to you right now. I'm in pain. And I left it there. Then I -- you know, I went back to my car and then stood on the side.

Q. Did she make any indications as to who she was going to talk to?

A. I think she said she was calling her husband. That's when I left.

Q. So you said that you kind of went back to your car and then you stepped back and waited.

What happened next?

A. I just -- I just sat in my car for a minute, and then I -- then I stepped out to -- on the sidewalk, I mean on the -- on the side. And then, about five to ten minutes after that, the ambulances started coming. I mean, you heard the sirens and the ambulance came. And I didn't -- I didn't call the ambulances. I don't know who did at the time, but ...

Q. Did the police arrive on the scene?

A. And the police arrived on the scene after that, yes.

Q. Okay. Did you speak with the police at all?

A. Yes.

Q. The police officer?

A. Yeah. The officer interviewed me and then interviewed Mrs. Seastrand.

Q. And when the officer interviewed you, what did you tell him?

A. I told him it's -- you know, it's -- how it happened and it's my fault. I was -- due to distracted, and I had ran into her bumper.

Q. Now, when the officer arrived, were the vehicles still in the street where the accident had happened?

A. Yes.

Q. At any point, did you move your vehicle?

A. I did move my vehicle. I put it -- there was a gas station right on the right side, right-hand side. I put it -- I went to the gas station.

Q. Was that before or after the accident -- the police officer arrived?

A. I think -- don't remember exactly, but I think it's after.

Q. Now, once you moved -- when did Ms. Seastrand's vehicle get moved? Do you recall?

A. I think soon after that, after -- because they were moving her out of her vehicle and onto the stretcher. And I think after her husband -- and I'm -- I did not know that her husband arrived on the scene.

I did not know who her husband was.

But I think now, looking back, I think that her husband moved her car back right next to mine on -- in the gas station.

Q. So at the time, you didn't know that her husband had arrived at the scene; is that correct?

A. Yes, at the time, I did not.

Q. That's something you have learned since then?

A. Yes. Well, that's -- when the cars were parked in the gas station, then I -- then I saw, you know, the commotion and all the ambulances and everything, then I started taking pictures. Yes, that's what I did.

Q. And why don't we take a look at those right now. Would you open to Defendant's Exhibit H.

A. (Witness complies.)

Q. Yeah, and let's --

Now, looking through Exhibit H, how many photographs do you see there?

A. Five.

Q. Okay.

MR. SMITH: Greg, would you put -- bring up the first photograph.

BY MR. SMITH:

Q. Now, just -- just for the benefit of the

jury, looking here on the screen, this picture that you see right here, is that the first picture that's marked in Exhibit H?

A. H1, yes.

Q. Okay.

MR. SMITH: Go to the next one, Greg.

BY MR. SMITH:

Q. Is that H2?

A. Two.

Q. Okay.

MR. SMITH: Greg.

THE WITNESS: H3.

BY MR. SMITH:

Q. Next one.

A. That's H4.

Q. Okay. And the last one, then?

A. H5.

Q. Okay. So those pictures that have been put up on the screen, they correspond with the Exhibits H1 through 5; is that your testimony?

A. Yes.

Q. And are those pictures that you took at the scene of the accident?

A. That's the pictures I took, yes.

Q. Did you have a camera there, or what did you

take those pictures with?

A. No, I used my cell phone camera.

Q. Now, why was it that you took photos?

A. Well, I felt that -- at the time that maybe some things going on more than I thought. I thought it was just a little bump and, you know, ambulances coming and police and everything, so I wanted to take pictures just in case.

Q. Did you know whether the police officer had taken any photos?

A. I thought he was, but, you know, somebody else was taking photos. But I didn't know whether the police officer or -- or somebody else. I wasn't sure.

Q. Okay. Is it fair to say that you took those photographs to -- just to make sure you had some proof of the damage?

MS. BRASIER: Objection. Leading.

THE COURT: Sustained.

BY MR. SMITH:

Q. Did you have any other purpose in taking photographs, Mr. Khoury?

A. Only purpose is to show that the damage happened to my car and the plaintiff's car. That's all.

Q. What was your impression of Ms. Seastrand's

reaction at the accident?

A. You know, I thought at the time that it was a little exaggerated. You know, this damage should not precipitate such a reaction. But, you know, I didn't know her condition. I didn't know anything about her.

Q. Now, did you get any cost estimates to repair the damage to your vehicle?

A. Yes.

Q. And how much was -- were the estimates to repair your vehicle?

A. I had two estimates. I think I -- the first estimate was $870, and the second estimate was like 950. But I don't have the second estimate with me. I only have the first estimate.

Q. Okay.

MR. SMITH: And can I approach, Your Honor? I'm sorry.

THE COURT: Yep.

BY MR. SMITH:

Q. Just looking at Exhibit H -- let's look at H4.

MR. SMITH: Greg, would you bring that up.

BY MR. SMITH:

Q. Now, is that representative of the damage that was done to your vehicle?

A. That's exactly what the damage is to my vehicle.

MR. SMITH: Okay. Will you move to H5 now so we can get a little more perspective, Greg.

BY MR. SMITH:

Q. Explain to me where -- that H4 -- Picture H4 is kind of zoomed in and H5 is zoomed out. Explain --

A. Right.

Q. -- where that is.

A. It is the --

Q. And you can even touch on the screen there and circle if you want.

A. I can?

Q. Should be able to.

A. Yes. Okay. This is the hook, the tow hook in the front. I have two of them, one on the right side, one on the left side. And this is the one that struck Mrs. Seastrand's car.

MR. SMITH: Okay. Now will you go to the next -- to 5 again. Sorry 4.

And will you clear that off, Your Honor.

BY MR. SMITH:

Q. Okay. So that's a close-up of the area that you just circled?

A. This is a close-up of where the tear in my

bumper is close to the hook, and that's the only damage I sustained.

Q. Okay. And will you identify where the tow hook is in that picture.

A. This is the tow hook right here. Sorry.

Q. And then the damage to the bumper, is that --

A. Is that tear right there and right there. (Witness indicating.)

Q. Okay. And you said the estimates that you got were between 800 and $900 to repair that?

A. Yes.

Q. Did you have that damage repaired?

A. No.

Q. Why not?

A. I considered that my -- the damage to my car was really cosmetic. It didn't affect the drivability of the car. It didn't affect, really, the look of the car, except if you, you know, put some goggles on or something. And I -- I thought it was too expensive to -- the estimate was too high.

Q. As you sit here today, do you still own that vehicle?

A. Yes.

Q. And is that damage still there?

A. Yes.

Q. Mr. Khoury, were you injured in this accident?

A. No. No.

Q. All right. Thank you.

MR. SMITH: I'm done.

THE COURT: Cross.

CROSS-EXAMINATION

BY MS. BRASIER:

Q. Good afternoon, Mr. Khoury.

A. Good afternoon.

Q. Just want to clarify something so that the jury might not be confused. You talked about your engineering background.

But do you have any training in biomechanical engineering?

A. No.

Q. All right. Do you remember I took your depo, it's almost been a year ago now, August of last year?

A. Yes.

Q. Okay. And during your depo and today, you told us that you inadvertently took your foot off the brake; is that right?

A. Yes.

Q. Okay. And when I took your deposition, you

gave me an estimate that you were 10 to 20 feet behind Ms. Seastrand.

Would you say that's still accurate?

A. Approximately, yes.

Q. Okay. And during your deposition, you also indicated that you didn't realize that your car was moving forward; is that right?

A. I -- if I did, I would have stopped, yes.

Q. Okay. So you didn't realize that your car was moving forward 10 to 20 feet?

A. I think the time frame is a little -- because we were stopped at a red light, so it wasn't like the light changed or, you know, instantaneously. It took a while to change. So I might have slipped, came closer a little bit as -- as I was waiting.

Q. Okay. But my question is, it's pretty specific: You didn't realize that your car moved forward that 10 to 20 feet.

A. No.

Q. Did you tell the officer who responded to the scene that you accelerated before the impact because you assumed that Ms. Seastrand was about to make a right turn?

A. I did not say accelerated, no.

Q. Okay. And are you aware that -- are you

aware that that officer's deposition was taken in this case?

A. I wasn't aware, but now I am aware.

Q. Okay. And are you aware --

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

THE COURT: Sure.

(Whereupon a brief discussion was held at the bench.)

THE COURT: Overruled.

BY MS. BRASIER:

Q. All right. Mr. Khoury, are you aware that -- that Officer Kahn when he was deposed, he stated that you told him that you accelerated and that's when you ended up striking her?

A. I wasn't aware of that.

Q. Okay. Are you -- is it your testimony that that's not accurate what -- what Officer Kahn testified to?

A. Well, I mean, if you're starting from a complete stop and you are moving forward, then you're accelerating. Is that what he meant maybe? I don't know.

Q. So are you saying that Officer Kahn's statement that you told him you accelerated, are you

saying that that's not accurate?
A. I did not tell him I -- I accelerated, no.
Q. Okay. Do you have any reason to believe that Officer Kahn wouldn't be truthful during his deposition?
A. Yes.
Q. You do?
A. Uh-huh.
Q. Okay. What would that reason be?
A. You said he would be truthful, right?
Q. Oh, my question was: Do you have any reason to believe he would not be truthful? I'm sorry.
A. Oh. I thought you other way around. Okay. No.
Q. Okay. All right. What color was the light when you got to the intersection?
A. It was red.
Q. Okay. And did that light ever change before the crash happened?
A. I think -- I don't recall, but usually you can make a right turn on red, and I anticipated that the cars in front of me would be making a right turn on red, and that's why I kept approaching that intersection.
Q. Okay. My question was: Do you remember the

light changing to green before the crash happened?
A. No.
Q. All right. How long was it after the crash before you got to the plaintiff's vehicle?
A. Could you repeat that, please.
Q. Of course. How long from the time the crash happened till you got out and you got to Ms. Seastrand's window?
A. Oh, less than a minute.
Q. And you just testified that her demeanor when you got there was that she was in panic and she told you she was in pain and couldn't talk to you; is that right?
A. Yes.
Q. Okay. Do you think that in the one minute it took for you to get from your vehicle to her window, do you think that she decided to -- to fake all these injuries or to exaggerate them?
MR. SMITH: Objection, Your Honor. Calls for speculation.
THE COURT: Sustained.
MR. CLOWARD: Judge, can we approach?
THE COURT: Sure.
(Whereupon a brief discussion was held at the bench.)

MR. SMITH: Sustained, Your Honor?
THE COURT: Nothing's changed. There's not an objection pending.
BY MS. BRASIER:
Q. So was it your impression in the one minute from the time of the impact till you got to her window, that she was faking these injuries or these complaints she had?
MR. SMITH: Same objection, Your Honor.
THE COURT: Overruled.
THE WITNESS: Question is if I --
BY MS. BRASIER:
Q. If in the one minute between the time of the impact until you got to her window, was it your impression that she had somehow decided to fake these injuries or symptoms that she was expressing to you?
A. No, that's not my impression. Just I did not believe that such an impact would cause anybody pain. That's my -- at least my impression.
Q. Okay. And you're not a medical doctor; is that right?
A. No.
Q. Okay. Do you have any training in the medical field?
A. No.

Q. Okay. And you testified earlier that you admitted at the scene that it was your fault; is that right?

A. Yes.

Q. Okay. And we understand, based on your testimony, that you were out of the country at the time the answer was filed in this complaint -- or in this case; is that right?

A. Yes.

Q. Okay. And I don't want to get into any communications you had with your attorneys, but you did say that July 18th of 2011 was the first time you were able to talk to them; is that right?

A. That's when I came back to the country, yes.

Q. Okay. But you are also aware that July 15th, 2013, about two years later was the first time that that answer was ever changed to admit liability.

Are you aware of that?

A. I was not aware of that.

Q. Okay. But you talked to your attorneys two years earlier; is that right?

A. Right. But I don't think this situation -- this question came up until he mentioned it in his opening statement.

Q. All right. And, Mr. Khoury, if you could

just answer yes or no to me for these questions. If you can't answer yes or no, then let me know that. Okay?

You admit you're responsible for the crash.

A. Yes.

Q. Do you admit that you're responsible for the damages caused by the crash?

A. Yes.

Q. I'm sorry?

A. Yes.

Q. Okay. And at your deposition, you stated to me that you thought that the damages didn't go beyond anything more than property damage; is that right?

A. Again, could you say that one more time.

Q. Of course. During your deposition when I asked you that same question, you said that you were responsible for the damages but that you didn't think it went beyond property damage; is that right?

A. Yes.

Q. Okay. And now that you've had the opportunity to sit through trial and hear from all the witnesses, do you think that the crash caused more than just property damage?

MR. JAFFE: Objection, Your Honor.

MR. CLOWARD: What's the basis?

MR. SMITH: Calls for an opinion on the ultimate issue pending, and it calls for an expert opinion.

THE COURT: Well, I think all of the witnesses have testified that the accident caused damages.

MR. SMITH: Can we approach, Your Honor?

THE COURT: Come on up.

(Whereupon a brief discussion was held at the bench.)

THE COURT: Objection sustained. Let's move on.

BY MS. BRASIER:

Q. Okay. Mr. Khoury, you indicated that you thought Ms. Seastrand's reaction to the crash was exaggerated; is that right?

A. My impression at the time, yes.

Q. What evidence did you base that on other than the property damage?

A. Just a feeling.

Q. I'm sorry?

A. Just a feeling.

Q. Okay.

A. Impression.

Q. What was that feeling based on?

A. You know, I was in the car that hit Mrs. Seastrand's car, and I really -- didn't feel to me like a bump -- like more than a bump.

Q. Okay. Did she -- did you ever ask her what it felt like to her?

A. Didn't talk to her.

Q. So you didn't -- you didn't ever talk to her about that?

A. I -- I wanted to, but she couldn't talk.

Q. Okay. And that's because she told you she was in too much pain?

A. Yeah. Well, she was in pain, and she was trying to call her husband, yes.

Q. Okay. Before she left the scene, did you ever ask her what kind of pain she was in or what she thought -- what her injuries might be?

A. No.

Q. Is it still your impression today that she was exaggerating her reaction at the scene?

MR. SMITH: Same objection, Your Honor. He told what his impression was at the time.

THE COURT: Overruled. Let him answer.

BY MS. BRASIER:

Q. You can answer.

A. I can answer?

Q. Yes.
A. Not totally.
MS. BRASIER: Nothing further. Thank you.
THE COURT: Mr. Smith.

REDIRECT EXAMINATION

BY MR. SMITH:
Q. Now, Mr. Khoury, you still own your vehicle, so you've been driving it for a number of years.
If you take your foot off the brake, what happens to your vehicle?
MS. BRASIER: Objection. Leading.
THE COURT: Overruled.
THE WITNESS: The car moves forward, and the -- depending on your -- I mean, we were on a downslope a little bit, so the car moves forward.
BY MR. SMITH:
Q. So if you're completely stopped and you take your foot off the brake, does your car accelerate?
A. That's the definition of acceleration, change in velocity.
Q. Thank you.
MR. SMITH: Nothing further.
THE COURT: Anything more, Ms. Brasier?
MS. BRASIER: Nothing more, Judge.

THE COURT: Ladies and gentlemen, anybody have any questions for Mr. Khoury? I don't see any hands.

Thank you, sir.

Next witness.

MR. JAFFE: Thank you, Your Honor. At this point the defense calls Dr. Juan Pablo Villablanca.

MR. SMITH: Your Honor, can I move that exhibit binder?

THE COURT: Yes.

MR. JAFFE: Judge, I think it's going to take a minute or so. We have to move the laptop up there, so Dr. Villablanca can testify.

THE COURT: You want to take a break or --

MR. JAFFE: It will just take -- it will take one minute.

THE COURT: Okay.

MR. JAFFE: Greg, why don't you hit one of those just to make sure everything's working right? Good to go. Okay. You can X out of it. Thanks.

Doctor.

THE COURT: Come on up, Doctor. I'm going to ask you to come up, if you would. Come up to the witness stand and you can put your binder down, if you want. Remain standing next to the chair there, raise

your right hand, if you would, please.

THE CLERK: You do solemnly swear the testimony you're about to give in this action shall be the truth, the whole truth, and nothing but the truth, so help you God.

THE WITNESS: I do.

THE CLERK: Please state your full name and spell it for the record, please.

THE WITNESS: Juan Pablo Villablanca. That's J-u-a-n first name. Middle name P-a-b-l-o. Last name Villablanca, V-i-l-l-a-b-l-a-n-c-a. That's all one word.

THE CLERK: B-l-a?

THE WITNESS: N-c-a. Villablanca. It's a mouthful.

THE COURT: Go ahead and be seated. Thank you, Doctor.

DIRECT EXAMINATION

BY MR. JAFFE:

Q. Good afternoon, Doctor.

A. Good afternoon.

Q. Sir, would you please tell us, what do you do for a living, sir?

A. I'm a neuroradiologist and an academic in a

medical center. I work at UCLA. In that capacity, I'm the chief of the section of neuroradiology, and I oversee the functioning of the department in both the clinical and administrative aspects, make sure that our faculty are progressing in their research, make sure that our clinical service is appropriate, and then we conduct our research. And we teach residents, fellows, and people that come from other places including other countries to get training at our facility.

Q. Okay. And, sir, I referenced during my opening statement that you are actually an interventional spine neuroradiologist.

Is that true?

A. Correct. So I have certification as part of my fellowship training which is training that occurs after medical school and after the residency. The residency is specialty training in radiology in general, and then in addition to that, I did two additional years of training in diagnostic neuroradiology as well as interventional spine work at UCLA.

And in that scope, I see patients in the clinic, I evaluate their symptoms, and I correlate their symptoms to their scans and make recommendations about what would be the best way to evaluate them and

to treat them for their problem.

In addition to that, I interpret the scans, the CTs, the MRIs, and other studies that we do on these individuals in the service as a whole and patients that I might see in the clinic.

Q. We'll talk about that more in a moment, sir, but would you please give us the benefit of your academic credentials.

A. Well, I went to undergraduate at UCLA and my major was psychobiology. Then I went to medical school at the University of Minnesota. After that, I completed a medicine internship at UCLA. And that was followed by a four-year residency -- that internship was one year. That was followed by a four-year residency in diagnostic -- a four-year residency in radiology and then a two-year residency, or fellowship rather, in diagnostic neuroradiology and spine work. And then I joined the faculty in 1996.

Q. Dr. Villablanca, have you been published at all?

A. Yes.

Q. Would you please give us some summary of the publications --

A. I published fairly extensively in my areas of interest, which are cerebral vascular disease, disease

of the arteries, of the neck and brain, ways to image nerves, peripheral nerves in the body outside of the spinal canal, specifically in the setting of trauma or injury using MRI and more advanced techniques than MRI --

(Clarification by the Reporter.)

THE WITNESS: I'm sorry. I forgot you were there.

Spectroscopy, s-p-e-c-t-r-s-c-o-p-y, spectroscopy and diffusion tensor imaging.

And it's basically trying to push the field ahead in these areas so that we can do better tomorrow as compared to how we're doing today. And also, in the area of traumatic brain injury and brain degeneration.

BY MR. JAFFE:

Q. Approximately how many publications have you authored, sir?

A. I think we're probably now, I'm probably around 80 to 90. These are peer-reviewed publications that are sent to major journals for their consideration.

Q. And, sir, have you also been asked in the past to present lectures and other types of presentations in the professional setting?

A. Yes. Numerous.

Q. And can you estimate the number of those?

A. I don't recall offhand, but somewhere between, you know, 75 and 100. These are generally either local or at the national level. Sometimes they're international. And, again, they're in the areas of stroke, cerebral vascular disease, and spine problems. Particularly back pain and nerve pathology, neck pain, how to evaluate patients with those disorders and what are the most effective tools, and what does the data show in terms of what are the best tools for us to use.

Q. Sir, have you been the recipient of any grants?

A. Yeah. We currently have and have had in the past a number of grants. These deal with interventional nerve imaging projects, particularly for traumatic nerve injury, as well as projects that have to do with stroke and the visualization of aneurysms. So those have been the major projects.

Q. So is there a research component to your job as well?

A. Absolutely. That's the reason I'm in academics.

Q. Okay. So sounds like you have clinical practice and you also have a research component?

A. Yeah. I tell my family and my friends that I got the best job in the world because I have the contact with patients that many radiologists don't have by having the -- the privilege of seeing them in the clinic, plus I get to teach and do my research and -- and enjoy a very healthy section.

Q. Okay. Sir, have you been the recipient of any awards?

A. Yes, over the years.

Q. Can you give us an idea of the types of awards you received?

A. We received -- I and our section have received awards for teaching our trainees. I have received awards for my clinical service. We have Who's Who in America, which is a objective body that looks at physicians without our knowledge and determines whether they think we've contributed to the fields that we're in, as well as something that's called Super Doctors. And I've had the privilege of being selected to both of those bodies by, I presume, my patients, and then a body of physicians who nominate you without your knowledge. And then there's a committee that goes through some type of evaluation to determine whether they think that you, in fact, determine the merits that they are -- that your patients or your peers, your

colleagues have -- have recommended.

And one of the criteria that I know for the Super Doctors is would you send your family member to this doctor?

Q. Hopefully the answer is yes before you're on there.

A. Yeah. The answer apparently is yes.

Q. Okay. And, Doctor, I've had a radiologist testify before that he's a man who sits in a dark room looking at dark pictures all day long.

Is that what you do?

A. No. Far from it.

Q. Walk us through your typical day.

A. Yeah. It's actually more like a week. In a given day, I would look at some scans in the morning, start with some X rays, some MRIs, some CAT scans, review those with my trainee, go over how to approach these scans, how to be objective, and how to make sure that the language is precise so that whatever that trainee wants to say in that report, it's actually what comes out and that there's no way that those phrases can be misinterpreted, meaning that you have to use unambiguous and direct language.

And I may have meetings with some of my research colleagues about work that we have ongoing

sprinkled throughout the day, and then I have time that I devote specifically to see patients in the morning and then also do procedures in the afternoon different days of the week. And I see patients either in my Westwood facility, Manhattan Beach, or in Santa Monica where we have practices.

Q. Now, how does an interventional spine radiologist differ from a radiologist?

A. A general radiologist normally is in a dark room and spends the majority of all their time interpreting scans. With any specialty, they may be asked to do basic procedures that require fluoroscopy or low-level X rays to -- to visualize a procedure.

For a neuroradiologist who doesn't have a spine -- interventional spine presence, that would indicate that they might do a spinal tap on somebody to get fluid if they think they have meningitis or they might put dye into the spinal canal and do a myelogram where we get pictures of the nerves within the spinal canal. Those are standard procedures.

And they might also give medication into the spinal canal through a needle, what's called chemotherapy or intrathecal chemotherapy. But beyond that, they really wouldn't do procedures related to the spine nerves or bones of the spine. And they certainly

wouldn't administer medications for painful conditions.

In contrast, somebody who has an interventional spine experience and training would do those procedures. And not only interventional spine individuals who are diagnostic neuroradiologists as well will have a clinic where the clinicians send the patient to them for evaluation.

I'm very -- I'm blessed that I have that which I enjoy seeing patients and I enjoy evaluating them, and particularly putting together the clinical presentation with their imaging findings to make treatment recommendations. If it is appropriate to go beyond physical therapy and muscle relaxants and so on to doing treatment, then I would schedule the individual for the appropriate treatment that I thought was indicated, whether it's a nerve block or an epidural or a facet block.

And that would be done either with fluoroscopy or with CAT scan machine that makes tomographic images like X rays, cross-sectional X rays of the body to use those images to guide the precise delivery of the medication exactly to where it needs to go.

And then I would evaluate the patient afterwards to see how they're doing. Do you feel

better? What happened? How effective was this intervention? And it helps two things to -- No. 1, to confirm the clinical suspicion and also, hopefully, to provide some relief. The body has an amazing capacity to heal itself over time. And even big things can go away on their own. But sometimes we need to give patients the opportunity to have some freedom or reduction of pain while their body heals itself.

Q. So what types of spinal interventional procedures will you actually perform?

A. So I will perform lumbar, cervical, and thoracic epidural steroid injections. I will perform facet blocks and rhizotomies. A facet block is where steroid or anesthetic is delivered into a little joint in the back of the neck or in the spine at any location, and then that medicine serves to decrease inflammation. A rhizotomy is when I've already confirmed that that facet is a problem and the patient hasn't responded to the block but the block has not had a long-lasting effect.

In that case, I'll put the needle much like I would for the block, but instead of delivering medicine, I deliver a little burning, electrical current that cauterizes that little twig that goes to that joint to have a more long-lasting relief of pain.

I'll also inject needles into the disks to see if they are painful. And at our institution, we're no longer doing provocative diskography where we try to cause the patient pain. We actually put an anesthetic in to see if we can get the patient's pain to go away, which I find to be more helpful.

And then I will also do biopsies of the bone of the spine, the vertebra, going through the tunnels of bone that connect the back to the front into that vertebra, right next to that spinal canal to get tissue when we think there might be an infection or a cancer living in that bone and to get that information for the doctors.

I'll do injections of the sacroiliac joints. I'll biopsy paraspinal soft tissue masses.

The one thing that I don't do and I have been trained to do is to implant stimulators into the back or to implant pumps that deliver medication. Those are generally done by our anesthesia colleagues at our hospital.

MR. JAFFE: Your Honor, at this time, I would like to offer Juan Pablo Villablanca as an expert in the field of neuroradiology and interventional spine neuroradiology.

MR. CLOWARD: Your Honor, I don't think I

have an objection, but, again, I would like to approach.

THE COURT: Come on up.

(Whereupon a brief discussion was held at the bench.)

MR. CLOWARD: Judge, do you want me to just do that outside?

THE COURT: You can do it now.

MR. CLOWARD: Your Honor, we have no objection to the qualifications of Dr. Villablanca. We do have the standing objection regarding his testimony based on the procedural issues.

THE COURT: The Court will recognize Dr. Villablanca as an expert in neuroradiology or interventional spine radiology.

Go ahead.

MR. JAFFE: Thank you.

BY MR. JAFFE:

Q. Dr. Villablanca, did I hire you as an expert on behalf of my client in this case?

A. Yes.

Q. And how much are you being paid for your appearance in court today?

A. Our rates are set by the university. I think that for a half day in the court, it's $2,300. And I

don't remember how much it is for a full day.

Q. Does the money go to you or the university?

A. It goes to the university. And then there is a possibility that some of the funds can come back to myself, for instance, to use for student projects for the summer and this type of thing.

Q. So it's not going into your pocket, then.

A. No. Not generally, no.

Q. Okay. Dr. Villablanca, have you -- would you please tell us the opinions that you reached with respect to this matter.

A. I have reached several opinions. The first is that all of the studies that have been provided to me for review, including the cervical spine radiographs that were done on the day of the accident, March 13th, 2009, the noncontrast CT scan of the brain that was done on that same day, as well as the MRI studies, the cervical and lumbar spines performed on April 3rd, 2009, showed degenerative changes of the cervical and lumbar spine and do not show changes, focal abnormalities, that could be attributable to the motor vehicle accident of March 13th, 2009, and that the brain is normal.

So to a reasonable degree of medical probability, I'm unable to find focal specific

pathology that would be attributable to this motor vehicle accident on these studies.

Q. We're going to go into that in more depth now.

But first, would you please tell us and even as a spine -- an interventional spine radiologist, I know you do have the opportunity to meet with patients.

You did not meet and examine the plaintiff, correct?

A. I have not.

Q. You did not speak with her to correlate findings versus symptoms.

A. That is correct.

Q. And would you -- also, the findings on the -- on the films taken before her surgery, if you were to meet with her a year or two after the surgery had been completed, would that have been of limited, if any, value in -- due to the timing?

MR. CLOWARD: Objection. Leading.

THE COURT: I'll overrule.

THE WITNESS: It would have been of some value, but because she had already been examined by experts, I have the benefit of reviewing those experts' comments and findings at the time of the -- around the time that scans were obtained for correlation.

BY MR. JAFFE:

Q. Okay. And by that, you mean her treating doctors.

A. Correct.

Q. Now, would you please tell us what in particular you have had the opportunity to review.

A. I have had the opportunity to review the medical records that you've sent to me in numerous correspondences. The most recent correspondence, I believe, is from May 22nd, 2013, and it's about four pages of documents that were made available to me for review. I don't know if you want to me to list all -- the contents of all those pages.

Q. How about the records that you reviewed prior to writing the reports?

A. The records that I reviewed prior to writing the reports which were dated August 1, 2012, and October 15 of 2012, were those that were sent to me as attachments prior to those dates and did include the expert neurosurgical case review and medical life-care plan of Dr. Jeffrey Gross as well as a supplement that he generated. And that -- I'm sorry, that first document is dated August 7th, 2012, and then he generated a supplement on September 29th, 2012. That was a 21-page document.

Q. What about medical records reflecting her treatment?

A. Medical records would have been those sent to me through -- through the last date of my supplemental note on October 15th.

Q. Can you identify which records you would have seen as of that time?

A. I believe it would be everything but the depositions of Drs. Muir, Belsky, Khavkin I think it's pronounced, Dr. Belsky, Dr. Jeffrey Gross. And then I believe he prepared yet another supplemental report dated May 20th, 2013. I did not review those.

But I had access to everything that I felt was important that was around the time of the accident and until the time of the first surgery. To me, that's the critical time to tie carefully what's happening with her clinical symptoms to the imaging findings.

Q. Would that have included records predating the accident?

A. Yes.

Q. So did you see records from 2004 through 2008 --

A. Yes.

Q. -- prior to writing your reports?

A. Yes.

Q. Did you see records from MountainView Hospital, Dr. Belsky, Dr. Muir, Dr. --
A. Yes.
Q. -- Lurie and Dr. Shah --
A. Yes.
Q. -- prior to writing your report?
A. Yes.
Q. Dr. Khavkin's records as well?
A. Yes, I believe so.
MR. CLOWARD: Your Honor, I'm going to object as to leading.
THE COURT: It's foundational.
MR. JAFFE: Thank you, Your Honor.
BY MR. JAFFE:
Q. Did you see the physical therapy records from Matt Smith prior to writing your reports?
A. I believe so.
Q. And you -- all the films that had been available as of that date, have you -- have you seen those?
A. I -- yes.
Q. Okay.
A. The ones I listed as well as ones that were done after the surgery.
Q. Now, let's -- let's talk first about the

X ray. Okay?

A. Yes.

Q. There was an X ray taken on the date of the accident?

A. That's correct, March 13th, 2009.

Q. Okay. And, you know what, let's kind of break this down. Let's talk about the cervical spine first. Then we'll talk about the lumbar spine. Okay? I think that's probably going to be the easiest way to do things.

Would you please go through -- you know what, I'll tell you what. Let's talk about the X ray. Let's talk about the cervical spine x-ray on the date of the accident. Okay? There we go.

A. So by double clicking here, I should be able to bring that up. Able to extract one dye contrast image. So maybe what I can do is go back to the database, see if I can get the others loaded. Those are there. So let me come back. So I'm not sure why the radiograph of March 13th, 2009, that --

Q. Is that another one just below it?

A. Yeah. I clicked on that one. Let's see if that file folder may have it. That's the spine.

Q. Was that the C2 or was that the --

A. That was the MRI, but I'd like to show you,

to start with, the cervical radiographs, which I think are very helpful. So let me page through what's here and see if that will give us -- that's after the fusion. Radiographs. That was our diskogram study. So everything is loading but that one dye contrast image.

Q. Can we --

A. So I may ask for -- this is the Scout. Let's see here.

MR. JAFFE: Your Honor, can we have -- would it be okay if my technical assistant jumps in there and tries to help on this one?

THE COURT: Over here on the computer?

MR. JAFFE: Yeah.

THE COURT: Let's do this: Let's take a quick break, folks, and see if we can get them to -- see if we can figure these out, and maybe when we come back, we'll have it all working.

During our break, I'm going to instruct you to not talk with each other or with anyone else, about any subject or issue connected with this trial. You are not to read, watch, or listen to any report of or commentary on the trial by any person connected with this case or by any medium of information, including, without limitation, newspapers, television, the

Internet, or radio. You are not to conduct any research on your own, which means you cannot talk with others, Tweet others, text others, Google issues, or conduct any other kind of book or computer research with regard to any issue, party, witness, or attorney, involved in this case. You're not to form or express any opinion on any subject connected with this trial until the case is finally submitted to you.

Take about ten minutes.

THE BAILIFF: All rise.

(Whereupon jury exited the courtroom.)

THE COURT: We're outside the presence of the jury. Anything we need to take care of?

MR. CLOWARD: Can I use the restroom?

THE COURT: Yeah. Let's go off the record.

(Whereupon a short recess was taken.)

THE COURT: Let's bring them back.

THE BAILIFF: All rise.

(Whereupon jury entered the courtroom.)

THE COURT: Go ahead and be seated. We're back on the record, Case No. 636515.

Do the parties stipulate to the presence of the jury?

MR. JAFFE: Yes, sir.

MR. CLOWARD: Yes, Judge.

CASE NO. A-11-636515-C

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CLERK OF THE COURT

DISTRICT COURT

CLARK COUNTY, NEVADA

* * * * *

MARGARET G. SEASTRAND,

Plaintiff,

vs.

RAYMOND RIAD KHOURY, DOES 1 through 10; and ROE ENTITIES 11 through 20, inclusive,

Defendants.

REPORTER'S TRANSCRIPT

OF

JURY TRIAL

BEFORE THE HONORABLE JERRY A. WIESE, II

DEPARTMENT XXX

DATED WEDNESDAY, JULY 24, 2013

REPORTED BY: KRISTY L. CLARK, RPR, NV CCR #708, CA CSR #13529

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I N D E X

I N D E X

LAS VEGAS, NEVADA, WEDNESDAY, JULY 24, 2013;
9:06 A.M.

P R O C E E D I N G S

* * * * * * *

THE BAILIFF: All rise.

(Whereupon jury entered the courtroom.)

THE COURT: Go ahead and be seated. Good morning, folks. Back on the record in Case No. 636515. Parties stipulate to the presence of the jury?

MR. JAFFE: Yes, sir.

MR. CLOWARD: Yes, Judge.

THE COURT: At least you got doughnuts this morning.

ALL JURORS: Thank you.

THE COURT: We're in the defense case. Who's your next witness?

MR. JAFFE: Your Honor, at this time, defense would like to call Dr. John Siegler.

THE COURT: Okay. Doctor, if you want to come up and drop your stuff, I guess. And remain standing next to the chair, and raise your right hand, please.

THE CLERK: You do solemnly swear the testimony you're about to give in this action shall be the truth, the whole truth, and nothing but the truth, so help you God.

THE WITNESS: I do.

THE CLERK: Please state your full name and spell it for the record, please.

THE WITNESS: John Blackburn Siegler, S-i-e-g-l-e-r.

THE CLERK: And John is J-o-n or --

THE WITNESS: J-o-h-n.

THE COURT: Thank you, Doctor. You can sit.

THE WITNESS: Thank you.

THE COURT: Try to talk into that microphone so we can all hear you.

THE WITNESS: Okay.

DIRECT EXAMINATION

BY MR. JAFFE:

Q. Good morning, Doctor.

A. Good morning.

Q. Would you please tell us what you do for a living, sir.

A. I am a physician, specifically a physiatrist, which is a specialty called physical medicine and

rehabilitation. I do pain management and musculoskeletal and some -- I guess, neuromusculoskeletal, like the electrodiagnostic studies and things like that.

Q. And where do you practice, sir?

A. My office is near St. -- St. Rose and Seven Hills, that intersection there.

Q. Okay. And now, would you please give us the benefit of your medical and academic credentials.

A. Sure. I attended undergrad at Northwestern University, and I also attended medical school there. And I also stayed there for my residency, actually their hospital and then their affiliated rehab hospital which -- rehab as in withdrawal rehab, but rehab from like chronic conditions, spinal cord injuries, stroke. It's basically the physical medicine and rehabilitation hospital. So I was -- did my residency there for four years.

Q. Okay. What is a residency?

A. That's the post medical school training where you get the specialty training, essentially. You are a physician. You -- you can function as a physician, but you still have the oversight of -- of the attending physicians. It's an academic center.

Q. Now, pain management actually falls within

the arena of two different specialities, doesn't it?

A. Correct. As of yet, there's not a -- a pain management specialty, although that may change. But in general, anesthesia and -- and physical medicine rehabilitation tend to be the most common specialists who practice pain management.

Q. Okay. And your practice, is it -- what percentage of it is treating patients versus reviewing charts in a forensic setting like you're doing today?

A. It's 95 percent clinical.

Q. You mean seeing patients in your office?

A. Correct.

Q. And, sir, do you have any board certifications?

A. Yes.

Q. What is a -- what are you board certified in?

A. Well, the physical medicine rehabilitation, the American Board of Physical Medicine and Rehabilitation, which is my primary residency training specialty. But also, the American Board of Pain Medicine, the American Board of Electrodiagnostic Medicine, and then the independent medical examination, American Board of Independent Medical Examiners.

Q. Now, what does it take to become board certified? How does one become board certified in a

specialty area?

A. Well, typically if they've done a residency in the particular area or in pain management in one of the appropriate areas, and then have -- have documented the appropriate experience. Or in the case of the electrodiagnostic medicine have done a certain number of electrodiagnostic studies.

And then there's usually -- well, no. In every case, there's a written test. And I believe there -- in the American Board of Physical Medicine and the electrodiagnostic medicine, there's also an oral examination as well.

Q. Okay. Now, physiatry is sort of an area that not many people have either heard of or understand. So why don't you tell us, as a physiatrist, what do you do on a day-to-day basis with your patients?

A. Sure. And you're right, not a lot of people have heard about it. Usually either -- when I mention that, either people tell me about their foot problems or about their anxiety problems. But -- and there's only about 5- or 6,000 of the -- of the specialty nationwide. So it is a PR problem.

But it really -- there's two -- there's two branches. There's the physical medicine aspect and then the rehabilitation aspect. The rehabilitation

aspect is -- is more the dealing with chronic injuries that aren't expected to improve. People who have had debilitating strokes and may have spasticity or weakness or have had spinal cord injuries or traumatic brain injuries. So functional deficits that are stable or becoming stable but need to be addressed.

And that -- so once someone has had a stroke and maybe is then medically stable but obviously isn't functional enough to return home with -- with their spouse or family members, they would come to the rehabilitation hospital. We would work on maximizing their function. And then once they're at a point where they can return home, hopefully then we would continue to see them and treat -- treat the condition and try to maintain their function.

The physical medicine aspect is more the neuromusculoskeletal medicine where we do a lot of, basically, nonoperative orthopedics. Instead of -- you know, if someone, for example, has back pain, a lot of times, they may go to a surgeon first. Well, the surgeon is going to look at someone and say if they're surgical or not surgical, whereas someone who's not really geared towards surgery is going to look more at trying to look at more the bigger picture, so to speak. So what -- where is the problem coming from? Is --

what can we do to address this before necessarily getting to surgery. Where is the pain coming from? What therapy, you know, diagnostic injections to see where -- what the pain generator may be coming from.

Electrodiagnostic studies can be helpful in certain settings if there's, you know, multiple things going on, to help isolate, say, a pinched nerve in the neck versus, you know, a pinched nerve in the wrist from carpal tunnel syndrome and that sort of thing.

Q. So, for example, when you talk about electrodiagnostic studies, what is that? What does that mean?

A. Basically, there's two components to that. There's the nerve conduction studies where you put electrodes either on muscles and then -- and then apply a current to a nerve and the current will then activate the nerve. The -- the nerve response will go down the nerve and then activate the muscle and cause the muscle to contract. And you record both how much of a shock you give the nerve and how fast the response occurs and how robust that response is. And you can tell how well the nerve is functioning, how quickly that -- that nerve response is getting to where it needs to go. And it gives you good data on -- on -- on basically the health of the nerve.

The second part of that, the electromyography, is you put a small needle into different muscles, and you can -- you listen to a -- basically a conversion of the electrical activity inside the muscle into sound as well -- as well as a visual representation on the screen. And from that, you can deduce certain things about if that muscle is functioning correctly and how that nerve supply to that muscle is functioning.

So -- and because we know that certain muscles have specific nerves that go to them, if -- if we find something abnormal, you can a lot of times tell, by checking different muscles and finding out which ones are abnormal and which ones are functioning correctly, where a nerve problem might be.

Q. Now, in your practice, it sounds like there's quite a lot of different types of tests that you rely on to make determinations on patient treatment and status, sort of like these electrodiagnostic tests.

A. Yes.

Q. Now, when you're treating a patient, do you typically see them before they become surgical, after they're surgical, or a combination of both?

A. Probably both.

Q. Okay. Are there times that you see patients

who you're basically trying to help them to avoid surgery?

A. Oh, very much.

Q. And if that's the case, I guess what I really want to find out is, what is the role of the physiatrist with respect to a spinal surgeon? I mean, how do the two interact and how do the two differ?

A. Well, the surgeon basically is -- is trained in -- in the mechanics of surgery, and, you know, will see the patient, how to open up the patient, how to perform surgery. The -- and involved with that, I mean, they do learn to look at films, and -- and, you know, perform examinations and so forth.

But in my experience, most surgeons are very directed towards is this patient someone I can help with surgery or not. Most surgeons aren't -- aren't -- and this isn't universally true, but by and large, most surgeons, if someone's not surgical, don't necessarily want to continue to treat someone. They will turn them over to a physiatrist or -- generally a physiatrist would be the best choice.

Q. And are you the type of physician who will occasionally -- well, as part of your practice, see patients to try and help them avoid surgery?

A. Yes.

Q. Okay. Now -- okay.

MR. JAFFE: Your Honor, at this time, I would offer Dr. John Siegler as an expert in the field of physical medicine and rehabilitation, physiatry, with a subspecialty in pain management.

MR. CLOWARD: Your Honor, I don't think we have an objection, but may we approach?

THE COURT: Sure.

(Whereupon a brief discussion was held at the bench.)

MR. CLOWARD: Judge, no objection.

THE COURT: All right. He will be recognized as an expert in the field of physical medicine and rehabilitation with a specialty in pain management and physiatry.

BY MR. JAFFE:

Q. Now, I just want to clarify one thing, Dr. Siegler. You're not a surgeon, right?

A. No, I'm not.

Q. You don't make surgical recommendations or determinations as to whether somebody is a surgical candidate or not.

You leave that to the surgeon to decide?

A. Ultimately. A lot of times I'll-- you know, I have a pretty good idea that someone --

MR. CLOWARD: Judge, I'm going to -- I'm just going to object.
BY MR. JAFFE:
Q. Let me just -- let me ask --
MR. CLOWARD: Move to strike.
BY MR. JAFFE:
Q. Let me -- let me ask this, sir: If you have concerns about whether somebody is surgical, will you -- is that when you turn them over to a surgeon?
A. Yes.
Q. So what I want to do is this: We're going to talk about the -- your review and your opinions within your field of practice. We're going to leave the surgery to others since you're not a surgeon, right?
A. Okay.
Q. Okay. Just want to make sure that we have a fair understanding of the ground rules. Okay, sir?
A. Yes, sir.
Q. Now, Dr. Siegler, did we hire you in this case?
A. Yes.
Q. And we're paying for your time --
A. Yes.
Q. -- is that correct?
And how much are we paying for you to be in

court today?

A. I believe it's about 5,000 for -- for today.

Q. Okay. And, again, that reflects the fact that had you not been here, would you be doing work and earning money in your practice?

A. Yes.

Q. Keeping the doors open and the lights on?

A. Yes.

Q. Okay. Now, Doctor, let's talk for one second about testimony.

Sir, you -- you've testified in court on other occasions as well?

A. Yes, sir.

Q. Have you testified for defendants in the past?

A. Yes.

Q. Have you testified for plaintiffs in the past?

A. Yes.

Q. The testimony that you've given in the court, how would you break that down between plaintiffs and defendants?

A. It's roughly about 50-50.

Q. Now, when you testify for plaintiffs, is that -- is that because the plaintiff happens to be a

treating patient of yours?

A. Sometimes. But sometimes it's also as an expert capacity as well.

Q. Have you worked as a physician treating patients that were coincidently being represented by Mr. Harris's office?

A. Yes.

Q. And have we had situations where you're treating patients that are -- that I'm defending against?

A. I believe so, yes.

Q. In fact, we've got one very significant one going right now, don't we, sir?

A. I believe so, yes.

Q. And, Doctor, have you ever testified for me before?

A. I don't believe so.

Q. Now, in this particular case, sir, you did not examine the plaintiff; is that right?

A. That's correct.

Q. What did we ask you to do?

A. I was provided with the records, asked to review them and basically provide my medical opinion on -- on the diagnoses related to the accident of March 13th, 2009, and the treatment and what was

related.

Q. Sir, what -- what is your opinion regarding the injuries sustained by Margaret Seastrand regarding the accident that occurred on March 13, 2009?

A. Basically she had a recurrence of cervical and lumbar pain as well as a headache which I believe was related to her neck pain.

Q. Do you believe that she sustained injuries to her disks in either of the cervical or lumbar spine as a result of this accident?

A. No, I don't.

Q. Okay. Sir, would you please tell us, what have you had the opportunity to review in -- in this matter, generally speaking?

A. Sure. I reviewed a multitude of -- of records from other -- other physicians prior to her -- the motor vehicle accident. She saw Dr. Lambert, Dr. Diaz, some hospital presentations. State of Nevada Traffic Accident Report, hospital records after the motor vehicle accident in question, EMS reports, records from Dr. Lurie and Dr. Olmstead, Dr. Fisk, Dr. Weeks, Dr. Belsky, Dr. Weber, Dr. Muir, Dr. Shah, Dr. Longoris, electrodiagnostic studies, records from Dr. Khavkin, Dr. Grover, physical therapy notes from Matt Smith Physical Therapy, imaging study reports,

some X rays before the accident, some imaging studies after the accident.

Q. Okay. Have you also had depositions available for your review as well?

A. I have not reviewed any deposition testimony.

Q. Okay. Now, were you able to make a determination -- your determination based upon review of the medical records?

A. Yes.

Q. Now, was there any one particular record or series of records that you believe were critical for your analysis?

A. Yes. The -- in this instance, the record -- there's a series of records detailing complaints prior to the motor vehicle accident that demonstrated -- demonstrated neck and low back complaints being present beforehand, with complaints into the extremities that mimic complaints she had after the motor vehicle accident. And I believe there were also some records from the -- Dr. Lurie that alluded to -- to the fact that -- that she had had neck and low back complaints before the accident as well.

Q. Let's turn to the records before the accident. And I assume we're talking about those from October 27th, 2008? Would those be the critical ones?

A. I believe that that was one set of records that did -- that did denote complaints, yes.

Q. Okay. I would like to focus on those for a bit.

MR. JAFFE: And, Your Honor, if we could have the ability to use the screen.

THE WITNESS: I can either pull them up from here or from my computer. Which would be --

BY MR. JAFFE:

Q. Well, what we're going to do is this: We've already got them downloaded, so we're going to put up them on the screen as well. And they'll be on the screen in front of you, so if you want to refer to what's on your computer as well, go right ahead.

A. If it's on the screen, that's fine.

Q. Okay.

A. Thank you.

MR. JAFFE: Your Honor, I'm going to -- I had the wrong designation. I was thinking JJ, but it's actually Exhibit J that I want.

You know, Judge, I'm just going to use the ELMO. Thank you, sir.

BY MR. JAFFE:

Q. Showing Exhibit JJ -- or J rather, J7. And, Doctor, I'm going to put this up, and this is a visit

from October 27th, 2008; is that correct, sir?

A. Yes.

Q. Now, would you explain to us your interpretation of why the plaintiff was seen that day and what the results were.

A. She had been having chest pain with associated numbness and tingling into both arms and shooting pain in the left arms, no shortness of breath, and it was actually going away with -- with exercise. It said -- it says with numbness. And then below, under the Assessment, they recommended an X ray of the neck.

So the concern was with -- two concerns there. One with -- the chest pain, the concerns are always it may be a cardiac issue. But it was pretty atypical for cardiac pain to go away with exercise. The other concern was of -- of a neck issue, and so they ordered an X ray of the neck.

Q. Now, sir, do you believe that this was a cardiac event that she was ultimately seen for in terms of the cause of the visit?

A. No, I don't think so.

Q. Why is that?

A. The workup was -- was negative for that. I mean, she wasn't -- didn't end up getting any cardiac

treatment. She was sent to a cardiologist and had some testing, but it didn't suggest that she'd had a cardiac event. And there was some findings on the X ray that were consistent with some cervical processes that could present like this.

Q. And later today we're going to hear from Dr. Villablanca, a radiologist, who's going to go through what -- the films themselves, and, you know -- or rather what's on the films.

But can the cervical spine produce the symptoms that she was seen for that day?

A. Yes.

Q. How so?

A. It would almost be easier to -- to draw it. I don't know if there's a board.

MR. JAFFE: You know what, Greg, do we have the --

BY MR. JAFFE:

Q. If I had a model of the spine, would that help?

A. That -- that might -- I mean, basically --

Q. I hate to say it, but the days of easels and crayons are long since gone from the courtroom.

A. Really? I got to do that a year ago. That was fun.

Q. Let's -- okay. Let's explain it the best we can.

A. Basically, there's -- there's two parts to the -- to the spine. You got the front part which are the big columns, the big bones that are really the -- provide the stability, that prevent us from being Jell-O. Sort of the tent pole to our body, so to speak. The spinal cord runs behind that, and then behind that pole is basically a -- sort of a enveloping canal of bone that surrounds it.

And there's -- there's ridges in the back as well that bone -- that muscles connect to, and it forms a plate. And that's when you -- you know, when you look at someone's back and you see the ridges, that's really the plates that protect the spine. But it's not solid. There's -- because the spine moves and bends and extends and so forth, there's -- the plate has to move relative to each other. So there's -- there -- there are joints there where it can bend, but it's essentially a protective plate.

So -- but what can happen because -- just with age and wear and tear, those -- those joints -- both the joint in the back can -- can get spurring, and -- and then that impinges upon that canal that the -- that the spinal cord runs through.

And as well as in between those bones, there's -- there's disks, soft disks that cushion as well as allow movement of those pillars relative to one another so we can move in multiple planes. And those generate and can -- also, as they lose height and can blow out more, those also can impinge upon the spinal cord and the nerves that come out of there.

So as, basically, we get older, there's a -- an accumulation of -- of degeneration that can, and often does, lead to compromise of nerves that come out of and go into either the arms or legs. And that can happen slowly, a progressive sort of symptoms into the extremities, or it can happen acutely. You can wake up or turn a certain way and get sudden pain into the arm or leg.

You can also get increasing pain in the disks. Disks themselves can become sensitized, and you can get pain in the neck or low back that can happen -- it can be a constant pain that you live with every day or it can periodically flare anytime -- you know, couple times a year to a couple times a month. So that's sort of how that can manifest with pain in the neck, pain -- and that can radiate into the chest and certainly into the arms as the nerve gets sort of crimped off with the progressive degeneration and bone

spurring.

Q. Now, Dr. Kermani offered a couple of potential diagnoses at that time or concerns.

Would that be fair to say?

A. Yes.

Q. One of which was the cervical spine?

A. Yes.

Q. And based upon your review of this record, were the plaintiff's symptoms consistent with a -- with a spinal etiology?

A. Yes.

Q. Do you believe that Dr. Kermani during this visit eliminated cardiac as the cause of her symptoms?

MR. CLOWARD: Object to form. Calls for speculation, Doctor -- I mean, Judge.

THE COURT: Hold on. Hold on.

MR. JAFFE: Judge --

THE COURT: I think he can -- why don't you rephrase it based upon the records.

MR. JAFFE: Sure.

BY MR. JAFFE:

Q. Reviewing these records, does it appear as if Dr. Kermani analyzed the plaintiff as -- and considered whether her heart or her cardiac system was producing her symptoms?

A. Yes.
Q. What in that chart and in that record do you see that goes to an analysis of her cardiac system?
A. They -- well, one was the questions that were asked in the history. And two, was some of the assessment recommendations, EKG and echocardiograms stress test and referral to a cardiologist.
Q. How about the objective findings? Do you see where he tested the heart there?
A. Correct, as well as the physical exam findings, the auscultation or listening to the heartbeat, which that was normal. The heart rate was regular. It wasn't elevated. There wasn't any abnormal sounds, murmurs, gallops, or rubs which are abnormal sounds that can be present. The lungs were clear, meaning there wasn't any fluid backing up in the lungs which can happen if someone's going into cardiac failure.

So correct, there wasn't any physical exam findings to suggest that anything abnormal cardiacwise.
Q. Did he also note that there was no shortness of breath?
A. Yes.
Q. If there was shortness of breath, would that potentially have pointed to the heart?

A. Yes. Shortness of breath is a common finding when there's a cardiac issue going on.

Q. In light of that and given that, sir, do you see anything in what Dr. Kermani has documented which in any way suggests that the heart was producing the symptoms?

A. I mean, just the fact that there was chest pain, you have to consider that. But beyond that, everything else with it going away with exertion, the lack of shortness of breath, the benign physical exam findings, that really points away from a cardiac etiology.

Q. Now, sir, the nerves that come out of our spinal cord, do they innervate various parts of our body?

A. Yes.

Q. And when they innervate parts of our body, do they go to all different parts of the body including the chest?

A. Yeah. Pretty much anywhere neck down is all coming from the spinal cord.

Q. Okay. And the chest area, is that innervated through the upper cervical nerves?

A. Yes. There's a mantle distribution in the cervical spine, so it can definitely radiate to the

chest.

Q. Would that explain in some way why Dr. Kermani was concerned about the cervical spine?

A. Yes. That certainly -- the chest pain in and of itself was -- the left arm pain certainly -- the shooting pain in the left arm is even more suggestive of a cervical processes.

Q. And I talked in my opening statement about how we can basically tell, because we're all pretty much hardwired the same way, based upon where we have symptoms what nerves you're going to be looking at.

Would that be fair?

A. To some degree. I mean, there's a little variation. But in general, if someone's got pain radiating to the middle finger, you usually think the C7 nerve. If it's -- you know, one of the monikers we learned in medical school is six-shooter. This is the C6, the sixth cervical nerve, so ...

Q. Okay. And which disk would most impact the C6 nerve root?

A. C6 would involve shooting pain in the arm. It would generally go into the thumb and index finger, the -- the forearm, and you can certainly get pain into the shoulder and chest as well.

Q. Okay. But which disk in the cervical

spine --

A. Oh, I'm sorry.

Q. -- would most likely affect the C6 nerve root?

A. Most often it would be C5-6. But, you know, it's certainly not always, but most often would be C5-6.

Q. And you're aware that she was sent for an X ray that day?

A. Yes.

Q. What disk space was found to be compromised?

A. I believe it was C5-6.

Q. Tell you what, I'll show you the radiology report which is J. I want to say it's 19, but I'm -- 19 -- 18. I'm sorry.

A. So C5-6, yes.

Q. Okay. And it was found to have -- was there found to be any abnormal pathology at that level?

A. Yes.

Q. Degeneration?

A. Yes.

Q. Okay. Now, what does that suggest to you? What is the significance of this October 27th, 2008, finding relative to the reason we're here?

A. Well, to me, it seems the most likely reason

that she had those symptoms and -- and presented -- and thus presented was that there was a cervical processes that involved the C5-6 disk that flared and precipitated symptoms that radiated into her chest and into her arm that caused pain to the degree where she presented for treatment.

Q. Now, you haven't seen any other medical records from then up until the time of the accident where she saw a doctor for her cervical spine, did you?

A. That was 2008?

Q. October 2008.

A. Correct. I didn't -- I did not have any other medical records until -- from 2008 until the time of the accident where she was seen for cervical complaints.

Q. Okay. So then as a result of this accident, do you believe the plaintiff was injured?

A. Yes.

Q. Okay. What injuries do you believe she sustained?

A. I believe she likely sustained soft tissue cervical and lumbar sprain-strain injuries.

Q. Is that consistent with your review of the emergency room records?

A. Yes.

Q. Is that consistent with your review of the records from Dr. Belsky?
A. Yes.
Q. Is that consistent with your review of the records from Dr. Shah?
A. Yes.
Q. Is that consistent with your review of the diagnostics that were done after the accident?
A. Yes.
Q. Doctor, in your experience, can people independently suffer sprains and strains in some sort of traumatic episode like a car accident even though they already have a compromise of disks in their neck or low back?
A. Absolutely.
Q. Does it necessarily mean that the neck or low back disks are made worse because they've suffered a sprain or strain?
A. No.
Q. Can the two happen independently?
A. Yes.
Q. Do you believe that's what happened here?
A. Yes.
Q. Now, sir, you also addressed in your report, a life-care plan prepared by Dr. Gross; is that

accurate?
A. Yes.
Q. Do you believe that has anything -- the need for any of that care is causally related to this accident?
A. No.
Q. Do you believe she needs that care?
A. Potentially. But I can't attribute it to -- the need for that care, I can't attribute to the accident.
Q. Have you seen any physical therapy records since January 2011?
A. No.
Q. In your experience, sir, is past conduct regarding following up with care a good indication of how somebody is going to act in the future?
A. Yes.
Q. Sir, have you seen any indication that she's had the need for any pain medications relative to this accident or anything whatsoever since July 2011?
A. No. It didn't appear that she's been taking pain medication from the records I reviewed.
Q. For at least two years.
A. Correct.
Q. Dr. Siegler, have all your opinions been

stated to a reasonable degree of medical probability as a board-certified physiatrist with a specialty -- subspecialty in pain management?

A. Yes, sir.

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

THE COURT: Cross.

MR. CLOWARD: Yes, Judge. May I have the Court's indulgence for a moment to set some things up?

THE COURT: Yep.

MR. CLOWARD: May I approach, grab one of these easels?

THE COURT: Sure.

MR. CLOWARD: Thanks. Thank you, Judge. I'm about there.

CROSS-EXAMINATION

BY MR. CLOWARD:

Q. How are you today, Dr. Siegler?

MR. JAFFE: Your Honor, may I see what's being shown to the jury before it's shown to them?

MR. CLOWARD: Something that I would have drawn while I was sitting here in court.

MR. JAFFE: Okay.

THE WITNESS: Good. Thank you.

BY MR. CLOWARD:

Q. How are you doing today, Doctor?

A. Good.

Q. You and I have worked together before.

A. Yes.

Q. Yeah. You were given certain information by Mr. Jaffe, correct?

A. Correct.

Q. And you had to rely on just the information that he gave you, correct?

A. Correct.

Q. You didn't get Ms. Seastrand's deposition, did you?

A. I don't believe so. Or if I did, not by the time I did the reports.

Q. Sure. You didn't have an opportunity to examine Ms. Seastrand.

A. No, I did not.

Q. In fact, you've never been able to actually meet her, have you?

A. No, I have not.

Q. Never been able to talk to her, have you?

A. No, I have not.

Q. That's something you would have liked to do.

A. Certainly that potentially could have

provided additional information.

Q. Sure. I believe you have testified that you never provide treatment to your own patients without physically examining them, true?

A. True.

Q. So, Doctor, and this one record that Mr. Jaffe presented to you, I'd like to talk about that in a minute, but before I do that, I would like to know, what is your understanding of Ms. Seastrand's playing field or her baseline before the crash versus after the crash?

So, Doctor, can you tell me what restrictions did she have before the crash that you're aware of?

A. As far as like formal induced physician restrictions?

Q. Sure.

A. I'm not aware of any.

Q. What about restrictions with her activities, like things that she's not able to do based on her neck or lumbar spine?

A. Prior to the accident?

Q. Correct.

A. I'm not aware that there were any formally -- formal restrictions provided by her physicians.

Q. Okay. And as provided by her physicians,

but, Doctor, it's fair to say that you're also -- because you've never met Ms. Seastrand, you're also not aware of any restrictions that she had based on her own testimony, correct?

A. That's correct.

Q. Doctor, can you tell us, what was her pain level like before the crash? And if you could just give us a rating, you know, what was her neck pain like before versus her back pain? And we're going to rate it on a scale of 1 to 10. Can you -- can you do that for us, Doctor?

A. My recollection from the notes was that she would -- would get pain in the neck at about 3 out of 10.

Q. Now, Doctor, that's -- that's a -- that's given in the history after.

A. Correct. But it was what she described as happening before the accident.

Q. Okay. So 3 out of 10 in the neck.

A. If I recall. And the low back, I think it was a 3 or 4 out of 10. I don't recall exactly what she had described. I can --

Q. Okay. And, Doctor, so that's based on I believe Dr. Lurie's note, correct?

A. I believe so, yes.

Q. So setting aside Dr. Lurie's note, just based solely on the records that you were provided by Mr. Jaffe, what was her pain level?

A. Well, setting aside that note, I have -- the notes that I do have don't record her -- her level of pain on a scale of 0 to 10. So I can't answer that specific.

Q. Fair to say you don't know?

A. Correct.

Q. Okay. Now, Doctor, regarding this -- this Dr. Kermani record, I want to talk to you about that in a moment, but was there actually a reference in there of neck pain? Axial neck pain. Cervical pain.

A. On that visit, I don't believe there was.

Q. Okay. Just going to put a zero there.

Now, regarding the pain -- and, again, I don't want you to consider Dr. -- Dr. -- Dr. Lurie's record.

A. Lurie's record?

Q. Sorry. Thank you, Doctor. Thank you. I appreciate it.

I don't want you to consider Dr. Lurie's. I want you to -- just based solely on the records that you were provided by Mr. Jaffe from before the crash, what was the pain frequency that she had?

A. Again, there was I think two or three records alluding to neck and low back pain and arm pain over the years, but they -- there wasn't enough to identify a frequency prior to Dr. Lurie's record.

Q. Fair to say that you -- you're unaware -- based on the records that Mr. Jaffe provided you, you're unaware of the frequency or duration of her pain complaints?

A. Well, again --

Q. Before the crash.

A. Well, Dr. -- Dr. Lurie's note was, though, an integral part of that -- of my analysis with reference to her description of what her pain was like beforehand. So it's hard for me to -- my -- that was part of my analysis.

Q. Sure. Dr. Lurie's report where Ms. Seastrand reported her pain levels was important to you, correct?

A. And the frequency, that -- that she had had prior to the -- prior to the motor vehicle accident.

Q. So it would be equally as important, her testimony, of how her life changed as a result of this motor vehicle accident.

A. Potentially.

Q. And she's in fact testified that this accident had a significant life-altering impact on her.

Would you have liked to have known that in your review of this case?

A. Certainly the information of her history could potentially be relevant, yes.

Q. You had to rely on what Mr. Jaffe gave you, though, correct?

A. I had to rely on the records provided, correct.

Q. Doctor, now, regarding -- so I think we've gone over the back. And I know that you relied on Dr. Lurie's, but -- and I don't mean to be persistent, but I want to make sure there's an answer to the question.

Specifically based on just the records from before the crash, are you aware of the duration or frequency of the pain complaints for the lumbar spine?

A. I believe it was at least since '04, and there was a -- a reference to her having intermittent back pain. I think in '07. So it was not limited to one episode, so there was at least several years duration of more than one episode.

Q. Sure. And -- and my question specifically, Doctor, was -- was the pain level and the frequency.

So how often, like every single day versus, you know, occasionally versus chronic? You know, what

is your understanding of that in regard to the lumbar spine?

A. Sure. The -- limiting to the records that were prior to the motor vehicle accident only, I -- there was no documented pain level there, so I can't comment as to a level from 0 to 10 limited to those records. Nor can I say anything regarding more specific frequency other than it was, I believe, the -- she said intermittent or --

Q. But that was in Dr. Lurie's, correct?

A. There was a note that -- or infrequent I believe was maybe the term that was used in one of the other notes.

Q. She actually said infrequent back pain, correct?

A. In '07, I believe so.

Q. Okay. So regarding the frequency, the only information you have from the records that predated the accident is that the back pain was infrequent.

A. And that there was chronic neck and low back pain noted I think in '04.

Q. Okay. But as far as the duration, how many times, how often? It was infrequent, correct?

A. As far as the low back pain, that's what was mentioned in the one note in '07, yes.

Q. So infrequent.

Now, Doctor, you were -- you were asked about some -- some -- these records. I'm going to get to the heart records here in a moment.

But before I get -- get to that, so one of the last things that you -- you testified to during Mr. Jaffe's direct examination was that past conduct is a good indication of follow-up, correct?

A. Correct.

Q. You're aware that Ms. Seastrand had a automobile crash in 1985, true?

A. Yes.

Q. And you would expect that if she had ongoing and residual complaints from that, that she would go to the doctor.

A. Yes.

Q. Okay. So the past conduct that I'm interested in and from 1985 to 2009. And the question that I have is: What medical treatment was there where the chief complaint was for her neck or her lumbar spine?

A. Well, I mean, it's obvious that I don't have near the medical records from that period of time. And it -- typically it's hard to get medical records from that remote of a time period.

Q. Sure.

A. Because my understanding is she had a pretty bad concussion then, and, you know, I'm sure there would have been a lot of treatment addressing that which I didn't have. So, you know, I simply don't know because those records either weren't available or weren't able to be obtained. I'm not sure what -- why they weren't specifically.

Q. I appreciate that, Doctor.

So it's fair to say that you're aware of zero records from 1985 to 2009 where the chief complaint was for neck and low back, correct?

A. Where her initial -- where her presentation was for -- specifically for neck and low back?

Q. Correct, the reason it brought her to the doctor, the chief complaint.

A. Correct, I would agree with that.

Q. Okay. Now, Doctor, let's compare her playing field before the crash to her playing field after the crash.

So, Doctor, can you tell me, what restrictions are you aware of that Ms. Seastrand has now?

A. Well, certainly having had a fusion, there would be restrictions in place. I don't know

specifically what -- what was recommended. I'd have to look at the -- at -- I don't recall exactly what the notes had said.

Q. Fair to say that as you sit here, you're not able to tell me specifically what the restrictions are at this time?

A. I can't recall from memory. I'd have to look at the record, yes.

Q. Would you like to take a moment to do that?

A. Sure. Would there -- I mean, it might take a while unless -- is there a specific section for the surgeon?

Q. Sure. Doctor, I don't -- I know it's a little bit time consuming, but I understand you've been paid by Mr. Jaffe to come here and give some opinions and so --

A. Well, I can state that in general, after someone's had a fusion, that it's pretty standard for them to have restrictions in place.

Q. Okay. Are you aware of how her activities of daily living have been impacted?

A. Specifically, no, I'm not at this point.

Q. Okay. Now, Doctor, what about her pain level and frequency? Can you talk to me a little bit about that after the accident.

A. No. Unfortunately, the records I reviewed basically are about the time of the fusion, and then I don't have any information after that. So I can't really speak to the clinical status after the fusion.

Q. Sure. Again, you had to rely on the records that Mr. Jaffe gave you, correct?

A. Correct.

Q. You would have liked to have seen everything.

A. Well, I mean, more information is always better. Although, again, the relevance of the fusion -- the fusion I didn't think was -- whereas, you know, may well have been medically necessary, I didn't feel was related to the accident.

Q. Okay. Sure. Thanks, Doctor.

Do you know -- well, I guess for the records that you did review, are you aware of how many treatments she had where the primary complaint was for neck and back after the crash?

A. Maybe 55, 60 treatments.

Q. Okay. And those 55 or 60 treatments took place after the motor vehicle accident, correct?

A. Correct.

Q. So, Doctor, is it your testimony today that without this automobile crash, on a more likely than not basis, Ms. Seastrand would have required those 55

to 60 visits during the same period of time that she did require them?

A. No. I think the -- the chiropractic treatments were reasonable. I do believe she suffered soft tissue injuries, and I do believe even evaluation by pain management was reasonable. So I think the majority of those visits were -- were -- were indicated, medically necessary, and related to the motor vehicle accident.

I just -- it was the -- the diagnosis of the disk pain and the subsequent fusion that I don't believe was -- was causal to the motor vehicle accident.

Q. Okay. Doctor, are you aware, based on your review of the records, at any point -- based on just the 55 to 60 visits that you reviewed, are you aware of any -- any time when Ms. Seastrand returned to the base level of 3 to 4 out of pain on the neck, 3 to 4 out of 10 pain on the back that was intermittent.

A. No, I don't see a lot of documentation of pain level, so I don't know what her specific pain level was. I'm sorry.

Q. So you're not sure whether she ever returned to this base level, correct? When I'm referring to this base level, the base level that -- that she would

have been before the crash, true?
A. True.
Q. Is it your -- is it still your opinion that the motor vehicle accident did not cause the serious injuries that required a fusion?
A. Yes.
Q. Doctor, I want to talk about this Heart Center record. This is the one that Mr. Jaffe showed.
What is the date of that record?
A. 10/27/2008.
Q. Okay. Is there any indication that there was cervical pain, cervical, axial pain?
A. No.
Q. And that -- it was 10/27, correct, Doctor?
A. Correct.
Q. The X ray was -- what is the date on the X ray there?
A. 10/27/2008.
Q. So Dr. Kermani wants to -- in this record, he thinks that the cervical symptoms, as you've testified to, or the arm symptoms might be related to her neck, so he requested a cervical MRI -- or cervical X ray, correct?
A. Correct.
Q. That was done on the same day, true?

A. Yes.
Q. 10/27. Okay.
So, Doctor, from 10/27 until 12/15/08 when Ms. Seastrand had had a stress test report or, you know -- what are these things called again?
A. A stress test?
Q. Stress test. That's for the heart, right?
A. Yes.
Q. That's not for the neck.
A. Correct.
Q. So from 10/27/08 to 12/15/08, are you aware of any treatment that Ms. Seastrand had as prescribed by Dr. Kermani for physical therapy?
A. No.
Q. Chiropractic?
A. No.
Q. Orthopedic consultation?
A. No.
Q. Neurology consultation?
A. No.
Q. Pain management consultation?
A. No.
Q. Or to see a doctor such as yourself, a physiatrist?
A. No.

Q. Now, on this 10/27 here, Doctor -- that's 10/27, correct?
A. Yes.
Q. What does it say the reason for the visit is?
A. Requesting heart check.
Q. Okay. And are -- Dr. Kermani, he actually did a physical evaluation, did he not?
A. Yes.
Q. What were the findings for the neck?
A. Normal check.
Q. Okay. Still believe those arm symptoms were more likely than not due to the neck?
A. Probably. I'm not sure how detailed of an exam the cardiologist does for the cervical spine, and I think it's very reasonable to rule out a cardiac etiology before proceeding with a therapy program or treatment for a neck issue.
Q. Okay, Doctor. So from some 12/15/08 to the date of the crash, are you aware of any record where Dr. Kermani referred Ms. Seastrand to a physical therapist?
A. No, I'm not.
Q. Any record where Dr. Kermani referred Ms. Seastrand to a chiropractor?
A. Is Dr. Kermani -- that was an emergency room

visit?

Q. Doctor, it's a yes-or-no question.

A. I'm sorry. No, I'm not aware of that.

Q. Any record from 12/15 to the date of the crash by Dr. Kermani to an orthopedic surgeon?

A. No, I'm not aware of that.

Q. To a neurologist?

A. No, I'm not aware of that.

Q. To a pain management specialist?

A. No, I'm not aware of that.

Q. To a physiatrist?

A. No, I'm not aware of that.

Q. Okay. Doctor, you have previously testified, and you agree, that trauma can cause a disk herniation, correct?

A. Yes.

Q. Trauma can cause internal disk disruption, correct?

A. Yes.

Q. Trauma can cause -- an internal disk disruption can occur with or without herniation, correct?

A. Yes.

Q. Internal disk disruption is often not seen on an MRI.

A. No. Usually you'll see some abnormality on an MRI.

MR. CLOWARD: Your Honor, may I approach?

THE COURT: Sure.

MR. JAFFE: Your Honor, if he is showing the doctor something, I would hope it's been marked as an exhibit and in evidence. I'd like to see what it is.

MR. CLOWARD: I'm just asking if this refreshes the witness's recollection.

MR. JAFFE: Well, yeah, but, if you're -- Your Honor, I think it's appropriate to show it if you're going to use it to refresh recollection.

THE COURT: It should be shown to the other side. Doesn't have to be admitted into evidence yet.

MR. JAFFE: Wait. Your Honor, could I see it beforehand? Your Honor -- okay. I object. This is one page --

MR. CLOWARD: I'm going to get the whole deposition for you.

MR. JAFFE: Very good.

MR. CLOWARD: Can I just reask the question?

THE COURT: Yes.

BY MR. CLOWARD:

Q. Doctor, have you previously testified that internal disk disruption is often not seen on an MRI?

A. It would appear I did. Although, I guess I would like to clarify that, I guess.

Q. Doctor, the question was just: Have you previously testified --

A. Yes, I -- I did.

Q. Doctor, you previously testified that treating physicians are in a better position to discuss causation because they get to evaluate the patients, correct?

A. All things being equal, yes.

Q. Doctor, do you agree that in order to have a disk protrusion or disk injury from an automobile accident that you have to have a broken bone?

A. No.

Q. Okay. And, Doctor, you agree that just because you cannot see on an MRI a serious injury like a broken bone or blood does not mean the person is injured, correct?

A. Correct.

Q. And you agree that the neck is a very complex structure, and that even a small finding can cause a big problem.

A. Correct.

Q. Doctor, you agree that property damage does not determine whether someone is injured, correct?

A. Correct.
Q. You agree that you can have major property damage, like a rollover, and you can have no injury, correct?
A. Correct.
Q. And, in fact, you can have minor property damage, and you can have a major injury, correct?
A. Correct.
MR. JAFFE: Your Honor, is this being shown? This is argument, these slides.
MR. CLOWARD: Judge, he's been showing slides the entire time.
MR. JAFFE: Judge, I've been showing the exhibits that are marked in evidence.
THE COURT: Okay, guys. Come here for a second, please.
MR. CLOWARD: I don't have any other questions either.
(Whereupon a brief discussion was held at the bench.)
THE COURT: All right.
MR. CLOWARD: No further questions, Judge.
Thank you, Dr. Siegler. I appreciate it.
THE WITNESS: Sure.
THE COURT: Redirect.

MR. JAFFE: Yeah. You mind taking this down, Ben?

MR. CLOWARD: Not at all.

THE WITNESS: Could I clarify about internal disk disruption?

THE COURT: When he asks a question.

MR. JAFFE: I'll ask you the question.

MR. SMITH: Your Honor, can we have the computer?

MR. JAFFE: I think we've got our connections fixed.

MR. SMITH: Hopefully.

REDIRECT EXAMINATION

BY MR. JAFFE:

Q. Now, internal disk disruption, I believe your testimony previously was that often it is viewed or not viewed on an MRI; is that correct?

A. I -- actually, I didn't -- I'd have to look at that again, but ...

Q. Explain to us the --

A. Sure.

Q. -- the role of MRI when it comes to determining an internal disk disruption.

A. Sure. I'd love to do that at this point.

Q. Thank you.

A. Basically -- an MRI is a very, very sensitive test. And if the disk is pristine, if it looks normal, if it's well hydrated, it's got good height, if it's not -- if there's no deviation in its anatomy, it looks normal, then -- then there's -- very, very unlikely that there's internal disruption of the disk. And so I guess if that MRI is normal, I think that is -- does rule out internal disk disruption.

That being said, a lot of disks aren't normal even if they're not painful. They can be -- they can be dehydrated. They can be protruded. And those disks potentially -- do have some disruption, but that doesn't mean they're painful.

So I guess that's how I would clarify that. And I'm not sure in what context I was asked that question before, but that's why I would say that an MRI can -- internal disk disruption be present on a normal disk on MRI, I would say no.

Q. Now, are there indications on an MRI which would give a clinical clue to an internal disk disruption?

A. Certainly.

Q. Is that what you just explained?

A. Correct. I mean, but that -- again, that

doesn't mean the disk is painful. But, you can have -- I mean, again, you can have loss of height of a disk. The disk can appear darker on an MRI, meaning it's lost water content. You can have areas in the disk that light up a little lighter, meaning that the -- it's called a high-intensity zone. That's indicative of an annular tear potentially.

So yes, there's certainly findings on MRI which suggest there's disruption to disk architecture. But there -- there's not really any correlation between those findings and the presence of pain, hence why a lot of clinicians use diskography to diagnose if a disk is painful or not because you really can't just based on an MRI.

Q. Okay. Let's move on. Let's talk about an examination. And it was brought out again that you did not examine the plaintiff, correct, sir?

A. Correct.

Q. Had she had two surgeries before you were retained in this case? Well, I'll tell you. Her surgeries were in January 2010 and May 2010.

A. Okay.

Q. I hired you --

A. I was aware of one.

Q. Well, she had -- January was the cervical.

May was the lumbar.

A. Okay.

Q. Did those occur before -- two years before you were retained?

A. Yes.

Q. Given that and given -- well, does the surgery alter the condition of her spine?

A. Yes.

Q. Does it alter her symptoms?

A. Yes.

Q. Does it alter her presentation?

A. Yes.

Q. Would the value of an examination have been much greater before she was operated on?

A. Yes.

Q. Relative to the strains and sprains she sustained in this accident?

A. Certainly it would have been -- an examination been the -- few months after the accident would have been the best period of time. After that, it would have been less and less helpful.

Q. For your purposes?

A. Yes. For causation purposes, yes.

Q. Now --

A. Causation determination purposes.

Q. Counsel asked you to ignore Dr. Lurie's note from a week after this accident. For your purposes, is that a note that you reasonably can ignore?

A. No. That was very important for my analysis.

Q. Okay. Now, let's -- you know, we're going to come back to Dr. Lurie's note in a moment.

And by the way, do you have the documents that were sent to you by my office?

A. Most of them are in digital format on my computer.

Q. Including letters?

A. I believe somewhere in e-mail format, I've got -- I do have a couple letters in here as well.

Q. Would you check if in June 2012. We sent you her deposition.

A. (Witness reviewing document.)

Q. And while you're doing that, I want to ask you: How critical is it to have looked at her deposition, vis-a-vis the records, for the purposes of your analysis?

A. Well, in general, depositions tend to be taken several years after the incident, and there's a lot of intervening stuff that happens and memories fade and so forth. I -- I find the -- certainly it's useful, particularly if the documentation right after

the accident is -- isn't very good. But ideally, a good history and documentation in the period right after the accident is much more reliable. You don't have those intervening -- the intervening loss of memory and all the other issues sort of that can alter a history.

Q. And, sir, counsel talked about her life-altering injury. Is there a difference between patient perception and medical diagnostic analysis?

A. Certainly.

Q. What is that difference?

A. Well, I mean, that's a pretty philosophical question. I mean, the perception is -- is purely just what someone, you know, perceives, their sensory input, and -- and, you know, is often, you know, tainted by all sorts of things. Where, you know, medical analysis is -- you know, sort of puts all the -- the diagnostic studies, the history, physical, all that together in trying to do an analysis of -- of causation, treatment, recommendations, and that sort of thing.

Q. So --

A. Does that answer your question?

Q. Yes.

While she perceives this as being -- having been a life-altering injury, including the fusions, do

you believe that this accident was any more than the sprains and strains.

A. No, I don't. Again, the -- in reviewing the records, her symptom constellation, I mean, certainly there was a flare of pain in the period after the accident, but her -- but then her overall symptom constellation wasn't significantly different pre- and postaccident.

Q. We're going to get to that in a second.

And by the way, and counsel also brought up the issue of the fact that between 1985 and 2009, there having been no records regarding treatment or where she went specifically for spinal pain.

We haven't seen anything before 2004; isn't that correct?

A. Correct.

Q. Sir, in the medical practice, how long are you required to retain medical records?

A. I believe it's seven years.

Q. And if this lawsuit was filed in 2011, that would mean the earliest we would be able to go back with doctor having to have maintained records, would have been 2004; is that right?

A. Yes.

Q. Does it necessarily mean that there wasn't

treatment prior to 2004 for spinal injuries, for spinal complaints?

A. No.

Q. You just wouldn't know what's there because we don't know what records have been preserved and not preserved.

A. Correct.

Q. Now --

A. I did get the deposition, to answer your question.

Q. I just wanted to clarify that. Thank you, sir.

Now, counsel also brought up --

MR. JAFFE: I believe it's Plaintiff's Exhibit 9, and what I'd like you to do is pull up page -- let's have page 9, and then we're going to move over to page 10. And, Greg, can you bring out that bottom paragraph. It continues over.

BY MR. JAFFE:

Q. Dr. Lurie is talking about lower back pain, and at the very bottom, he says, At the time of the motor vehicle collision, Mrs. Seastrand -- and of course it ends right there on that page.

MR. JAFFE: Let's go to the next page, Greg, and pull up the very top paragraph.

BY MR. JAFFE:

Q. -- rated her lower back pain as 4 out of 10. She stated prior to the accident, she was not experiencing any lower back pain, but she previously rated her intermittent lower back pain as 4 out of 10.

So would that be a baseline representative of her pain symptoms?

A. Yes.

Q. Sir, can sprains and strains take 9, 10, even 12 months to heal?

A. Yes.

Q. I'd like to go to Exhibit 11, page 31. Oh, you know what, this one is -- is not downloaded.

MR. JAFFE: Your Honor, could I switch over to the ELMO?

BY MR. JAFFE:

Q. I'm going to show you a note from Dr. Belsky, and this is dated 12/15/2009, nine months after the accident.

See that, sir?

A. Yes.

Q. See where my finger is? What does it say her lumbar pain is?

A. Five out of 10.

Q. Is that basically back to baseline?

MR. CLOWARD: Object to form.
MR. JAFFE: Your Honor --
THE COURT: Overruled.
MR. JAFFE: Thank you.
THE WITNESS: Very close.
BY MR. JAFFE:
Q. Would that be consistent with having healed from a sprain-strain and returning over nine months to pretty much to where she was?
A. Yes.
MR. JAFFE: Thank you. I have no further questions.
THE COURT: Redirect --

RECROSS-EXAMINATION

BY MR. CLOWARD:
Q. That's just --
MR. JAFFE: -- cross.
MR. CLOWARD: Yes.
BY MR. CLOWARD:
Q. That's just one record, right?
A. I'm sorry?
Q. Mr. Jaffe just showed you one record, just pulled out one record.
A. That -- Dr. Belsky's record there.

Q. Sure.
A. Yes, that was one record.
Q. Sure. Just one, right?
A. Yes.
Q. Okay. Now, regarding this -- this examination and the change of condition and things like that, despite not being able to examine her after the motor vehicle accident, you still did make a causation opinion, true?
A. True.
Q. And tell me a little bit about the medical-legal field. You do IMEs on people who already had surgeries all the time, right?
A. Yes.
Q. And you do -- you're asked to review records when spine surgeons are also on the case, correct?
A. Yes.
Q. And the spine surgeons and yourself do IMEs after the surgeries have already taken place, correct?
A. Correct.
Q. And you're not a spine surgeon.
A. Correct.
Q. You don't do spine surgeries.
A. Correct.
Q. You never have.

A. I never have.
Q. Hey, Doctor, do you expect -- does pain decrease after an injection?
A. It can. I mean, depends what's causing the pain and what's injected.
Q. Sure. Hypothetically speaking, say somebody had a lumbar problem, you know, like a lumbar disk disruption that was causing pain, and they had a series of transforaminal steroid injections in the lumbar spine.
Would that decrease the pain?
A. Potentially.
Q. Okay. The -- the report that Mr. Jaffe didn't show you is this one, and this one's just six days before the record he showed to you.
What happened here six days before the record he just showed you?
A. 12/9/09, she had a caudal epidural steroid injection.
Q. Does that help decrease pain?
A. It can.
Q. Now, you authored some reports in this case, correct?
A. Yes.
Q. And in those reports, you did not list the

deposition as something you reviewed, correct?
A. Correct.
Q. And you didn't review it, correct?
A. I -- I don't recall if I -- I didn't review it prior to authoring the reports.
Q. Okay.
A. And if I did review it, I don't recall it at this point.
Q. Okay. Doctor, you agree that degenerative disks are more prone to injury, true?
A. Yes, I would agree with that.
Q. You agree that degeneration can cause potentially mechanical instability, correct?
A. Yes, I would agree with that.
Q. You agree that an asymptomatic degenerative disk can become symptomatic as a result of a traumatic event, correct?
A. Yeah, it can.
Q. Doctor, some -- some providers keep their records for longer than seven years, do they not?
A. Yes, they do, I would assume.
Q. And Mr. Jaffe is a great attorney, correct?
MR. JAFFE: Your Honor, while I appreciate the compliment, I don't believe my competency is at issue in this lawsuit.

THE COURT: Sustained.

THE WITNESS: I've never had -- I've never used him personally so --

BY MR. CLOWARD:

Q. Sure.

A. -- he certainly seems like he knows what he's doing in -- from my -- when I've ever been cross-examined by him.

Q. I'll represent to you that he's a great attorney.

Do you have any reason to believe that if there's a record out there, some smoking gun, that Mr. Jaffe was not able to find that?

MR. JAFFE: Your Honor, calls for speculation. And obviously I'm -- you know, I'm not going to argue this without going to the bench.

THE COURT: Sustained.

MR. JAFFE: Obviously --

THE COURT: Move on.

MR. JAFFE: Thank you.

BY MR. CLOWARD:

Q. What was her pain scale when she got into the ER?

MR. JAFFE: Objection. On what day?

/////

BY MR. CLOWARD:

Q. Right after the crash.

Do you have any reason to disagree if I represent that it's an 8 out of 10?

A. No. That -- I would have no reason to disagree with that.

Q. That was the flare of pain that you referenced?

A. Well, yeah, she -- I acknowledged there was -- she was injured. Absolutely.

Q. Okay. Doctor, you agree that minor soft tissue injuries of the spine do not usually present with or have ongoing or persistent radicular symptoms?

A. In that, but if -- limiting it to sprain-strains, I mean, technically, you know, a disk is soft. But if we're talking about sprain-strain injuries, yes, I would agree with that.

Q. Okay. And you agree that sprain-strains typically resolve within 6 to 12 weeks.

A. Typically, yes.

Q. Doctor, you agree that after a failed course of conservative treatment, a diskectomy and fusion is a reasonable and appropriate treatment for internal disk disruption.

MR. JAFFE: Your Honor, this goes beyond the

scope of redirect.

THE COURT: I don't think it does. I'm going to allow it.

THE WITNESS: Okay. Could you repeat the question.

BY MR. CLOWARD:

Q. Sure. After a failed course of physical therapy or chiropractic, you agree that a fusion is a reasonable and appropriate treatment for internal disk disruption.

MR. JAFFE: Your Honor, now I object because counsel -- you know, I don't want to argue.

THE COURT: Come on up for a minute.

MR. CLOWARD: Judge, I'll just withdraw.

THE COURT: Okay.

MR. CLOWARD: Just trying to get the doctor back to his practice.

BY MR. CLOWARD:

Q. Doctor, earlier you talked about degeneration and that a majority of people around 50 have degeneration, correct?

A. Yes.

Q. Do the majority of people require fusions?

A. No.

Q. So, Doctor, absent the motor vehicle

accident, can you state to a reasonable degree of medical probability that Ms. Seastrand would have required the fusion?

A. I believe she would have, yes.

Q. Do you believe that she did have internal disk disruption at the levels in the lumbar spine?

A. Yeah. I mean, that was shown on the -- on the imaging and I think the diskography.

Q. Doctor, have you calculated a more probable cause of the internal disk disruption than the automobile crash?

A. I mean, the evidence suggests that it was present beforehand. And if -- there's a history of chronic neck, low back pain, pain into the extremities. It lasted several years. Disk pain is the most common cause of spine pain. So yes, in my opinion, that -- based on the information I have, it's most probable that that was -- she had preexisting disk degeneration.

Q. A history that you really are not very familiar with.

A. Well, again, based on the history that I do have.

Q. Thank you, Doctor.

MR. CLOWARD: No further questions.

FURTHER REDIRECT EXAMINATION

BY MR. JAFFE:

Q. Doctor, do you have the records from Surgery Center of Southern Nevada? I want to direct your attention to December 9, 2010.

A. Yes, I do.

Q. Do you have a document entitled "Pain Management Preoperative Record"?

A. Yes, I do.

Q. Now, was that the day she went for the caudal injection in the low back?

A. Was it 12/9/09, the date of the --

Q. 12/9.

A. Yes, I have it for that date.

Q. Is it common to take pain levels before the injection and after the injection?

A. Yes, that's --

Q. What was the recorded pain level before the injection?

A. Five.

Q. What was the reported pain level after the injection? Look at the post-op record.

A. I believe it was 5.

Q. Post-op?

A. Post-op? Oh.

Q. Preop was 5.
A. Is that on a couple of pages down or --
Q. It should be. Probably be about four pages down.
A. Discharge pain level 0 out of 10.
Q. So she actually reported the 5 before she had the injection, correct?
A. Correct.
Q. How long do those injections last?
A. Everyone's different.
Q. Could be a couple of days?
A. Could be -- could be from no relief to permanent relief to minutes to hours to weeks to months. It really depends on the etiology of the -- of -- one, if the pain -- if the pain is being caused by what you're treating, if it's an inflammatory etiology versus, you know, physical, like bony anatomic changes that if -- that once the anesthetic wears off, all the steroid in the world's not going to relieve the pressure on the nerve. So yeah, it's so variable.
Q. So then when she came back six days later to Dr. Belsky and reported her pain at 5 out of 10, was she back to the preinjection baseline?
A. Yes.
Q. Is that a common result for people who have

had injections like this?

A. Yes.

MR. JAFFE: I have nothing further, Your Honor. Thank you.

THE COURT: Mr. Cloward.

FURTHER RECROSS-EXAMINATION

BY MR. CLOWARD:

Q. Doctor, does neck and back pain wax and wane?

A. Yes.

Q. In fact, people can have a pain level on one day and a pain level could increase the next, correct?

A. Correct.

Q. They can have pain on one day and the pain level can decrease, correct?

A. Correct.

Q. Things that can decrease pain are medications, such as narcotic medications, correct?

A. Yes.

Q. Are you aware of whether Ms. Seastrand was on any narcotic medications at the time she reported those?

A. That would take me a few minutes to determine. Unless you can represent whether or not she was or not.

Q. I prefer to just have your testimony, Doctor.
A. Okay. What was the date of that injection again?
MR. JAFFE: 12/9/10.
THE WITNESS: Thank you.
MR. JAFFE: 12/9/09. I'm sorry. Or was it 12/10/09? Now I'm confused. It was 12/9/09.
THE WITNESS: Yes, she was.
BY MR. CLOWARD:
Q. And that would affect the pain levels?
A. It could have, yes.
MR. CLOWARD: Thank you, Doctor.
Oh, one final -- I'm sorry. One final question.
BY MR. CLOWARD:
Q. Are you aware of whether Ms. Seastrand was on pain medications prior to the automobile crash for either neck or back pain?
A. I don't believe she was.
MR. CLOWARD: Thank you.
THE COURT: Mr. Jaffe?

FURTHER REDIRECT EXAMINATION

BY MR. JAFFE:
Q. Was the pain medication she was on low-level

dosages? Or mild pain medications?
A. It looked like it was Lortab which is sort of, I guess, midlevel.
MR. JAFFE: Okay. Nothing further, Your Honor.
MR. CLOWARD: One last, I promise.

FURTHER RECROSS-EXAMINATION

BY MR. CLOWARD:
Q. If I wanted Lortab, could I go down to Walgreens and buy some?
MR. JAFFE: Your Honor, objection.
THE WITNESS: If you had a prescription. It's not over the counter.
THE COURT: Overruled.
BY MR. CLOWARD:
Q. So a doctor actually has to prescribe that.
A. Yes.
Q. It's in fact a narcotic.
A. Yes, it is.
Q. It's controlled by the department of -- the DEA, right?
A. Yes, it is controlled.
MR. CLOWARD: Thank you, Doctor.
MR. JAFFE: If I stand up and ask one more

question just to get last word, will you hold it against me?

THE WITNESS: Nope.

MR. JAFFE: Nothing further.

THE COURT: Ladies and gentlemen, does anybody have any questions for this guy? We have at least one.

(Whereupon a brief discussion was held at the bench.)

THE COURT: All right. Doctor, a few questions. First page I got two questions.

First one: Did you examine the cervical spine X rays taken on 27 October 2008?

THE WITNESS: No. I just looked at the report. I did not actually have the films.

THE COURT: Okay. Second question: Regarding the injections for pain, were the injections done in December of '09 or 2010?

THE WITNESS: She had the caudal epidural in December of 2009.

THE COURT: Okay. Mark that the Court's next in order.

Last question: Since Dr. Siegler agrees with Dr. Smith that Ms. Seastrand's injury was due to prior injuries, do you agree with Dr. Smith's testimony that

vertebral bodies without exception will fracture with disk rupture?

THE WITNESS: No. I mean, hardly anything is -- is without exception. It's very common for -- for when a disk is -- is ruptured for it to actually pierce the bottom or top of -- of the -- again, you got these columns and the disk in between and the disk can actually -- the bottom and top of the disk are actually -- of the bone is pretty weak, and it can pierce there, and that's common. But it's not universal. A disk can be disrupted front, back, to the side. So no, I would not agree with that, that it's without exception.

THE COURT: Okay. Mark that Court's next in order.

Mr. Jaffe, any follow-ups?

MR. JAFFE: Yes.

FURTHER REDIRECT EXAMINATION

BY MR. JAFFE:

Q. With respect to the fracturing issue, if the fracture -- if the disk rupture occurs in a car accident, from the trauma of a car accident, is the fracture of the bone then effected or more common?

A. I -- I wouldn't -- I am not aware of that

being the case.

Q. Okay. You -- obviously you are not a biomechanical expert, sir?

A. Correct.

Q. Would you leave those sorts of issues as relates to the biomechanics of an accident and the forces related to disk ruptures in the bone to a biomechanic?

A. I mean, certainly, that would be one expert I would -- I mean, ultimately, it would be an anatomic study to look at a control group of disk injuries in nonautomotive accidents versus automotive accidents to determine. I actually would be curious to see if that was the case. But yeah, I would -- but I would certainly consider a biomechanic expert's opinion on that to be very relevant.

Q. And if the biomechanic also happens to be a medical doctor with board certification credentials, would that --

MR. CLOWARD: Objection. I'm just going to object to form, leading.

MR. JAFFE: I'm not --

THE WITNESS: I would certainly weigh it heavily.

THE COURT: Hold on. I'm going to sustain

the objection just because the question wasn't completed before he started the answer, so ...

THE WITNESS: Sorry.

MR. JAFFE: Thank you.

BY MR. JAFFE:

Q. Would your -- would the value of the biomechanic -- biomechanical expert's opinion be increased if I was to tell you that he also has board-certification credentials as a medical doctor in several fields including radiology?

A. Yes.

MR. JAFFE: Thank you.

FURTHER RECROSS-EXAMINATION

BY MR. CLOWARD:

Q. Doctor, you -- actually, you never reviewed any of the films in this case, correct?

A. Correct. I did not have access to them.

Q. Before or after, correct?

A. Correct.

Q. Okay. And, Doctor, you review MRIs all the time, right?

A. Yes.

Q. And you treat patients that have been in automobile crashes all the time, right?

A. Yes.
Q. And without exception -- just more likely than not, without exception, are there fractures every single time when there's a disk disruption?
A. No. Most often, there's not fractures with -- when there's a disk disruption.
MR. CLOWARD: Thank you.
THE COURT: Mr. Jaffe.

FURTHER REDIRECT EXAMINATION

BY MR. JAFFE:

Q. But if a biomechanic testified regarding car accidents causing disk ruptures, including bony involvement which may include fractures, would you exclude that?
A. I'm not sure what you're asking me.
Q. In other words, if a car -- if a biomechanic who's board certified in radiology and in other medical fields, has a medical degree, testified that car accidents causing disk herniations are traumatic to the point of including bony involvement, possibly including fractures or other disruptions from the disk and the bone, would that be consistent? Or would you leave that to the expert, that other expert?
A. Potentially. I mean, what is -- I would

have -- what does bony involvement mean? I mean, that could mean anything, so yeah, it could be consistent.

Q. And you weren't here for Dr. Smith's testimony to hear exactly what he said, correct?

A. Correct.

THE COURT: Anything else?

MR. CLOWARD: No.

THE COURT: Do I have any other questions over there? All right.

Thank you, Doctor.

THE WITNESS: Thank you.

THE COURT: You're excused. We appreciate your time.

THE WITNESS: Thank you.

THE COURT: Folks, let's take a quick break.

During our break, you're instructed not to talk with each other or with anyone else, about any subject or issue connected with this trial. You are not to read, watch, or listen to any report of or commentary on the trial by any person connected with this case or by any medium of information, including, without limitation, newspapers, television, the Internet, or radio. You are not to conduct any research on your own, which means you cannot talk with others, Tweet others, text others, Google issues, or

conduct any other kind of book or computer research with regard to any issue, party, witness, or attorney, involved in this case. You're not to form or express any opinion on any subject connected with this trial until the case is finally submitted to you.

See you in about ten minutes.

THE BAILIFF: All rise.

(Whereupon jury exited the courtroom.)

THE COURT: Anything outside the presence, Counsel?

MR. JAFFE: Nothing, sir.

MR. CLOWARD: No, Judge.

THE COURT: Off the record.

(Whereupon a short recess was taken.)

THE COURT: All right. Let's bring the jury back.

THE BAILIFF: All rise.

(Whereupon jury entered the courtroom.)

THE COURT: Go ahead and be seated. Welcome back, folks. Back on the record, Case No. 636515.

Will the parties stipulate to the presence of the jury?

MR. JAFFE: Yes, sir.

MR. CLOWARD: Yes, Judge.

THE COURT: Mr. Jaffe, you may call your next

witness.

MR. JAFFE: Thank you, sir. At this time, defense calls Dr. Joseph Schifini.

THE COURT: Dr. Schifini, come on up, if you would, and come up next to the chair. You can drop off your stuff and raise your right hand. Remain standing.

THE WITNESS: Thank you.

THE CLERK: You do solemnly swear the testimony you're about to give in this action shall be the truth, the whole truth, and nothing but the truth, so help you God.

THE WITNESS: Yes.

THE CLERK: Please state your full name and spell it for the record, please.

THE WITNESS: It's Joseph Schifini, S-c-h-i-f-i-n-i.

DIRECT EXAMINATION

BY MR. JAFFE:

Q. Good morning, sir.

A. Good morning.

Q. Dr. Schifini, would you please tell us what you do for a living.

A. I'm a physician, specializing in pain management. I'm an anesthesiologist by training, and I

have branched off into doing pain management.

Q. Okay. And we actually heard from Dr. Siegler that pain management is a -- an area of subspecialty that actually crosses over between various medical practices?

A. Yes, that's correct.

Q. And while he's a physiatrist, you are an anesthesiologist by original training?

A. Yes.

Q. And is pain management an area that generally falls within anesthesiology as well?

A. Yes, it does.

Q. Sir, would you please give us the benefit of your educational credentials.

A. Sure. I grew up here in Las Vegas, went to high school here, received a scholarship, went to UNLV, graduated from UNLV with a major in biology and a minor in chemistry, was accepted to medical school at the University of Nevada School of Medicine in Reno, attended medical school there for four years and was accepted into an anesthesia residency which is a three-year program. But prior to going to the anesthesia residency, we had to attend an internship, so first year of residency.

So I did that here at UMC, in internal

medicine where we dealt with patients, you know, various different, you know, problems like high blood pressure, heart problems, things of that nature, which gave me some excellent background to go into anesthesiology at the University of California at Irvine. I attended the residency program there for three years, the last year serving as a chief resident. And spent approximately six months of that year focusing on pain management before returning to Las Vegas to start private practice.

Q. And, sir, for how long have you been in private practice in Las Vegas?

A. Since July 1st, 1997.

Q. What does your practice typically involve?

A. My practice involves taking care of patients who are injured in one way or another. I -- I spend a lot of my time dealing with industrial injury accidents, so people who get injured at work. That's probably 75 percent of the practice that I have. So they're usually involved in some sort of accidents whether it's a trip and fall or slip and fall or they lifted something heavy at work. They will be referred to me by a primary care physician who is taking care of them beforehand, and then I will typically see them if they don't get better with conservative care.

Q. Do you testify in court at times?
A. Yes, I do.
Q. Now, do you occasionally work for defense performing forensic reviews and evaluations?
A. I do, yes.
Q. Is that what you've done in this case?
A. It is.
Q. When you testify in court, more often than not, is it for plaintiffs or defendants, or is it split somehow?
A. It's probably one-third plaintiff and one -- two-thirds defense as far as courtroom testimony.
Q. Have you ever worked with Mr. Harris or his firm before?
A. As of last week, yes.
Q. Okay. Dr. Schifini, have you ever testified in a trial that I was involved in?
A. Yes.
Q. Was it for me or against me?
A. I guess it would be against you at that point.
Q. You were testifying for the plaintiff and I was defending the case?
A. Yes.
Q. Doctor --

MR. JAFFE: You know, Judge, at this time, I would like to offer Dr. Schifini as an expert in the field of anesthesia with a subspecialty in pain management.

MR. CLOWARD: Judge, I don't think we have an objection. I just wanted to approach again.

THE COURT: Come on up.

(Whereupon a brief discussion was held at the bench.)

MR. CLOWARD: No objection, Your Honor.

THE COURT: Dr. Schifini will be recognized as an expert in anesthesiology with a subspecialty in pain management.

BY MR. JAFFE:

Q. Now, Doctor, have I paid for you to be here today?

A. Yeah, you paid for my time away from my office.

Q. And how much are we paying you?

A. $5,000.

Q. And, sir, in this particular case, were you hired for a very limited purpose?

A. Initially, I was hired to review records that were provided to me, but specifically focusing on the area of pain management provided by a provider named

Dr. Marjorie Belsky.

Q. Okay. Now, sir, you're not a surgeon, right?

A. I am not, no.

Q. Do you leave surgical recommendations for surgeons?

A. Well, that's kind of a difficult question because I'm involved up to the point of actually operating on the patients. So I assist the surgeons oftentimes in working up the patients to the point where the surgeon and I agree that the patient needs surgery. The type of surgery is oftentimes left up to the surgeon obviously.

Q. Okay. We're going to leave surgery alone for the purposes of your testimony today since that has nothing do with why you were hired. Okay, sir?

A. Okay.

Q. And after you wrote -- and you've written a few reports in this case; isn't that correct?

A. That would be accurate, yes.

Q. How many have you written?

A. I want to say five.

Q. And after your initial report, did your role sort of expand a little bit after -- in rebuttal?

A. It did because of a rebuttal that was performed by two physicians that were involved in this

case as treating physicians that felt the need to comment on my initial report, so my role expanded because of their comments regarding my initial report.

Q. Since you were hired for a limited purpose at first, did my office provide you with all the records or the ones that were related to your role?

A. Initially I was missing records, and I outlined those in my -- in my report. But as my role expanded, I received the records that I was missing, yes.

Q. And depositions?

A. Yes.

Q. Okay. Sir, would you please give us a summary of your opinions that you have reached with respect to this case?

A. Sure. Ms. Seastrand was involved in a motor vehicle accident on March 13th, 2009, which was a rear-end motor vehicle accident. She likely suffered some injuries to the soft tissues or muscles and ligaments of her cervical spine and lumbar spine or neck and low back. Those types of injuries were made a little more complicated by the preexisting nature of the conditions that she's described to physicians following this accident, police officers following this accident, and chiropractors following this accident

that she had preexisting complaints of pain in these areas. So she likely had an exacerbation or a temporary worsening of her preexisting conditions which is sometimes hard to separate from the soft tissue type of injuries that she would have had following this accident.

But the type of injuries that it is my belief that she suffered following this accident are oftentimes limited in time. Sprain-strain type injuries typically resolve in weeks not years. So it is difficult for me to explain why she continues to have pain. The difficulties is in the time frame, but the difficulty in explaining it is also partly due to the physicians workup of her at the time she was injured. She received diagnostic testing in the form of MRI studies of her neck and low back which showed degenerative changes. There was nothing that was shown to be acute, meaning something that happened at the time of the accident.

There were also inconsistent reporting of results from injections that were performed on her. During the time of the performance of these injections, the reporting of these were not contained within the physician's note. The only place they were located were in the surgery center records and were not

available to any of the treating physicians. The decisions to pursue additional injections in the form of something called a diskogram, I'm not sure if that was discussed, but a test where you pressurize the disk which led to a procedure which is called plasma disk decompression which is a nonstandard procedure. The failure of that procedure led to another recommendation for surgery. So it's difficult for me to understand the progression beyond the initial sprain-strain injuries.

Q. Now, sir, you did not examine the plaintiff, correct?

A. No, I have not.

Q. Would the value of an examination be limited by the fact that she had two surgeries prior to having filed this lawsuit?

A. Yes. It would have been extremely difficult to re-create what an examination would have been like before the -- the surgeries of her neck and low back had been performed.

Q. Okay. And, sir, in your experience, have you encountered patients who have a preexisting degenerative disk condition but then suffer an independent sprain or strain?

A. Yes.

Q. Is that a common occurrence?
A. It is.
Q. Do you have any opinion as to whether that's what happened here?
A. Well, I do believe that that's what happened. It's hard to separate the two. She may have had a temporary worsening of a condition. She may have had only a sprain or a strain or she may have had combinations of those two. So there's probably three possibilities in my mind that are likely.
Q. Okay. Now, it sounds like the -- the problem that you're having in forming any of these conclusions is the workup that was done.
A. Yes.
Q. Can you be specific and tell us precisely what it was about the workup that made things more difficult?
A. Well, the physician performing the injections, kind of my counterpart, an anesthesiologist --
Q. Is that Dr. Belsky?
A. Yes, Dr. Belsky.
-- an anesthesiologist with a subspecialty in pain management performed multiple injections on Ms. Seastrand during the course of this case I'll call

it. Those injections were oftentimes performed at multiple sites at the same time, some of them including, you know, the different structures.

And when we're trying to design these injections, what you're -- what you're essentially attempting to do is answer a question. If you believe one structure in the spine, to be specific for this case, is causing the problem, you want to place local anesthetic or numbing medicine on that structure. If the pain is relieved when that structure is numb or anesthetized, you can then make the conclusion that that structure is the most likely source of a person's pain. When you anesthetize multiple structures all at the same time, the conclusions are difficult, if not impossible, to make.

It becomes even more impossible based on the lack of documentation of basic pain scores. Again, the reason why we're doing these is trying to figure out something and also to try to help the patient and treat them with some anti-inflammatory steroid medicine. But if you do not include pain scores, the typical 0 to 10 scale, 0 being no pain and 10 being, you know, the worst pain you can imagine, if somebody comes in with an 8 out of 10 and they say that's what -- what their pain is before the procedure, you're supposed to

measure that pain after the procedure so that you can determine the answer to your original question: Is this causing the pain? That information was not contained within Dr. Belsky's notes so, therefore, that information couldn't be transferred to any other physician who was involved in the care.

The additional factor that made the diagnosis of -- of Ms. Seastrand more difficult during the performance of these injections was the choices of medication for sedation. There were three different medications that were most commonly used. One is a medicine called Versed which is a medicine similar to Valium or alcohol. What it basically does is to calm a person down. If you're nervous about something, that medication calms you down. It would take extremely high doses to actually put someone to sleep. So it's probably the ideal medication to be used for what we call conscious sedation, meaning awake sedation.

There's a second medication that was used by Dr. Belsky which was a medicine called fentanyl. Fentanyl is an opiate-based medication. It's much like morphine or heroin-type medicines made from opium. It's a derivative of that, and it can cause pain relief regardless of the injection. If you just give somebody through an IV that particular medicine, you can induce

pain relief without even performing the injection. So even if she had measured the numbers, the numbers may not mean anything because that medication was given.

And then there was another medication called propofol which is a -- what we call a sedative hypnotic or general anesthetic agent which is oftentimes used to put people to sleep for general anesthesia purposes if you're having an appendectomy or something. That medication was also used which oftentimes decreases the level of consciousness and most of the time makes patients unconscious; therefore, making the determination following the procedure even that more -- much more difficult.

Q. Okay. Let's sort of break this down, and let's get into the actual dynamics of this treatment and the injury and Ms. Seastrand's spine --

A. Okay.

Q. -- so that we actually understand -- so we have a good understanding of what you're talking about and how it relates to this.

A. Okay.

Q. Now, let's talk first about injections. And is part of pain management diagnostic?

A. It is, yes.

Q. So, in other words, you're going to do some

procedures with a goal of trying to figure out what is the actual pain generator.

A. Yeah. You're trying to answer that question that I talked about. You have a question: Is this particular structure in the spine actually the cause of the pain? If so, the example I gave earlier was a patient that comes in with an 8 out of 10, their pain goes down to a 0 or a 1 out of 10, and you can say that structure, by getting it anesthetized, you sort of took it out of the -- the equation from it and said, How do you feel now? Boy, I feel great. You can then make the conclusion that that structure is actually the cause of the pain.

On the other hand, if your pain is at an 8 and it goes down to a 7 or it stays at an 8, you can make the conclusion that the structures that were anesthetized are not likely to be the cause of the pain, and you need to look further for something else that could be the cause of the pain.

Q. So in this particular case, it seems like we were looking at the disks, the cushions between the bones, and the facets, the joints that connect the vertebra.

Would that be fair to say?

A. It is. And -- and a lot of people will refer

that to -- or refer to that as a segment of the spine because those are the parts that move in the spine.

Q. Okay. So in this particular case, I believe you were critical of injections performed at the same time as relate to the facet and the disk?

A. And that it was -- and that they were performed at multiple sites targeting those -- those two different structures, yes.

Q. Okay. Let's talk about the specifics of Ms. Seastrand and your criticisms of the work done by Dr. Belsky.

A. Okay.

Q. Now, with respect to the diagnostics and the injections, I believe there was one injection referred to as a facet injection; is that correct?

A. That's correct, yes.

Q. What is a facet injection?

A. A facet joint -- I'll have to start there first. A facet joint are the joints on the sides of the spine that allow you to move in kind of awkward positions. Instead of having to move your spine as a unit so that you kind of look like a robot, the facet joints are the connections between the bones that allow the bones to move individually, allow you to twist and move. You have them throughout your spine. They're

the joints that are commonly referred to by chiropractors as the knuckles of the spine because they make the cracking noise when you move around.

You see people moving their neck or twisting their back and making their -- their neck or back move. Sometimes that's associated with pain. The pain is coming -- or, excuse me, that noise is coming from the actual facet joint itself. So they are located on the back of the spine and they're present from the neck all the way down to where the spine sort of connects with the tailbone. You have left side and right side.

Q. Okay. So then the type of pain if the facets were involved, would that be an axial pain or radicular pain or both?

A. It's usually described as an axial pain, meaning a pain that's limited to the spine, but oftentimes it can be what we call radicular in nature. But very rarely does it extend below the knee, meaning the pain can extend from the spine through the buttock and typically down the back of the leg to approximately the knee.

Q. Now, do the facet injections, are they targeted specifically toward determining if the facet is an actual pain generator?

A. That is the goal. By anesthetizing the

actual joint itself, you're trying to determine whether or not the facet joint is the source of the pain in the same fashion, measuring those pain scores that we talked about.

Q. Sir, have you -- are you familiar with the term "staged injections"?

A. Yes.

Q. What does staged injections -- what are staged injections and what are their diagnostic value?

A. Well, staged injections doesn't refer to an injection that's just fake and we're trying to do it like in the man on the moon type of a thing. What they refer to is an injection that you're not sure if the pain is coming from one source or another. So you kind of have a Plan A and a Plan B, and what you're trying to figure out is is Plan A the right answer to your question, or is Plan B the right answer to your question?

So a staged injection oftentimes involves a patient being at a surgery center for a longer time than they normally would be there. The reason why we do these injections typically at surgery centers is because an X ray machine is used so you can specifically identify the structures.

But let's say, for example -- and I don't

mean to refer to patients as numbers, but just as an example, patient would be No. 1 on -- on a schedule and No. 3 on the same schedule. And perhaps as the injection that was intended to be performed when they were Patient No. 1 would be an injection focusing on the facet joints. You would reassess the patient -- after their injection, they would go to a recovery room. You would reassess them, kind of measure their pain score. If their pain score had gone from an 8 to a 0, you've identified the pain structure. The patient doesn't need to come back for the second stage of that injection or the Plan B as Patient No. 3. What would happen is they would then have a diagnosis, and we would see if the steroid or the anti-inflammatory medication would help them.

If on the other hand, as Patient No. 1 and we did the injections focusing on the facet joints, their pain went from, let's say, an 8 to a 4, we would know that half of their pain was likely coming from the facet joints but that we're still trying to figure out where the other half was coming from, we would then bring them back to the procedure room at the surgery center and try to figure out if by performing the next injection, their pain went from a 4 to a 0, remained at a 4, that type of thing.

So essentially, you know a person has a 100 percent of their pain. You're trying to divide up the two possibilities, and you're trying to determine how much of a contribution one structure has as far as pain goes versus the other structure. So staged injection is the way to separate those out rather than to be done like was done in this particular case where they were all lumped together and it's very difficult to make conclusions. If you separate them out, you can make better conclusions that will make more sense.

Q. So in this particular case, there was a facet injection administered to the plaintiff?

A. Along with other injections.

Q. Right. But the facet injection is a purely diagnostic procedure.

A. It should be, yes.

Q. The other procedures that were done, what effect -- what were they and what was the effect with respect to trying to use the facet injection as a diagnostic tool?

A. They were a hindrance to that because if you're trying to diagnose a facet as a pain generator, you don't want to perform other injections associated with that. Because if you perform them together, you'll never be able to reach any conclusions regarding

your original target which would have been the facet injections.

Q. Well, let's cut to the chase of this. If you're actually using an injection to diagnose whether the facet is the pain generator, is that going to have an effect on future treatment recommendations such as a surgery?

A. It would. And in this case, it had significant recommendation -- or significant impact on the recommendations for even further procedures, not -- not even going as far as surgery. Because if you look at the nursing records, Ms. Seastrand's pain following a -- what we call a global block or a segmental block where you're blocking the disk, the nerves, and the facet joints, her pain only went from an 8 to a 7. So it almost disproves that the disks and/or the facet joints in those segments are actually causing the pain.

Q. What's left in the anatomic structure at that point?

A. The muscles, the ligaments.

Q. Would the injections the plaintiff received have any bearing or impact upon the pain generated by those muscles?

A. As a potential secondary effect. If the disks or the facets were involved in radiating pain to

the muscles, then yes. But they're not specific for the muscles themselves. They're not directly intended to place medication into the muscles to -- to treat them. So, secondarily, it may treat them, but not as a primary purpose.

Q. So the injections that the plaintiff had -- well, she had the facet injection. What was the other injection that went along with it?

A. The epidural injections.

Q. What is an epidural and what is its purpose?

A. An epidural injection is different than what most people imagine. The most common context is dealing with pregnant women. And when these were performed, Ms. Seastrand was not reportedly pregnant at the time. They were performed for a different purpose under X ray guidance, targeting the disks and the associated nerves in that particular area to anesthetize something, probably an inch and a half, 2 inches in front of the facet joints along with the facet joints.

The purpose of these injections is to anesthetize the nerves in the posterior or the back portion of the disk to isolate those structures to see if those are the likely sources of the pain as well. Those are oftentimes performed separately from the

facet injections, but when you perform them with the facet injections, you're isolating that entire segment of the spine.

Q. So it's sort of like bathing the whole area with the anesthetic?

A. It's a little more high-tech than that, but yes.

Q. Does it have that -- that effect?

A. It does, yes.

Q. And so because of that, does it eliminate the diagnostic value of the facet injections by infiltrating the facet?

A. The facet and the other structures, yes. It -- it ruins the diagnostic value as well as the other things that I spoke about earlier.

Q. So then given the lack of a response even to that, was that -- were you able to at least draw some conclusions relative to the injuries in this accident?

A. Well, the only conclusion that could be drawn was it wasn't likely that the facet or the disks and associated nerves were likely sources of the pain. But that information came from further digging into the nursing notes or records because of the -- that information was not available through Dr. Belsky's own records.

Q. Now, as a result of this, did Dr. Belsky eventually perform the diskogram?

A. She did, yes.

Q. Do you believe diskogram is a highly controversial procedure in the medical community?

A. A diskogram, depending on how it's performed, is considered by some a highly controversial procedure, especially when it's performed in the cervical spine. But there are some controversy that still remains regarding lumbar spine diskography.

Q. Is that even generally within our own medical community?

A. It is, yes.

Q. And Dr. Gross told me that the only one -- the only ones in our medical community who have problems with that are the people that I hire.

MR. CLOWARD: Objection. Leading.

MR. JAFFE: I'm just using it as a foundational statement, Your Honor.

THE WITNESS: I don't think that's --

MR. JAFFE: Hold on, Doctor.

THE COURT: Let him ask a question.

MR. JAFFE: Pardon me?

THE COURT: Go ahead and ask a question.

MR. JAFFE: Thank you.

IN THE SUPREME COURT OF THE STATE OF NEVADA

RAYMOND RIAD KHOURY, Appellant, vs. MARGARET SEASTRAND, Respondent.	Supreme Court Case No. 64702 Supreme Court Case No. 65907 Supreme Court Case No. 65172

APPEAL

from the Eighth Judicial District Court, Clark County

The HONORABLE JERRY WEISE, District Court Judge

District Court Case No. A-11-636515-C

APPELLANT'S APPENDIX

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Exhibit 39 July 24, 2013, Reporter's Transcript of Jury Trial, JA 2821-3028 (Day 8), pages 1-208