IN THE SUPREME COURT OF THE STATE OF NEVADA

EVANGELINA ORTEGA, AN INDIVIDUAL; AND MIRIAM PIZARRO-ORTEGA, AN INDIVIDUAL, Appellants, vs. CHRISTIAN CERVANTES-LOPEZ, AN INDIVIDUAL; AND MARIA AVARCA, AN INDIVIDUAL, Respondents.	Electronically Filed Feb 17 2016 01:48 p.m. CASE NO.: 68471 Tracie K. Lindeman Clerk of Supreme Court

APPELLANTS' APPENDIX TO OPENING BRIEF

VOLUME 7

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lower back starts hurting immediately. I cannot bear either -- I have to hug one of those big pillows in order to be more comfortable when I'm laying down and in order to sleep better. And I cannot, for instance, bear any kind of hugs or even when my husband tries to put his -- his leg, when we're laying down, put his leg on -- on top of me, I cannot bear that. And even when we -- our bodies are close to each other, I cannot stand that, either.

Q You worried about your future?

A A lot.

Q Okay. How so?

A Because if I have the pain right now when I'm not that old, what is going to happen when I become older?

Q Okay. And you want to have a family?

A Yes.

Q And at the time of the accident, you were trying to have a family?

A Yes.

Q Okay. Thank you for your time here.

A You're welcome.

THE COURT: Cross.

CROSS-EXAMINATION

BY MR. BAIRD:

Q When did you find out there was a difference between the nerve procedure that Dr. Lanzkowsky wants to do

and the injections you had received before?

A Well, because I thought that they were talking about injections that I had to get again. And actually, they were not helping. They -- they helped a little, but not as much.

Q 50 percent pain relief was not enough for you, are you saying?

A I'm sorry, I don't understand the question.

Q Let me ask this instead. Did -- did the doctors not take the time to explain to you the difference between the procedures they were offering you?

A I don't remember.

Q Now, you have testified before that your attorney prescribed Dr. Coppel for you; do you remember that testimony?

A Well, we -- I was sent to -- by Dr. Adair to see Dr. Coppel because I was having more pain. But we have to go to the attorney to explain to them what was happening and that was all.

Q So -- but your testimony was true and you believe your attorney had prescribed Dr. Coppel to you?

A I don't remember.

Q Okay.

MR. BAIRD: I'd like to publish her deposition.

THE COURT: Okay.

BY MR. BAIRD:

Q Now, you remember giving deposition testimony at my office, correct?

A Yes.

Q Okay. And you remember that you took an oath to tell the truth?

A Yes.

Q Okay. Okay. Let's look at page 22, line 17. And there I asked you, "So how did you find Dr. Coppel?"

And your answer was, on line 18, "Our lawyers prescribed."

Then I asked, "That was for both you and your husband, right?"

And your answer was, "Yes." Do you see that?

MR. SIMON: What page are we on?

MR. BAIRD: 22.

THE WITNESS: Yes, I can see it.

BY MR. BAIRD:

Q And you -- there was an interpreter at my office to translate my questions in Spanish and your answers from Spanish to English, correct?

A Yes.

Q Okay. Did you tell me the truth that day?

A Yes.

Q Okay. You've testified today that your pain is

unbearable?

A Yes.

MR. BAIRD: Sorry. Just one second here.

(Pause in proceedings.)

BY MR. BAIRD:

Q And when you first went to see Dr. Coppel, you also testified that your pain was unbearable, correct?

A Yes.

Q Okay. Let's go to I think it's Exhibit 18, page 8. Okay. This is a form that you filled out; is that your signature at the bottom?

A Yes.

Q Okay. And there's some pictures of some faces, says, "Choose the face that best describes how you feel." Which number did you circle?

A I mean, are you talking about that day or right now?

Q That day.

A 2.

Q Okay. And under the number 2, it says, "Can be ignored," correct?

A Yes.

Q Thank you. When I took your deposition in November of 2013, you testified it had been more than one month since you had taken any pills for your unbearable pain,

correct?

A Yes.

Q And after the deposition at my office, your attorneys sent you to Dr. Lanzkowsky, correct?

A Yes.

(Pause in proceedings.)

Q Okay. Okay. You saw we went through this with your husband, we showed him a verification that when signed, you sign it when you say these answers are true and correct; is that your signature on that page?

A Yes.

Q Okay. If we go to Question No. 23 in that document, just like your husband, we asked you to describe how your injuries affected your recreational activities. I'll ask the interpreter to interpret your answer.

(Interpreter reads document in Spanish.)

MR. BAIRD: Oh, no. Sorry. I forgot. You -- that looks different for you. Just the answer.

THE COURT INTERPRETER: Plaintiff reports?

MR. BAIRD: Yes.

(Interpreter reads document in Spanish.)

THE WITNESS: Yes.

BY MR. BAIRD:

Q Okay. Now, you agree that that does not mention anything about your dogs, or anything with you and your

husband or pillows, anything like that that you've discussed today with your attorney?

A Well, I don't remember about this, but what I said is what I feel now.

Q Okay. So at the time you filled this out, were your injuries only affecting your ability to remain seated or standing for long periods of time?

A Could you repeat the question, please?

Q Is it your testimony, then, that at the time you signed that this answer was true, the injuries you claim were only affecting your ability to sit or stand for long periods of time?

A Yes.

Q Did you know that you had a duty to supplement this answer as your circumstances changed prior to this trial?

A No, I don't remember.

Q When you -- your pain went away for a little while, when you were treating with Dr. Koka and Dr. Adair, and then you bent over to pick up some clothes, and your pain came back; so didn't it then go away again?

A Well, the thing is that the pain is there. It comes and goes. The pain is sometimes lower and some other days is stronger.

Q My question, though, is it wasn't just comes and goes. Wasn't it weeks, many days without pain even after you

picked up those clothes?

A Yes. I actually picked up the clothes and I felt, like, a pinch. But it was the same pain.

Q Okay. Let's look at I think it's Exhibit 16, page 48. Actually, let's -- not -- it's 16, let's start off, January 16th. So that is page 44 of Exhibit 16.

Okay. So underneath the top grid it says, in quotes, "Almost better." Notes --

MR. SIMON: Which page are you?

MR. BAIRD: Oh, 44.

MR. SIMON: Thank you.

BY MR. BAIRD:

Q It says, "Notes slight discomfort." I can't really read what that is. But then "No HA, no headache, no dizzy." You would agree this is from January 16th of 2012?

A I don't remember the date.

Q Well, if you look on the screen, does it say January 16, 2012?

A Yes.

Q Okay. So let's turn the page to 45. And it says, "No pain in last few days." Can you agree that was on January 18th of 2012?

A Yes.

Q Okay. So now we go to page 46. It says, "Better, no pain for one week." And do you agree that was on

January 24th of 2012?

A Yes.

Q Let me go to page 47. "Continues to experience decreased pain, no complaints. No difficulty or pain with ADLs," activities of daily living. And you agree that was on February 1, 2012?

A Yes.

Q Okay. Now we go to February 8th on page 48. Here it says, "My neck is better, my low back has been hurting since I picked up clothes on the floor, nothing heavy." And that was on February 8th, 2012; is that correct?

A Yes.

Q So is it your testimony that once you picked up those clothes, your back never started hurting again -- or never stopped hurting?

A Well, the thing is that the pain has never went away.

Q Well, let's turn to page 49. And there it says, "She states she had no pain at this time. She's not sure why her back hurt last week, but is pain-free now." Will you agree that's on February 14th?

A Yes.

Q Okay. Let's do one more. Page 50. "Patient states no pain since last visit." Do you agree that says February 20th, 2012?

A Yes.

MR. BAIRD: I have no further questions, thank you.

REDIRECT EXAMINATION

BY MR. SIMON:

Q All right. Exhibit 15, page 48, we talked about this a little bit. While you were still in the care of Dr. Adair, you told her your neck is better, and then your neck or your low back has been hurting since I picked up clothes off the floor, nothing heavy.

Okay. You also said they asked if you had difficulty performing activities, and you replied, "When I bend or lift, my low back hurts."

A Yes.

Q Okay. And then after this time you went to Dr. Coppel and reported pain to him, right?

A Yes.

Q And you discussed with Dr. Coppel treatment options?

A Yes.

Q Then Dr. Coppel looked at your MRI?

A Yes.

Q And because of the MRI and the pain at that time with Dr. Coppel, you later did an injection with Dr. Coppel?

MR. BAIRD: Objection. Foundation. I don't know if the -- she can testify as to diagnostic decisions made by Dr.

Coppel.

THE COURT: I'll let her testify if she knows.

BY MR. SIMON:

Q Did you -- did you have injections with Dr. Coppel?

A Yes.

Q And your pain comes and goes?

A Yes.

Q You have good days, you have bad days?

A Correct.

Q It's no fun being here today, right?

A No.

Q No fun sitting in a deposition being questioned, right?

A No.

Q And have you been truthful here today?

A Yes.

Q You've done the best you can?

A Exactly.

Q Okay. Thank you.

MR. BAIRD: One question.

THE COURT: Sure.

RECROSS-EXAMINATION

BY MR. BAIRD:

Q Were you completely honest with all of your

doctors?

A I didn't have any reason to lie.

Q Thank you.

THE COURT: Is she -- are you finished?

MR. SIMON: All finished, Judge.

THE COURT: All right. Thank you, ma'am, for your time. You're free to step down.

Do you have any other witnesses today?

MR. BAIRD: Should we take a short break?

THE COURT: Yeah, very short break. Because I'd like to finish them up today.

Ladies and gentlemen, why don't we just do a couple-minute break, like, 10 minutes.

Again, do not talk about this case, do not research this case, and do not form or express an opinion on this case.

(Jury recessed at 3:37 p.m.)

MR. BAIRD: I'd like to make a record that I don't think we have to make a record of anything this time.

THE COURT: Shocking.

MR. SIMON: Judge, we have depos to read in.

THE COURT: Okay.

MR. SIMON: We could --

THE COURT: Sure. Who's going to -- who gets to read?

MR. SIMON: I don't know about you, but my back's

killing me.

MR. BAIRD: Keep this high-energy party going.

THE COURT: My back's killing me, too.

(Court recessed at 3:37 p.m. until 3:56 p.m.)

(In the presence of the jury.)

THE COURT: Welcome back, Doctor. It's been a few days since you've been in court, so we're going to have to re-swear you, sir.

GOVIND KOKA, PLAINTIFF'S WITNESS, SWORN

THE COURT: And, ladies and gentlemen, you'll recall this is Dr. Koka, he's one of the plaintiff's witnesses.

MR. SIMON: May I proceed, Your Honor?

THE COURT: You may.

MR. SIMON: Thank you.

DIRECT EXAMINATION - (Continued)

BY MR. SIMON:

Q Dr. Koka, just to refresh the jury's recollection, what is your specialty?

A Family medicine, urgent care.

Q Urgent care. And you're the guy that owns a couple of urgent cares?

A Correct.

Q And you also are a primary doctor that sees some personal injury [indiscernible] cases, but the vast majority of your practice is general practice?

A Correct.
Q And you also were a medical director somewhere?
A I was a medical director of a chiropractic physical therapy clinic for -- from 2002-2008.
Q And you're very familiar, then, with the treatment protocol of chiropractic physical therapy?
A I am.
Q And, in fact, you oversee that on a lot of different cases?
A I do, for multiple things.
Q All right. Turning to the case of Maria Abarca, which I have your exhibits in front of you, Doctor, can you tell the jury when your office first saw her?
A That was November 22nd, 2011.
Q All right. And can you tell the jury what the pain complaints were when she presented to your office approximately 10 days after the accident? And there's a little number at the bottom, if you can tell us which number you'd be referring to when you get there.
A Okay. Okay. It looks like she was complaining about pain in her right shoulder, abdominal pain, low-back pain, neck pain, and pain -- I don't know if it's -- I guess it would be the left abdominal area, maybe left hip area of pain.
Q Okay. Would those pain complaints as noted by

you or your facility -- did you diagnose an injury?

A Oh, yes. There were diagnoses made.

Q Okay. And what was the diagnosis on that day?

A Let's see. Cervical sprain/strain, cervical pain, lower abdominal pain, right shoulder pain, and all secondary to the MVA.

Q Okay. And there was low-back pain noted?

A It was noted in the physical exam, but I think there was some mistake made where they didn't mark down low-back pain, because it said in the chief complaint and it's talked about in the exam, but there's nothing said in the assessment. Let me look in the dictation, maybe she corrected herself there. No, there's no dictation in this one.

Q Okay. Can you provide an explanation; is there normally a dictation?

A Normally there's a dictation that's done on every initial patient. And, yeah, there normally is one, but just for whatever reason it wasn't done on this patient.

Q All right. But is it clear to you as the person in charge of this facility that there was a low-back injury on this first date?

A Yeah. Looking at the notes, yeah. Based on the complaints of the patient and the physical exam, yeah, there definitely is. It just was a mistake and not written on there.

Q All right. And in regard to the reason she came in to see your clinic, what -- what was the reason or the cause?

A The pains that she was having, she was referred to us by a chiropractor, and then she was asking her to help her out with the care of the patient.

Q Okay. And do you know what the cause of her pain complaints were when presenting to your clinic?

A An accident she suffered on 11/12/2011.

Q All right. And can you -- is it -- do you have an opinion to a reasonable degree of medical probability the cause of her neck, low-back, and right shoulder pain as presented to you on November 22nd?

A The accident she suffered on 11/12/2011.

Q Earlier today, Dr. Duke looked at this page of your records and suggested to the jury that there was no low-back injury on this day, because lumbar -- or a box wasn't checked.

MR. BAIRD: Objection. Misstates his testimony.

THE COURT: Overruled.

BY MR. SIMON:

Q Yeah. Go ahead.

A Yeah, it doesn't say -- it doesn't say low-back pain there, but that's a super bill. And on a super bill, you normally only have to put up to five diagnoses there. You can

put as many as you want, but you're only required to put five. There's only five boxes on a [indiscernible] form, which is the form that you generally fill out for billing.

Q All right. So just because something's not checked on this page, you just stated your opinion she had a low-back injury on this same date, even though this record, this one page, didn't reflect it?

A I do.

Q And you stand by that today?

A I do.

Q Can you tell us what your facility did for her on that day and what was expected of her as a patient?

A She was told to continue with her therapy for 12 to 15 weeks, told to come back and see us in approximately two weeks. She was prescribed two medications, one was an antiinflammatory of Naprosyn, it's an antiinflammatory pain pill, and the second was a muscle relaxant called Zanaflex, to help with the spasms of the muscles. Ad that was it until we -- we'd see her back in approximately two weeks.

Q All right. And did you see her back?

A She came back to the clinic on December 6th, approximately that, 2011.

Q All right. And did she continue -- did she continue to complain of pain?

A She did.

Q All right. And -- in what body parts?

A At this moment -- and the way we ask the question is we ask the patient, How are you feeling today, or at this moment? And at that moment she said that she had continued neck pain, but it was improving; she had areas of pain in her back, but there was a mistake on the records there, kind of looks like she says resolved, but she's still saying there's pain in her back. She has pain in her abdominal area, as well as in her right shoulder.

Q And then what was expected of her at that visit?

A At that point she was told to continue her medications, continue her therapy, and come back and see us in approximately two weeks.

Q And is this the type of patient that seems to be truthful in the records?

A I don't -- I don't see any reason for -- to not believe what she's saying. You know, I just -- I never met her, never talked to her, but the records don't show, like, she's exaggerating anything or anything like that, that I could see. And the pain drawing she did initially on her first visit with us, it doesn't show the kind of markers you see with patients who are overstating their pain. Because it's a totally regular, appropriate sort of pain drawing.

Q All right. And when was the next time you saw her?

A Next time she came in was on December 27th, 2011.

Q And what was going on then?

A She's still complaining of issues with her neck, her low back, and her abdomen area. The pain over the anterior portion of her shoulder -- I'm sorry, her -- of her waist area, sorry, some of that part, which is the front of her belly area, had improved. She said she was improving overall and has was told to continue with her therapy at this point in time.

Q All right. So looking at the pain diagram, I see there's some circles that are around some body parts?

A The way the question's asked, because the top one is what the patient -- we ask them how they're feeling at that moment, we circle the areas that are hurting or causing them problems or whatever the issue might be. Because this -- this whole chart should be filled out except for the name and the signature -- well, definitely the signature in the -- the provider's handwriting. And so they mark on there, and so she's saying that she has issues with her neck and her low back, as well as her -- some parts of her abdomen in the front.

Q Can you reconcile, then, for me where it says low-back pain, and it's -- the box is checked resolved.

A Yeah. At that moment she's saying that she

doesn't feel any pain in her low back. But she is telling them that she's having some issues with her low back as to how bad it's affecting her, it may not be at that moment, but she is saying that it's still bothering her.

Q Okay. So just because that box is checked doesn't mean she still has some ongoing symptomology related to this accident?

A All it means is that at the moment the question was asked, because the way we're told -- at least the way I instruct my PAs and doctors that work for us to ask the question as, How are you feeling at this moment? Not, How are you feeling two weeks ago, couple of days ago, or after therapy, before therapy. Because we see them at all random different times. And so it just kind of depends. So you just kind of ask them. All you can do is really ask them how they feel at that moment.

Q All right. And when was the next time that your clinic saw her?

A Last time we saw her was approximately four weeks later on January 24th, 2012.

Q All right. And what was going on there? And I'll just put up in a note.

A On the pain drawing, she has continued pain in her neck and extending into her right shoulder, her low back, as well as some in her abdomen. It states that her therapy is

going to one times a week, and she is denying any new onset pain.

Q All right. And we're looking again at that low-back pain box that's checked. Is that a box that's checked by her or you or?

A That would be Diana Rodriguez, the PA.

Q Okay. Tell us who Diana Rodriguez and what a PA is?

A A physician assistant is a -- a new thing that came maybe about -- when I say new, maybe about 20 years ago, 15 years ago. It's a degree granted to help out with the numbers of patients, not being enough doctors. So it's a mid-level degree. Usually it's either a bachelor's degree or sometimes it's a two-year master's, or three-year master's degree. And they -- they don't go through residency or anything like that. But they're able to come straight out of school and see patients. So instead of two years of book learning, two years of hospital learning, and then residency, they just do usually one year of classroom, one year of hospital, and then they go and they start practicing.

Q Okay. They don't have the full qualifications you do?

A No, they have to work underneath a medical doctor's license in the state of Nevada. I think most states, as well, but definitely Nevada.

Q All right. And was this particular PA that was treating Ms. Abarca at the time a experienced physician assistant?

A I think she was one year out.

Q Okay. And how long had she been with your practice, if you remember?

A She only lasted with us about six months. So sometime between then.

Q When is the last time you saw her? Not -- not the PA, the --

A Oh, the patient?

Q The patient.

A I've never seen the patient myself.

Q No, I mean, the last time your clinic saw her.

A Oh, I'm sorry. Sorry. That was February 14th, 2012.

Q All right. On February 14th, can you -- what -- what's the number at the bottom?

A 00014.

Q Okay. And on that day, at the time that she was released, which was February 14th, 2012, did she have any ongoing problems at that time?

A What was circled in the pain drawing as complained by the patient was the right shoulder, the neck, and the low back area.

Q Okay. And then is that when -- is that when she was discharged from your care?

A Correct.

Q When she was discharged from your care, does that mean that she was better because you released her?

A Well, it usually means two things. Either -- most likely there's nothing more we could do for the patient, or they're going on to other care of some kind, or we just can't, you know -- because if they're either seeing other doctors or if they're going back and they don't need us anymore, if we can't provide anything for the patient, it's kind of a waste of the patient's time to come to us.

Q All right. And so when you released Ms. Abarca in this case, what was the reason?

A Looks like there was nothing more we could do for her. We sent her back to Dr. Adair. She had some improvements, but, you know, she was till suffering from some things in terms of the shoulder pain, the neck pain, and the low back, according to the picture.

Q All right. At the bottom it says this note, "Discharged from clinic without residual pain in CSLS right shoulder." Do you see that? Oh, I'm sorry, at the bottom? Oh, there it is.

A Yes, I do.

Q Okay. Does that mean that she was -- didn't

have any ongoing injury?

A Well, that means today she didn't have any pain. And so the way we do it if she hasn't had any pain and there's nothing more we're really doing for the patient, because she's not taking medications. And a lot of patients don't want to take them, and that's fine, because there's side effects with them and there's -- you know, there's a lot of limitations to taking them, you can't drive or you can't do certain things with certain medications. So there was too much we were doing and so she was done seeing us and necessarily getting any benefits of coming to us.

Q All right. And so looking above where it says "other," it says that the patient only complains of mid-back pain while lifting, correct?

A Correct.

Q Would that be consistent with the pain diagram that's right next to it?

A You know, there's no real mid-back that's there, maybe you want to call it the top or the low back or the -- or the bottom or the mid-back area. But not necessarily. It just --

Q Does that say mid back or mild?

A It says mild.

Q Okay.

A I think. I mean, M -- it looks like -- it would

be -- it could either be mud or mild.

Q Okay. It's mild.

A I'm pretty sure it's not --

Q Pretty sure it's not mud?

A That wouldn't make sense. But. I overall am not very happy with the way these notes look, to be honest.

Q What's that? I'm sorry.

A I'm not very happy with the way these notes look, to be honest.

Q Okay.

A They're just...

Q And why not?

A There are just so many inconsistencies in there. They just weren't done very well.

Q All right. I'd like to turn you to Christian Cervantes' treatment.

A Which number is that?

Q And that is going to be Exhibit 6. Are you with me?

A Yep.

Q All right. Tell me about the first time that you saw Mr. Cervantes.

And just before we get going, I'm going to put up page 3, which is your super bill. In regard to Mr. Cervantes, the low back is clearly checked there on a couple of times,

right?

A It is.

Q And -- and on -- under "diagnosis" over to the right, it says, "Secondary to motor vehicle accident"?

A Correct.

Q Okay. What does that mean?

A That's what we do, basically, to -- it's an e-code or an environmental code that -- that's just kind of designating to -- that the billing companies kind of have or the administration has, the CPT codes, to allow you to kind of tell what the injury is from. That's what the "e" stands for, environmental.

Q All right. And then looking at page 4, I see with Christian a dictated note was actually done in this case, in his treatment --

A Yes, it was.

Q -- right?

A It was.

Q And that's what your clinic would expect and you would as the supervising physician?

A I would.

Q Okay. So in regard to this, a history was obtained from Mr. Lopez?

A It was, yes.

Q And what was -- what was advised of the -- the

nature of the illness?

A Let's see, he was diagnosed at that time with a lumbar sprain/strain and lumbar pain. Told to continue therapy for six to eight weeks, and then follow back up in two weeks, take some over-the-counter Motrin, and -- and that was it at this point.

Q And did he do what you said, to the best of your knowledge?

A I don't know about the over-the-counter Motrin, but he did return back in approximately two weeks.

Q All right. And then what was still ongoing at that time?

A At this point patient still had continued low-back pain, which had not improved. Patient was told to continue with the medications, continue the therapy, and return back in two weeks.

Q All right. And were there any pain levels noted for the low back?

A Not at this visit that I see.

Q Okay. And then what -- when was the next time you saw him?

A Next time was December 27th, 2011.

Q And what was his pain complaints or ongoing problems at that time?

A Neck pain which they say was improving,

continued low-back pain, and they did give pain numbers this time, a 2 out of 10 for the neck and 4 out of 10 for the low back.

Q What about the next visit?

A It was January 24th, 2012.

Q Okay. And what was -- was he cured at that time or -- or not?

A No, the pain drawing still has pain going to into the neck and into the low back.

Q And then what was recommended for him at that time?

A Just to continue his therapy and return back in -- looks like two weeks.

Q Okay. And when is the next time you saw him?

A February 14th, 2012.

Q And what was he complaining of?

A Still, according to the pain drawing, neck pain, low back, yeah, those are the two main complaints.

Q And during this time he's getting chiropractic treatments with Dr. Adair?

A Correct.

Q Right? And that's what you expected from him?

A Correct.

Q And he was just following your orders?

A Right. Just to continue with the therapy that

Dr. Adair was providing.

Q All right. When's the next time you saw him?

A February 28th, 2012.

Q All right. So you released Maria Abarca on the 14th?

A Correct.

Q So he continued to see you after the time that she was released?

A Correct.

Q Okay. So what was his complaints on that day?

A At that point he had continued low-back pain and that was it at today's visit.

Q All right. And then what did you recommend?

A At that point he was seeing pain management with Dr. Coppel, patient was told to follow up with Dr. Coppel and continue the therapy as prescribed and come back in four weeks.

Q All right. And did you see him again?

A Yes. Patient returned back on March 20th, 2012.

Q And then what was he complaining of, if anything?

A Neck and low back today.

Q And what did you do for him?

A At that point just told the patient to continue the therapy, follow up Dr. Coppel, and said -- note here says,

"Possibly discharged in one week."

Q All right. And then why would you discharge him if he had ongoing problems?

A There's nothing more we can do in terms of medication. He didn't want to take any medications, so we're not doing that. He's already seeing a pain management doctor, so we're a bit redundant at this point here.

Q Okay. And then when -- when was he eventually discharged?

A The last time he came in was a week later on March 27th, 2012.

Q All right. And did he have ongoing problems?

A According to the pain diagram, yes, in the low back.

Q And your discharge clinic note says, "Discharged from clinic with residual LS pain"; what does that mean?

A Lumbar spine, low back.

Q And then so after that point you didn't see him again?

A He's not returned back to our clinic, correct.

Q Okay. And, Doctor, in your opinion, to a reasonable degree of medical probability, is the diagnosis and treatment by your facility caused by the motor vehicle accident in November of 2011?

A Yeah. Based on the notes and the history that I

have, yes.

Q Okay. Is there anything been shown to you that it's not related to that accident?

A Not that I've reviewed.

Q Are you aware of any prior accidents, injuries, symptoms, or complaints of Christian Cervantes to his low back before he started treatment with you or before the accident?

A No, I'm not.

Q And just to clarify, Doctor, last time you were here, we went over a few different billing records.

A Okay. Yes.

Q And we obtained your opinion about the billing records. And just to refresh the jury's recollection and mine, my recollection, and tell me if I'm wrong, it was your bills and records for both Christian Cervantes and Maria Abarca, the MRI billings for both Maria and Christian, and then Dr. Coppel's bills for both Maria and Christian; I believe that's what we covered last time?

A I -- I remember the bills for [indiscernible] and for Dr. Coppel. I remember seeing one of the MRI bills. I don't remember looking at the second one. I'm not sure which one to say, yeah, it was. But if it's the same price, 1550, it would be appropriate. But I don't remember which one I said was appropriate or not.

Q All right. And so those bills that we did

review were reasonable and necessary and customary in your opinion?

A Ones I looked at, yes.

Q All right.

MR. SIMON: I'll pass the witness.

CROSS-EXAMINATION

BY MR. BAIRD:

Q Okay. Doctor, did you own the clinic where both Maria and Christian went for chiropractic care?

A No.

Q Okay. So you share an office or a building, but didn't you -- but you don't own that clinic?

A I do not own that clinic, no.

Q Okay. You've testified in trial and personal injury cases only on behalf of someone claiming injury in a personal injury case, correct?

A Does -- is that --

Q Let me ask it this way. You've never testified on behalf of someone who's being sued in a personal injury case?

A Personal injury on medical malpractice, yes.

Q Personal injury, like a car accident, not malpractice?

A Right. No.

Q Okay. You did not personally perform the care

contained in the records you've been discussing today with counsel?

A Correct.

Q Okay. So what you've done with respect to, I think, one visit each, I could be wrong, but what you've done today is you've read the records of a Diane Rodriguez mostly, right?

A I've only read her records. I've not seen her -- these patients at all.

Q And you did not consult with her before testifying today to find out what she meant in any of the instances where you've interpreted her records, fair statement?

A Correct. I've not seen her since she left my company.

Q Okay. You haven't produced at any time any policies or special definitions that your office uses for common medical terms, correct?

A No, I never have.

Q And you don't have an independent recollection of the plaintiffs because you didn't treat them?

A Correct.

Q You agree that just because a car accident happens, that doesn't mean someone was injured, correct?

A Correct.

Q And you've testified before, you're not aware of any scientific studies that endorse relying on a patient's verbal history as a basis for determining causation, correct?

A I don't know if I've said that, but I would agree with that.

Q Doctor, what is your definition of the term resolved?

A Resolved, e-d?

Q Yes.

A Yes. It means that it's finished or it's completed.

Q Okay. What about residual in -- in the context of medical care?

A You're left with something.

Q Okay. As you were testifying and there was a question about residual, I started to think about, like, when you drink milk and there's -- you try to get it all out, there's always a little bit left in the glass; is that a fair -- fair characterization of residual?

A That's some -- I mean, residual can be any amount. It doesn't have to be just a -- a little bit of stuff stuck to the surface of a glass, but it could be any amount.

Q Okay. And you would agree with the definition of resolved that indicates -- in the medical context, that it means an abnormality or a condition has been done; it's --

it's take care of, it's no longer symptomatic or it's no longer diagnosable; fair statement?

A I don't know if there's anything that says a timeline, like it's gone forever. But it's gone for that moment, yes. Because things do come back. Like when they say a person's in remission, I mean, using a different word, it means it's gone then, doesn't mean it can't come back.

Q Don't different words mean different things?

A Sure.

Q Okay. Your testimony is when you say that something is resolved, that doesn't mean it's done forever; that's your testimony today?

A It doesn't have to be done forever. I'm saying it's just -- at that point, the word that she wrote there -- again, how I use it when I'm seeing a patient may be different than what Diana did, or Ms. Rodriguez, did. But at the moment that I saw it there, it just looks like it's resolved. Because the way we're supposed to ask the questions is that how do you feel at that moment in terms of if you're talking about the pain drawings and stuff, if that's what you're replying about.

Q Okay. So in your opinion if a patient goes weeks without complaining of any pain to an area and doesn't identify any -- any limitations or residual effects from an injury, you would say it's resolved, but that doesn't mean

it's gone forever; that they still might treat for that injury, even though everything has stopped?

A Right. I mean, if you're talking about Ms. Abarca in particular? I mean, because it's a generalization, there's a lot of things that kind of go away and come back. But I -- I can't speak to everything. But in terms of her -- particularly about her pain, we can -- I can definitely answer questions about that in terms of your, you know, like the...

Q Okay. We will do that. Let's talk about -- well, let's go ahead and talk about Maria, then. So she...

Okay. So we've already talked about her first visit with your office on November 22nd, 2011, I'm in Exhibit --

A What -- what number is that, sir?

Q Pardon?

A What number?

Q I think it's 17. 16 or 17, some of my numbers are off a little.

A Okay. I'm there.

Q Exhibit 17, page 5, your testimony today has been that this chart, this diagram of pain, that documents an abdominal pain and a lumbar diagnosis, not a continuation of the same injury around the waistline; is that a fair characterization?

A That would be correct, yes. That's the way I would interpret these notes.

Q If we look -- oh. Did you know that when asked about her symptoms immediately after the accident in deposition, Ms. Abarca described it as waist pain?

A Okay.

Q Would you agree the waist is not typically considered to be the same thing as the lumbar spine?

A And the waist, if you want to call it, like, going all the way around the person, then that would kind of go over part of the lumbar spine, yes.

Q It would -- it would include it, but it's not just the lumbar spine; you agree with that?

A Right.

Q Okay. Now, as we've already covered, you don't know -- you don't have a crystal ball or something written down by Ms. Rodriguez to tell you whether or not she was identifying and a separate lumbar injury or just a waist injury at this point, correct?

A Not in these notes that I have here, no. Except for the only thing I can go by that is by saying that she had some bruising in her left lower area of her abdomen. So I would assume that that's corresponding to the waist injury there. But -- but beyond that, no.

Q Okay. So if we zoom in on this -- on the diagrams, is it your testimony that because she wrote -- is it this -- this 5 out of 10 line that goes to the left side?

A I can't see --

Q Oh, sorry, yeah. So right here -- you're saying because this line happens to end on the left side of the body, you're just saying that that's left-side abdominal pain, not waist all the -- all around?

A No. Because she wrote down here under "abdomen --

Q Oh, not on -- oh. Okay.

A -- "positive bruising, left lower quadrant."

Q Okay.

A Which is below that.

Q Okay. Let's pull that, then. Let's make sure we see what we're talking about.

A Right there.

Q Could you poke the screen again?

A Right -- oh, I didn't know mine works like that.

Q Oh. Right there.

A Right there. Sorry. I'm not good at that finger stuff.

Q Now --

A Can you see that? I'm sorry. I kind of scribbled over it.

Q It's the left lower quadrant. I see what you're saying. Okay. It also says, "Right chest bruising," correct?

A Yeah, it says, "right chest bruising from" --

Q Belt?

A Maybe -- it probably would be belt. B -- either that or beat.

Q Okay. Belt makes more sense, right?

A Right.

Q Okay. What positive lumbar findings were made on this visit?

A According to the notes here, it says, "Lumbar spine had decreased range of motion with pain with forward flexion." "Forward" -- yeah, "forward flexion."

Q Okay. Very good. And, Doctor, what I also want to know is, is there any reference to a loss of consciousness in this record?

A On this record, no, I don't see anything that says that.

Q And this record is missing the dictation that would have been Ms. -- I guess you just call it PA, a doctor still, right?

A No, Miss or Mister.

Q Okay. I think it was Diane, so, Miss, right?

A Yes. She -- I think she's married now. I don't know.

Q Okay. Ms. Rodriguez, we don't have her dictation that gives us her interpretations of these documents, correct?

A Right. The way the dictation's supposed to be done, it's supposed to be done right after the visit with the patient using this paperwork here as a guideline to kind of help her remember and then dictate something if more detail is needed on that.

Q Okay. When Maria left your care, your office's care, she left with no residual pain in her neck and shoulder, and only mild pain in her low back when she was lifting; is that true?

A Let's see. She wrote -- well, again, that's the part where the records, which I'm kind of worried about, it does say that she has pain in her low back, her right shoulder, and her neck. And then she writes down here that it's -- that the pain's only -- only complaints of mild back pain while lifting. So --

Q Oh, sorry.

A -- there's nothing made about --

MR. BAIRD: Page 14. I'm sorry.

THE WITNESS: I'm sorry?

BY MR. BAIRD:

Q I forgot to tell them what page we're on so the jury --

A Oh, okay.

Q -- could see --

A Oh, yeah. 0014.

Q Is it a reasonable assumption, doctor, that perhaps Ms. Rodriguez is circling areas that are not currently hurting, but areas that she has treated?

A That would be against anything I've ever taught her to do. But it's possible.

Q Does it make more sense --

A You'd have to ask her.

Q -- than her saying there's pain and there's no pain in the same document?

A It wouldn't make any sense to do it that way you said first. At least in my mind.

Q Okay.

A Again, you'd have to ask her.

Q Okay.

A But it would be against what I tell my PAs to do and doctors as I work with them.

Q Well, when Mr. Simon was asking you questions, he left it with under "other," where it says "subjectives," and there's all "resolved" checks. And a couple of lines down it says "other." And what was read was, "Patient only complains" -- CO, complains of mild or mud, you guys were talking about, "back pain while lifting." But then the next line, what does the next line say?

A It says, "One day last week, not on meds."

Q Okay. So when we read the whole sentence, it

doesn't say that she still has mild back pain on lifting, it says she had mild back pain one day last week; isn't that a more correct interpretation of what that sentence says?

A It could be, yeah.

Q And that's what the next line -- it says, "No pain anymore," match a little better if we interpret the words as they're written that way?

A Again, you're asking me to assume what she's saying. But yeah, I think -- I mean, it could be that way, as well, too, sure.

Q Okay.

A But the thing that worries me is that she has the discrepancy between writing "resolved" on one part and then having "pain" written in the pain diagram there.

Q Let's go down to the plan section of this document. And under "plan," this is where Ms. Rodriguez would recommend future care for any ongoing injuries. And what does she say?

A The discharge line? Oh, no. The plan -- oh, sorry. "Discharged today because no more pain."

Q In fact, when we deposed you, didn't you indicate that you didn't expect Ms. Abarca to have ongoing problems?

A I'd have to look at my deposition, but, you know, before I could say I said that.

Q When we deposed you, you had no plans to prescribe additional medication or perform any additional care for Maria, correct?

A You say me, you mean my office?

Q Your office, right.

A Correct. That's what it says on the paper, yes.

Q Okay. And you never told her we're done with you, never come back? Wouldn't your office have left the door open if symptoms return that she can come back?

A We always tell patients, at least that's what I tell patients when they resolved -- or when they resolve -- when they discharge from us.

Q And based on the way she left your office, you would have expected her to feel better today than she did at the beginning of her care with your office?

A I can't say that.

MR. BAIRD: I'd like to publish his deposition.

THE COURT: Sure.

BY MR. BAIRD:

Q Okay. So let's turn to page 30.

A 30? Okay.

Q Page 30, line 16. So I asked you, "based on the records you reviewed, would you surmise that Ms. Abarca's pain would be better today than it was right before she started treatment with your clinics?"

And your answer was? Go ahead and read it, yeah.

A "Assume something horrible happened, like RSD or those rare things, then I would say because it looked like towards the end -- towards the last visit compared to the first, she had improved a lot of her symptoms except for the back pain towards the end."

Q Okay. And we just looked at the last visit with your office; wouldn't you agree that the last record for your office, even her back pain is improved?

A I mean, there is the assumption there. You said the records you reviewed. Because I've reviewed other records since then.

Q Okay.

A I think at the time of my depo, I only had my visits or my own clinic's visits. And I think that is fair to say what I said in my depo, if I'd just looked at my own records.

Q Okay. Very good. Now let's talk about Christian for a while.

A Is it the same one?

Q Oh, you can just set that to the side. We'll talk about records. Looking through your records, which that is going to be Exhibit 5, 6, one of those.

A That's the -- it looks like a CT, starts with that --

Q Oh, no.
A -- the lumbar spine?
Q That's not it. Let's --
A No?
Q That's probably [indiscernible]. There we go. Okay. Let's flip through the notes from Ms. Rodriguez, I think -- well, see, one of these is [indiscernible]. Oh, no, I'm sorry.

Can you flip through here and tell me if there's any evidence that a disc injury was diagnosed in Mr. Cervantes?

A All I see in there are just the notation that an MRI was ordered, but I don't have the MRI report in there. So in that section of 6, I couldn't say that.

Q Okay. Do we see any diagnoses or even a reference to any significant shoulder pain?

A For Mr. Cervantes?
Q Uh-huh.
A No, I don't see anything indicating a shoulder injury for Mr. Cervantes.

Q Okay. And did you identify at any time any neurological symptoms?

A Not that I saw looking through these records --
Q Okay.
A -- just now, no. Aside from pain.
Q Okay. When you -- when we took your deposition,

you said that Mr. Cervantes first complained of low-back pain 10 days after the accident. Does that match your records?

A That would make sense. He had the complaint of low-back pain 10 days after the accident, yes. I don't know if it started then, but he -- he complained of it that day at least to us.

Q Now, Doctor, for -- for Christian, we do have the dictation. In this dictation, on page 4 of Exhibit 6, I think -- it's in the one in your hand.

A Okay.

Q Neurologically, he's within normal limits, correct?

A Correct.

Q Page 4. All right. And neurological signs are the sort of things you would look for if you were concerned that there was something impinging on or -- or affecting one of the nerves in the spine, fair statement?

A That would be definitely one of the things you look for.

Q And -- and it's negative in that -- in the dictation, the only time we get a real explanation from Ms. Rodriguez about her examination, correct?

A That I see here, yes, correct.

Q Okay. Thank you.

MR. BAIRD: No further questions.

MR. SIMON: Just a few.

REDIRECT EXAMINATION

BY MR. SIMON:

Q Doctor, you were asked when low-back complaints by Christian were first reported after the accident 10 days later?

A I thought he said shoulder. I mean, I made a mistake and you -- yeah, he did say low back, correct. Yeah. Yeah. I did say --

Q You think that's the first time he ever complained of low back after the accident to any medical provider?

A I doubt that. But all I was saying is that according to the records, because our first visit was 10 days after his accident, so he definitely complained about it on that day.

Q All right.

A Like I asked the question.

Q So -- so that's the first time you saw him, 10 days later?

A Correct.

Q All right. And it would surprise you that he -- if he would not have reported it earlier, right?

A Correct. To be absolutely sure, I would have looked at Dr. Adair's note to get a --

Q Because Dr. Adair referred him to you?
A Correct.
Q And you were asked whether he had a normal neurological exam at your visit?
A Correct.
Q Correct? All right. So I'm going to show you the initial evaluation by Dr. Adair three days after the accident, and under low-back pain --
MR. SIMON: Ms. Court Recorder?
THE COURT RECORDER: One moment.
BY MR. SIMON:
Q All right. In the low-back section. Okay. In the low-back section, it says he's experiencing low-back pain. Then it goes on to say the pain does radiate from the low back to the bilateral posterior thigh regions. He has tingling in the bilateral thigh regions. And he states that he's experiencing this pain daily. What would that mean to you, that finding made by Dr. Adair?
A That something is irritating a nerve. What is causing it, I don't know at this time.
Q Okay. And is that a neurological finding at that point?
A Pain, sensation changes are all neurological changes, or neurological science.
Q Okay. And so this entry by Dr. Adair

demonstrates neurological findings three days after the accident?

A Correct.

Q You also were asked whether or not Christian Cervantes was ever diagnosed with a disc injury in your records?

A Correct, I was.

Q Okay. And during the time that you treated him, you discharged him in March?

A I think March 20th.

Q All right.

A March 27th, sorry.

Q I'm going to show you the initial evaluation by Dr. Coppel in February, which is Exhibit -- Exhibit 8, page 22. And he has a diagnosis of lumbar facet syndrome and lumbar disc displacement. Can you tell the jury what that diagnosis means?

A Yeah. Lumbar facet syndrome is, the way I describe it to patients, you know, the bones of the low back, they stack up one by one, and there's a disc in between there. But on each bone there's a little wing on either side. So where a flat part of a bone touches another, that's a facet. And sometimes that gets irritated, because they smack into each other and they just have some swelling around it. Which usually doesn't show up on an MRI.

And the disc displacement is, I imagine a disc that's in between, it's kind of like a water balloon mixed with a stale jelly donut, where if you push on it, it's got to go somewhere, that little jelly in the middle. And usually it pushes backwards or slightly to the right or slightly to the left. And all it's saying there is it's been displaced somewhat. It's not being more specific than that, though.

Q All right. And so as far as whether or not there is some disc injury to Mr. Lopez in this case, would you agree with Dr. Coppel that there was more than just a myofacial strain?

A Yeah. I mean, without looking at the MRI, I'd say, yeah, that diagnosis right there says that there has to be something going on with the disc, because it's been displaced in the sense that the liquid-y jelly center is kind of pushing against it and tearing the skin on the outside, possibly, or deforming the skin.

Q All right. And this diagnosis was made while you were still treating Christian, accurate?

A I'm not sure of the date of that visit.

Q I'll just represent to you it was about a month before you discharged him.

A Yes, it was.

Q All right. And if this diagnosis was made by Dr. Coppel, who's someone you refer to --

A I do.
Q -- right? You trust his judgment?
A I do.
Q Is he an excellent doctor?
A Went to Johns Hopkins, he's a great doctor.
Q Okay. And so if he's rendering a disc diagnosis, would you agree with him that that is related to the motor vehicle accident several months earlier?
A I would.
Q And that opinion is to a reasonable degree of medical probability?
A It is.
Q Turning to Maria, you were shown a record about pain going around the waist and her describing it as waist pain. Is that something uncommon for someone who doesn't know medical terms?
A Well, I mean, you know, you usually think of waist pain if you're sitting -- in this kind of instance, if you're sitting in a car, it would be the lap that might hurt your waist, but it wouldn't radiate around to your low back. That would be something else. I've never seen that happen.
Q All right. Just want to show you that note real quick again, and then we'll be done. All right. There's these little lines that are going there, right?
A I do, yeah.

Q Is there -- what -- what's the meaning of the -- the lines? I see some definitions above.

A Yeah.

Q And you see on the screen where you have even definitions on your medical record?

A Let me go to this. That should be described as a stabbing-type pain, which are slash marks which go from the left to the right, rising.

Q Okay. So she had stabbing-type of pain in her low back?

A Correct.

Q In her lumbar region?

A Correct.

Q Which is where the L5-S1 is located in her spine?

A Correct.

Q Okay. And that's on the day that you saw her?

A That's on her initial visit, yes.

Q Initial visit. Doctor, what is waxing and waning?

A Comes and goes.

Q Okay. And are these type symptoms -- when someone has a disc injury, do those symptoms wax and wane?

A Oh, yeah. Mostly definitely they can.

Q Okay. And just because somebody is feeling good

one day and reporting no pain, does that mean the injury is forever cured if they have a disc injury?

A Well, I mean, usually when you have a disc injury -- this is usually -- again, I'm -- you know, just a global kind of thing, then you have musculoskeletal-type stuff, or muscles and tendons and things around it. So those can have -- wax and wane, as well, too. So you have two kind of things going on. So as one is improving, another one can still be there. And the disc, again, as it's sitting there in between the bones there, it may not be deformed that day. As you move it and stress it more, if there is a tear or can cause the little pulp to move more, the deformity to get worse, that could happen, as well. It just depends on what the patient's doing, their activity level, what they're trying to do, those kind of things.

Q Okay. And in this case, the -- the muscle ligament injuries and the disc injuries that you've identified in the records are related to this car accident?

A I do feel that's true.

Q All right. And that is stated to a reasonable degree of medical probability?

A It is.

Q Thank you, Doctor. Nothing else.

THE COURT: All right. Anything else?

RECROSS-EXAMINATION

BY MR. BAIRD:

Q Doctor, is it safe to say you, when your office was treating and when all these opinions on the diagnoses of Mr. Cervantes were made, you did not have access to all of the medical records in this case; fair statement?

A During the time of the visits? Yes.

Q Yes. And you -- and you personally have not had the opportunity to review the depositions of any of these medical providers or of the plaintiffs in this case, correct?

A I have not looked at those.

Q Nothing further. Thank you.

FURTHER REDIRECT EXAMINATION

BY MR. SIMON:

Q You've reviewed medical records in this case, though, right?

A Oh, I have reviewed the medical records. He said depositions.

Q Okay.

A Yeah.

Q But you've reviewed medical records?

A Medical records, yes.

Q Okay. And beyond your records?

A Correct.

Q Okay. And your opinions here today are informed opinions?

A They are.

Q Thank you, Doctor.

MR. SIMON: Nothing else, Your Honor.

THE COURT: All right. Thank you, Doctor, for your time. You're free to go.

Counsel, I think that we're going to call it a day. It's 10 till 5:00.

MR. BAIRD: Very good, Your Honor.

THE COURT: All right. Ladies and gentlemen of the jury, I think probably on Monday this is going to be submitted to you for deliberation. We'll see you back Monday at 1:00.

Until -- until we see you Monday, remember, you cannot discuss this case in any way, do not do any research, and do not form or express an opinion. See you on Monday.

(Jury recessed at 4:52 p.m.)

THE COURT: See you Monday. What time -- are you going to come a little bit early, try to get the jury instructions done?

MR. MICHALEK: Yeah. If we could -- we'll certainly be here at your convenience, Your Honor. So you want us to get here at 12:30 or 12:00?

THE COURT: I probably won't be out of court till close to 12:00. So could you give me till 12:30, please.

MR. MICHALEK: Sure. Just one foundational thing.

THE COURT: Uh-huh.

MR. MICHALEK: I -- remember we left off with Dr. Koka and you had asked for additional foundation regarding the UMC bills.

THE COURT: Uh-huh.

MR. MICHALEK: And just so we get it clear, I guess, counsel was withdrawing trying to get that through on Dr. Koka. He may try to do it some other way. But you had asked for additional foundation before the UMC bills would be admitted through Dr. Koka, and I think he's withdrawn that. But I just want to be clear, get that on the record.

MR. SIMON: The bills have been admitted. We just haven't --

MR. MICHALEK: The reasonableness -- the reasonableness.

MR. SIMON: The reasonableness is contested for the jury.

MR. MICHALEK: Agreed?

MR. BAIRD: Agree. Have a good weekend, Your Honor.

THE COURT: Have a wonderful weekend.

(Court recessed for the evening at 4:54 p.m.)

CERTIFICATION

I CERTIFY THAT THE FOREGOING IS A CORRECT TRANSCRIPT FROM THE AUDIO-VISUAL RECORDING OF THE PROCEEDINGS IN THE ABOVE-ENTITLED MATTER.

AFFIRMATION

I AFFIRM THAT THIS TRANSCRIPT DOES NOT CONTAIN THE SOCIAL SECURITY OR TAX IDENTIFICATION NUMBER OF ANY PERSON OR ENTITY.

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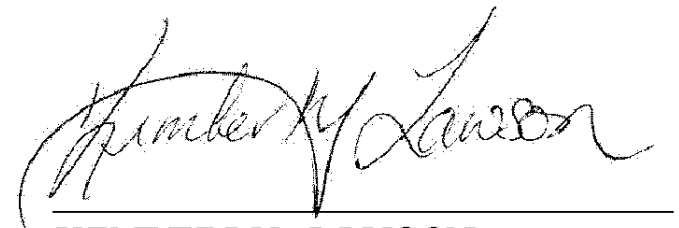

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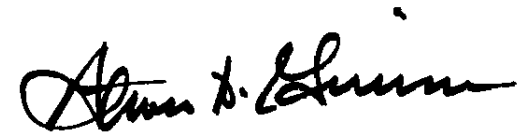

CLERK OF THE COURT

TRAN

DISTRICT COURT
CLARK COUNTY, NEVADA
* * * * *

CHRISTIAN CERVANTES-LOPEZ, Plaintiff, vs. EVANGELINA ORTEGA, Defendant.	)	CASE NO. A-12-667141 DEPT NO. XXIII **TRANSCRIPT OF PROCEEDINGS**

BEFORE THE HONORABLE STEFANY MILEY, DISTRICT COURT JUDGE

JURY TRIAL - DAY 6

MONDAY, MARCH 2, 2015

APPEARANCES:

For the Plaintiff: DANIEL S. SIMON, ESQ.
ASHLEY M. FERREL, ESQ.

For the Defendant: ROBERT KADE BAIRD, ESQ.
CHARLES A. MICHALEK, ESQ.

Also Present: Lorena Pike, Interpreter

RECORDED BY MARIA GARIBAY, COURT RECORDER
TRANSCRIBED BY: KARR Reporting, Inc.

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I N D E X

WITNESSES FOR THE PLAINTIFF:

LAS VEGAS, NEVADA, MONDAY, MARCH 2, 2015, 12:55 P.M.

* * * * *

(Outside the presence of the jury.)

THE COURT: Are you ready to go through the contested instructions?

MR. MICHALEK: Yes, Your Honor.

THE COURT: Okay. So Mr. Simon handed me a packet that's tabbed, and he marked defendant and plaintiff. I'm assuming -- wait, it's defendant, does that mean that's the one who proffered it?

MR. MICHALEK: No, Your Honor.

MR. SIMON: No.

MR. MICHALEK: These are ones that are agreed upon except for the ones that are tabbed.

THE COURT: Yeah, that's what I mean.

MR. MICHALEK: Right.

THE COURT: I have tabbed and it says defendant on one of the tabs. Is that who proffered the instructions?

MR. MICHALEK: No, no. That's who's objecting.

THE COURT: Oh, who's objecting? Okay.

MR. SIMON: We -- we both, I guess, technically proffered them. I prepared them, but that's the one they have concerns with and they're objecting. It's their objection to it.

THE COURT: Okay. So the first one is the reasonable

medical expenses plaintiff had necessarily incurred as a result of the accident, and the medical expenses which you believe plaintiffs are reasonably certain to incur in the future as a result of the accident.

MR. MICHALEK: Right. And that's just a technical objection to the request for future damages. Nothing wrong with the language in the instruction.

THE COURT: That goes back to our -- the original objection in the case?

MR. MICHALEK: Correct.

THE COURT: Obviously, I allowed testimony of future medical treatment, so I think this one would be proper. So I'll allow it.

MR. MICHALEK: Yes.

THE COURT: And I recognize you've had a continuing objection.

Okay. The next one is the physical and mental pain, suffering, anguish, loss of --

MR. MICHALEK: Same -- same technical objection -- objection. I expect you to give the instruction.

THE COURT: Given the fact -- oh, this -- yeah, because you just agreed that there shouldn't have been any testimony whatsoever regarding futures and the Court did allow it. So, okay, it'll be allowed.

The next one is, if you find that the plaintiffs had

a preexisting condition which was a dormant asymptomatic condition that was subsequently aggravated by this condition, then the plaintiffs are entitled to recover full compensation for the resulting disability, even though the resulting disability is greater than if they had not suffered from the preexisting condition.

MR. MICHALEK: Right. There are three instructions essentially going off the same line of preexisting conditions. And I'm not sure what the purpose of them would be. The plaintiffs have been arguing throughout trial that there are not preexisting conditions. There was preclusion from Mr. Baird on arguing that the plaintiff had any preexisting condition. So --

THE COURT: Didn't Dr. Duke get up there and say this tear, 5th-degree tear was pre -- pre-accident, it was a degenerative condition; so wouldn't that basically be a preexisting condition?

MR. MICHALEK: Well, it's a degenerative change. I don't necessarily agree that it's a preexisting condition. There was no -- I guess there was -- we can sort of argue over whether it was a condition or not. I do know that the plaintiff's argument has been there is no preexisting condition, and Dr. Duke's -- the thrust of Dr. Duke's testimony was there was no condition that was caused by the accident.

So -- so I don't think that the preexisting condition aggravated is really the -- the appropriate line of argument. Either there was an injury caused by the accident or there wasn't. I didn't -- I didn't hear the plaintiffs make the case that they had a preexisting condition that was aggravated by the accident.

THE COURT: They didn't. But you argued that a preexisting condition that was never aggravated by the accident.

MR. MICHALEK: I mean, I guess. I guess that's one way to phrase it.

THE COURT: Well, I don't know. Maybe we're just, like, splitting hairs. But I would call something that existed prior to the accident a condition.

MR. MICHALEK: Well, if you're going to give that, Your Honor, then I -- I --

THE COURT: Actually, I thought they were objecting to this originally.

MR. MICHALEK: No, no, no. That -- that was ours. But then that's true, we don't need three instructions on the same subject. So if that's -- if that's the instruction the Court's going to give, then I would object to the other two as --

THE COURT: Well, I think it's borne out by both of your evidence.

MR. MICHALEK: Right. But --

THE COURT: We know he had something -- we know he has something at L5-S1 that's a Level 5 tear. We just don't know what it's from. It's either before the accident or because of the accident. That's for the jury to decide. Okay.

So then the next one would be a person who has a condition or disability at the time of the injury is not entitled to recover damages therefore; however he is entitled to recover damages for any aggravation of such preexisting condition or disability proximately resulting from the injury. This is true even if the person's condition or disability made him more susceptible to the possibility of ill effects that a normally healthy person would have been, and even if a normally healthy person would not have suffered any substantial injury where a preexisting condition or disability is so aggravated the damages as to such condition or disability are limited to the additional injury caused by the aggravation.

Again, I thought, really, defense was proffering this.

MR. MICHALEK: Right. And -- and that's -- and I guess that's the issue. At least this tone. There's two competing ones, I take it, Your Honor. This one, at least based on the Nevada pattern jury instruction 10.06.

THE COURT: Uh-huh.

MR. MICHALEK: The following one is based upon I guess a law out of New Hampshire. I would object to both, but if the Court's going to give one of the two, I would suggest the Court give the one from the -- the pattern jury instruction.

THE COURT: Okay. Again, I assumed you wanted this one. But now that we know you don't...

All right. Mr. Simon?

MR. SIMON: Yes, Your Honor. In regard to both of those instructions?

THE COURT: Yes.

MR. SIMON: All right. The evidence in the case is that there is no prior injuries, accidents, or conditions. And if there is something that is a radiographic finding that Dr. Duke wants to present to the jury as a preexisting condition that existed at the time of this accident, the evidence is, is that these -- both of these plaintiffs were asymptomatic at the time. There's no prior records suggesting, no testimony, no evidence that they had symptoms. So the first instruction would correlate to that evidence.

The second -- the follow-up instruction also correlates to Dr. Duke's argument that -- when I showed him the disc, he just says, Oh, that's -- that's normal for their age, only a 10-year-old would be a little bit different than

that. But for their age, even though they're young, that's a normal disc. So you have all the other doctors saying it's not normal.

So if it's normal, there's an aggravation of that condition, of that disc, which is now, the evidence says, is the pain generator. And so that's where that instruction comes into play, that this accident would have aggravated that.

THE COURT: Okay.

MR. MICHALEK: And like I said, Your Honor, fine with the one on -- on -- based on the pattern. I guess I would -- I request the Court give that one and then not give the following one.

THE COURT: You got this -- do you have anything in Nevada? You received the second one from Rawson v. Bradshaw, which is 480 A.2d 37, which is New Hampshire, 1984 case. Is there anything in Nevada?

MR. SIMON: There's not, Judge. There's not a lot of instructions that are tailored specifically to this. All I could tell is, you know, we've had this instruction in other cases, it's used when there's no symptoms reported prior, that's the instruction that's always given.

THE COURT: And defense's objection is it's basically cumulative.

MR. MICHALEK: It's cumulative in the cause by -- it

just says a latent condition, that's sort of nondescriptive as to what the terms would be. If there is a preexisting condition for injury that was exacerbated, that -- that's fully covered under 10.06. I'm not sure what the latent condition, the injuries were rendered more serious [indiscernible] might have been -- I mean, I didn't hear any testimony along the lines that he has Asperger's or some condition that got -- that causes injuries to be more serious than otherwise not. I think there's a lot of problems with this instruction. And it's covered under -- under the prior one, 10.06.

THE COURT: Isn't this basically the same thing, though? Doesn't it talk about Mr. Simon, basically, an exacerbation of a preexisting condition?

MR. SIMON: No. What it talks about is that one deals with the symptoms, that where you don't have any symptoms that have been caused by an incident that, even if it was dormant and they had a condition, but it wasn't symptomatic, and the accident causes the symptoms, that's what they're liable for.

The other one is an aggravation of a preexisting condition causing a condition. So there's spine, their disc, that this accident caused it to degenerate more. So it separates out more the condition as opposed to the symptoms. So.

THE COURT: Oh, I understand. Okay. I'm going to allow it. I think that actually there -- I don't really think they're duplicative. And I do think that, again, they are borne out by the evidence, since Dr. Duke is claiming that any objective findings contained on the diagnostic studies preexisting the accident in this case were due to their normal degenerative processes for their age.

Next one is according to a table of mortality, a life expectancy of a male person aged 28 is 51.8 additional years; the life expectancy of a female age 30 is 54.2 additional years. These figures are not conclusive, there's an average life expectancy of persons who have reached that age. These figures may be considered by you in connection with other evidence relating to the probable life expectancy of the plaintiffs, including evidence of occupation, health, habits, and other activities, bearing in mind that many persons live longer, many may die sooner than the average.

MR. MICHALEK: I don't remember the issue of life expectancy or -- or damages coming up during trial, so this would be another technical objection. I'm not sure what the --

THE COURT: But there was testimony that the plaintiffs will continue to suffer pain until the body heals itself, which could be 30 years down the road. I figured that was what this was in response to.

MR. MICHALEK: Understood, Your Honor.

MR. SIMON: Yeah, the testimony from all the doctors, at least that we presented, that their condition was permanent and would be there for the remainder of their life. And those numbers are supported by the table of life expectancy that you can take judicial notice of.

THE COURT: Any other objection other than the fact -- I mean, as far as -- do you have any objection regarding the numbers?

MR. MICHALEK: No, I -- I agree with the -- if that's the instruction, then I agree that's -- the language is appropriate.

THE COURT: Yeah. I -- I think it's -- the evidence is certainly there in the case.

Okay. The next one is plaintiffs are only entitled to recover the net present value -- net present cash value for future medical expenses, future pain and suffering damages are not reduced to present value, present cash value means the sum of money needed down which, when invested at a reasonable rate of return, will pay future damages at the times and in the amounts that you find the damages will be incurred. In determining the amount of money for future medical expenses, you should consider that a person can invest money now and receive a return of 2.5 percent per year. However, in determining this amount, you must also offset this rate of

return with the rising costs of medical care, which is 4.5 percent per year.

MR. MICHALEK: Yes. It was my contention over the weekend that Mr. Simon had to reduce the future damages request at a present value. So even though we're objecting to future damages being asked for, we wanted some instruction. Mr. Simon was good enough to make that instruction.

I guess, I don't know how the Court has given instructions on future damages being reduced to present value in the past, but Mr. Simon has come up with some fiscal mumbo jumbo that he's certainly willing to talk about to support the instruction. So I guess the question would be, from our standpoint we don't agree that future damages should be requested, but if so, we do request that it be reduced to present value and there be some manner of calculation, which Mr. Simon...

THE COURT: There was only testimony regarding present value.

MR. SIMON: Your Honor, here's, I guess I'm not sure what the defense wants or doesn't want. I'm not so sure they want this --

MR. MICHALEK: Sure. I can --

MR. SIMON: I'm not so sure they want recalculation, because it doesn't benefit them. The reason is, is that the cost of rising medical care is at a greater rate per year,

4-1/2 percent. Then if they paid him today and they put it in the bank account and bought T-bills, which is a safe investment, which is what's required for the instruction, then they only get 2-1/2 percent over 30 years. And in fact over the next year, it's, like, .2 percent. I mean, it's terribly low, the return on investment, if they were going to invest the money, as opposed to the rising costs of healthcare. Under the Medicare studies, they're 4-1/2 percent.

And the mumbo and jumbo that he's referring to is the United States Department of Treasury. So I guess that federal government arm is unreliable. And then the other one is the U.S. Trustees for Medicare, who print out these reports. These are their government reports, not mine.

And the case law that's being presented is that when you talk about present value, the judge is supposed to instruct them on the methodology. That's it. And then it's up to them. So it's actually a greater number, if we were to calculate the net present value, it would be more than what we're asking the jury, not less.

MR. MICHALEK: Here's what I would like, Your Honor. I would like for, in closing, for the number to be whatever the -- the present value is. Not that there be request and said, Hey, today surgery costs 50,000, but you can determine any number in the future based upon whatever you -- you speculate.

So if there's going to be a cost of future surgery and that number is 50,000, then it should be 50. If -- if Mr. Simon is going to ask for a larger number, you know, saying, Well, if you -- surgery cost 50,000 now, but you can award as much as 100,000, then we'd have a problem, because there's been no reduction in the present value.

THE COURT: May I ask, Mr. Simon, because honestly, I didn't hear any testimony other than it was -- the numbers Mr. Simon was asking for were based upon present value. We had -- we don't have an economist. We don't have anyone qualified to do a net present value calculation. I assumed you were just going to present to the jury as far as present value.

MR. SIMON: Yeah, and whatever -- yeah, whatever the number is today. I'm not asking for more than that, for sure.

MR. MICHALEK: I withdraw --

MR. SIMON: But they were making that --

MR. MICHALEK: I withdraw that.

MR. SIMON: -- for sure, but they were making that argument --

THE COURT: Got it.

MR. SIMON: -- in trial, and they were -- I thought they -- they probably were under the assumption that after a calculation it would be less. But now knowing that it's actually more, I'm sure we could probably stipulate. Because the case, it's a United States Supreme Court case, Pfeifer v.

Jones, which allows the offset methodology to be used in these type of present value cases, which offsets inflation to cost of medical care. That's all it says. It's -- it's a well-recognized methodology.

So I guess I would like some stipulation and maybe some type of instruction what present value means in the context of our case going forward. Otherwise, I would ask give this instruction, we both argue numbers.

THE COURT: Why don't you just take off the third -- the fourth paragraph, present -- and -- and keep in present value means the sum of money needed now, which when invested at a reasonable rate of return will pay future damages at the times and in the amounts that you find the damages will be incurred.

MR. SIMON: Because the rising cost of healthcare is an imperative part to a present-value calculation when you're talking about a future surgery.

THE COURT: So you don't want this, though. Do you have a proffered instruction?

MR. SIMON: No, I want that.

THE COURT: Oh, you do want this one?

MR. SIMON: I want that. But unless we --

THE COURT: Oh, this wasn't marked defense objecting.

MR. SIMON: That's true. We knew we had to discuss it with you. That's why.

THE COURT: Okay.

MR. SIMON: Sorry.

MR. MICHALEK: If -- if Mr. Simon is simply going to say I -- the present value of the surgery is 50,000, award me that, then that's fine, I withdraw the instruction.

MR. SIMON: If --

MR. MICHALEK: If there's going to be some statement in closing that's going to say, It's 50, but you can certainly award 100,000 for the future surgery that might take place five years from now, then I think there's a problem, because there's been no economist, there's been no reduction of the present value. And I'm not sure that language is necessarily appropriate.

I think the Court was onto it maybe we just strike that, just say, Look, here's what present value is. And Danny can certainly argue what -- what that -- under that instruction what the sum would be.

MR. SIMON: Judge, I just would want instruction that the present value for the jury to consider is the numbers that they've heard in court.

THE COURT: Okay.

MR. SIMON: Can we agree to that?

MR. MICHALEK: That's -- yeah, I can -- I can agree with that. He -- he asked for --

THE COURT: Can you guys come up --

MR. MICHALEK: -- whatever -- he asked his expert what the cost is, and he can certainly bring that number up to the jury.

THE COURT: Okay. So the jury, because there's been testimony, it may be a confusing subject for some. Do you want to use this instruction or come up with your own that's mutually agreeable?

MR. SIMON: We can try to draft one real quick.

THE COURT: Okay. Because you guys agree that you need one, so we'll take this one out. And you'll come up with one for -- to explain present value.

All right. Next one is, once the plaintiffs demonstrate that defendant's actions were the cause of their injuries, the burden shifts the defendant to apportion damages. If the defendant fails to meet this burden, the defendant is then liable for the entire amount of damages attributable to the single injury.

MR. MICHALEK: Yeah, I wasn't sure the [indiscernible] of this one, either. We are the single defendant who's liable for whatever the sum that the jury determines. So I'm not -- I wasn't sure what the -- the point of this would be. There's no multiple defendants to apportion damages between.

MR. SIMON: This isn't a multiple defendant case. It's the -- we've established our case through our doctors.

They bring in Dr. Duke. I ask Dr. Duke on the stand, I say, Can you tell me what the cause of their ongoing pain, is it a preexisting condition, is it an intervening event? Apportionment goes to the cause, not multiple defendants. And so the burden shifts to them to point to a cause through Dr. Duke. And that's what Klietz says.

MR. MICHALEK: We're -- the purpose of Dr. Duke's testimony was essentially to say there is no injury that was suffered by the male plaintiff in this case. And as far as the female plaintiff, that was simply the chiropractic treatment. So I'm not sure -- he didn't admit that there was an injury. We went through the whole disc and the green disc scenario. So I don't see how we're apportioning anything between an injury, Your Honor. That's not -- that's not what Dr. Duke was saying. Dr. Duke was saying that Mr. Cervantes did not have an -- any injury from the accident except for a headache and -- and nausea.

THE COURT: So you're -- you're going to be an all-or-nothing approach in closing? You're not going to say, even -- your approach is simply the injury -- this accident does not -- did not cause that injury or any of the pain they're having? You're not going to say, Even if you believe that the injury exacerbate -- accident exacerbated it, they'd only be entitled to the exacerbation? So you're just doing an all-or-nothing defense?

MR. MICHALEK: We're -- yeah. And Mr. Baird can correct me -- correct me if I'm wrong, but no, that's -- that's exactly what we're saying that there was no injury caused by the accident to Mr. Cervantes. He -- he had nausea and vomiting, and that's it. So -- what -- there is no -- there's nothing to apportion between anything preexisting. As far as -- because --

MR. BAIRD: Let me -- let me clarify it.

MR. MICHALEK: Yeah.

MR. BAIRD: I mean, Dr. Duke's testimony was there's a myofacial strain. Whatever -- whatever can be related to the myofacial strain. But we aren't going to say that there was another cause for their pain or symptoms.

THE COURT: I don't think --

MR. BAIRD: There won't be any other --

THE COURT: Well, hold on. That's not really what I'm asking, though. I mean, I think there's a couple of scenarios. Either it preexisted and they did not become symptomatic, it preexisted and they became symptomatic, or it was caused by the accident. And those are the three different things that have been tossed around. And the jury's going to decide which one.

MR. BAIRD: The jury will determine whether this accident caused the injuries. That's the only issue. And we have agreed that this accident -- that there is evidence that

supports a finding of a myofacial strain. Everything else is -- is not caused by the accident. So the defendants are not obligated to posit an alternative cause, that's not our burden.

MR. SIMON: I don't -- it's not their burden, but it is their defense. Once I prove my case, they can't go, Oh, well, something must have happened during that gap in treatment, or when she picked up clothes, or when he was at work. If they start making any of those arguments, the duty's on them to point out what injury at work caused it, what injury when she was picking up clothes, that goes to the apportionment of the damages that we've proved. And that is their burden.

They do have burdens in this case. Their affirmative defense is -- is their burden. And that's what Klietz talks about. It shifts the burden after we've proven it to point to some other event, especially when there is no other event. And that -- and the purpose of the jury instruction is to inform the jury of that -- of that burden, if they didn't have the evidence and the law requires them to come up with an alternative theory.

MR. BAIRD: Your Honor, that would -- that -- that would put an absolutely impermissible burden on the defendants. We are in no way obligated to prove what caused their symptoms. Our argument is there's no objective evidence

of any injury from this accident. They can have symptoms from whatever they want and we're not obligated to say so. And Dr. Duke testified I could not posit an opinion, there's not enough evidence to decide where their symptoms may have come from.

Now, the Klietz case is very different, because, as Mr. Michalek said, that's where there are multiple accidents, multiple incidences. But when it comes to medical causation -- not legal apportionment, but medical causation -- the plaintiffs have the burden of proof, defendants do not. And that has been -- we don't have the cases with us, obviously, but there are multiple cases beginning in -- medical malpractice cases, like, I think the Sunrise case, where the Court has made clear that the defendants don't have to prove an alternative cause. We don't have to say it wasn't this, it was this. All we have to say is to a reasonable degree of medical probability not what plaintiff said.

MR. SIMON: Your Honor, the beginning of the instruction does talk about after we prove our case, we have the burden after we prove it. But to get -- and -- and the reason it shifts to them, because they can't get up and speculate to the jury about some other event that they didn't have evidence of. That's why it does shift the burden to them and that's what Klietz says. Even though Klietz involved a couple of different accidents, it's the same thing. It

prevents the defendant from speculating about something that there's no evidence of. And -- and that's their burden and --

THE COURT: Let me -- I have -- I don't know if I've read Klietz. I don't know if I've read it and I don't know if I've read it in years, if I have read it. I don't know that you even need this, frankly, because they're kind of taking an all-or-nothing approach. But let me look at Klietz.

MR. SIMON: Well, if they -- yeah, that's fine. And the only thing is when they get up here and say, We don't know what happened in that gap, he -- we know what type of work he does. He's a heavy laborer. Anything could have happened at work. Anything could have happened. And that's what Klietz prevents against, them asking the jury to speculate outside the record, because that is their burden.

Because they're going to get up through the whole closing arguments and tell this jury 15 times how it's my burden to prove everything. And after I do prove what I'm supposed to prove, they can't go and ask them to speculate all over the place about stuff that doesn't exist. And that's what Klietz tells the jury about. That's all.

THE COURT: Let me read Klietz again.

MR. SIMON: Okay.

THE COURT: If I have read it, it's been a real long time. I don't remember it.

Okay. The next one is the plaintiffs have a duty to

use reasonable efforts to mitigate damages. To mitigate means to avoid or reduce damages. The defendant has the burden of proving by the preponderance of the evidence, No. 1, that the plaintiffs have failed to use reasonable efforts to mitigate damages and, No. 2, the amount by which damages would have been mitigated.

What -- I don't understand how this would come in with the evidence. What should they have done to mitigate, not work?

MR. MICHALEK: Well, no. It's -- it's not the not work part, Your Honor. But certainly there were gaps in treatment. If the jury finds that a reasonable plaintiff would have gone to a physician or done something if they were in severe pain, or -- or as they -- you know, excruciating pain, there's a gap in treatment where they weren't treating. And maybe their condition could have been rectified, maybe the jury might determine that, if they had gone to a doctor during that gap in treatment.

So, you know, that's -- that's for the jury to determine whether they should have gone earlier, shouldn't have waited a year between their -- their treatment times.

THE COURT: Okay. Plaintiff, you're the one objecting.

MR. SIMON: I was just waiting to hear their explanation, Judge, that's all. So if that's their argument,

I think that they can make that inference.

THE COURT: I think that makes sense. All right. So that one will stay in.

Okay. So that's -- other than the one that references Klietz, that's the only one that we have not settled on.

MR. MICHALEK: Right. And then the -- the verdict form, I don't have a problem with the form. I do have a problem with the request for the future. So we've agreed on the form with that objection.

THE COURT: I'm sorry. Please tell me again, I wasn't processing all that.

MR. MICHALEK: Sorry, my bad. I spoke to you too fast. The -- the verdict form, we've agreed on the form with the understanding that -- that the defendant objects to any request for futures. So other than that, that the form is fine.

THE COURT: Oh, it's the same objection you've had throughout the course of the trial?

MR. MICHALEK: Right. Right.

THE COURT: Okay. And I believe that's something that you've had a chance to articulate throughout the trial, right?

MR. MICHALEK: I -- I believe we've covered this ad nauseam, Your Honor.

THE COURT: Okay. So it'll be on the form. So we have a verdict form. Great.

MR. SIMON: And as far as some other rulings, we were going to read some deposition testimony today.

THE COURT: Uh-huh.

MR. SIMON: And there's a few objections about what's to be read for you to consider.

THE COURT: There are? Okay.

MR. MICHALEK: You want to do that now?

MR. SIMON: That'd be great.

MR. MICHALEK: Great. Okay.

MR. SIMON: There's not many, and it's easy. May we approach, Your Honor?

THE COURT: Yeah, you may. Thank you.

MR. SIMON: Thank you.

THE COURT: Okay.

MR. SIMON: Okay. Which one do you want to start with, Coppel?

THE COURT: That's fine.

MR. SIMON: All right. So Dr. Coppel's -- where are they at and what page. All right. At page 17, line 23.

THE COURT: All right.

MR. SIMON: These are questions by Mr. Baird that they want to introduce today that discusses secondary -- secondary gain motivations generally. And you had already

excluded that information or any questioning along those lines in this case.

THE COURT: This is the same testimony I did not allow Dr. Duke to give, because I didn't feel that there was any evidence to show secondary gain. And I didn't think he was qualified to talk about secondary gain.

MR. SIMON: Yeah. And this takes us all the way through page 18, line 23.

THE COURT: So you want this in through Dr. Coppel? My only concern is what I can read through the blacked-out line is Dr. Coppel seems to be talking in generics. Addiction to medication may be one thing, there may be a multitude of different reasons that people go to the doctor other than just purely injury and pain related to that injury.

So I don't know -- I guess I don't understand why you want it. Well, I understand why you want it. But I don't know what the basis would be for it.

MR. MICHALEK: Right. And I think -- I think the basis was that even though [indiscernible] to Duke, this would be treating -- this is the treating provider or the plaintiff and the sub. That would be a different issue. But I certainly understand the Court --

THE COURT: Well, my -- again, and the same reasons I had concerns with Dr. Duke, I mean, they're both speaking in generalities. I mean, there's a lot of reasons people do what

they do. But none of it is -- it's just generalities about any person, speculating why a person may do certain things, but it's not really borne out by the evidence with respect to these particular plaintiffs.

MR. MICHALEK: Understood, Your Honor.

THE COURT: So, okay, what's the next thing?

MR. MICHALEK: Looks like page 20.

MR. SIMON: Actually --

THE COURT: Okay.

MR. SIMON: -- no, a lot of those we're letting go, Charles.

MR. MICHALEK: Oh.

MR. SIMON: The next one will be --

MR. MICHALEK: Oh, so -- just -- so -- yeah, okay.

MR. SIMON: Yeah, just page 37.

MR. MICHALEK: 37, okay.

MR. SIMON: Line -- starts at line 25.

THE COURT: Okay.

MR. MICHALEK: 37, line 25. Okay.

MR. SIMON: Yeah, and then the next page, through 20, 38-20.

THE COURT: Okay. So was this something the plaintiffs wanted to read or the defense wanted them to read?

MR. SIMON: Defense wants this, Your Honor.

MR. MICHALEK: Yeah, Mr. Baird is asking about if the

plaintiff's history's unreliable, whether the opinions might change. And I think that's a reasonable assumption that if the plaintiffs aren't truthful with their providers, that --

THE COURT: Okay. And I -- and I -- again, my concern has been throughout the course of the trial of as yet I haven't heard anything that there's any -- there's no -- there's no objective evidence that they had a preexisting condition or preexisting injury that would have caused or exacerbated what's at issue in this case. And this seems to just imply that there was a preexisting condition or injury when there is no evidence of that. That's my concern, is just putting that in front of the jury when there's no evidence.

MR. MICHALEK: Understood, Your Honor.

THE COURT: It would be different if there was evidence.

Okay. What else?

MR. SIMON: One last one on this deposition. Page 40, line 6, through page 40, line 8.

THE COURT: Well, the same thing. Again, refresh my recollection if I'm wrong, but I don't recall any testimony that they gave the doctor on medical history and it turns out it was belied by other medical records.

MR. MICHALEK: Understood, Your Honor. So that goes from -- it goes through page 41?

MR. SIMON: Yeah.

MR. MILLER: 40, line --

MR. MICHALEK: 41.

MR. SIMON: Page 40, line 6 through page 41, line 8.

MR. MICHALEK: All right. And then the other ones that are in here, we'll just ignore?

MR. SIMON: Yeah. Those are fine.

THE COURT: Okay. So we're finished with Dr. Coppel?

MR. MILLER: What about this objection?

THE COURT: Let's go to Dr. McCourt.

MR. SIMON: And then we just have two in the next deposition, Mr. McCourt -- or Dr. McCourt.

THE COURT: Uh-huh.

MR. SIMON: First one's at page 26, line 17.

THE COURT: Okay. Again, I -- I understand where defense is going. So defense wants this? I mean, again, unless it's continued onto the next page, it looks like these are just in generalities.

MR. MICHALEK: Understood, Your Honor. And I guess that's -- that's sort of the point, that if -- if the Court's not allowing any questioning on the -- the nature of prior neck and back or -- or just nature of the injuries, that sort of goes to why the preexisting jury instructions would be necessary. But -- so --

THE COURT: Well, I'm not allowing it just because there's not evidence.

MR. MICHALEK: All right. So that goes from -- okay. So that's 11 to 23. That's out. What's the next one?

MR. SIMON: There's one more. Page 35, line 1 to 7.

THE COURT: Okay. So there was testimony by the doctors about why people sometimes don't have certain complaints of pain immediately after the accident that they may have a few days after the accident. So this seems to be consistent with evidence presented. Is this -- defense wants this?

MR. MICHALEK: Yes, Your Honor.

MR. SIMON: Defense wants that, yes.

THE COURT: Okay. I think -- I don't know which doctor testified to it. It may have been Dr. Kaplan, since it's not unusual for people to wait a few days before they start noticing pain.

Okay. Is there anything else?

MR. SIMON: No, Your Honor.

THE COURT: Okay. Do you want these copies back?

MR. SIMON: Sure. Sure. Thank you.

THE COURT: You're welcome.

MR. SIMON: And do you have a present value instruction?

THE COURT: Oh, yeah. I just put it in the trash, actually. Sorry.

MR. SIMON: Where it belongs?

THE COURT: Here you go. Are you guys ready for the jury?

MR. SIMON: Yes, Your Honor.

MR. MICHALEK: Yes, Your Honor.

(Jury reconvened at 1:28 p.m.)

THE COURT: All right. Good afternoon, everyone. We're here on the trial of Christian Cervantes-Lopez vs. Evangelina Ortega, it's Case A667141.

I know at this point we're going to have -- is it -- are we going to go ahead and call the individuals to do the depositions at this point?

MR. MICHALEK: Yes, Your Honor.

THE COURT: And I believe this is in plaintiff's case in chief, because we've been switching back and forth.

MR. MICHALEK: Correct.

THE COURT: All right. So, Mr. Simon, where do you want to start?

MR. SIMON: Mr. McCourt first.

THE COURT: So, again, ladies and gentlemen, I -- I know we've been switching back and forth between the witnesses for each side. The -- what's going to happen now is you're going to be read some deposition testimony. A deposition is simply a questioning of an individual under oath outside the courtroom. And so portions of the deposition transcript are going to be read into the -- read into court for you, and

these are plaintiff's witnesses in support of their case.

MR. SIMON: Your Honor, we'll call Dr. McCourt from UMC to the stand.

THE COURT: All right. So this is not Dr. McCourt, obviously. He's just the gentleman who has been selected to do the reading today.

(BENJAMIN J. MILLER - Reader sworn.)

THE CLERK: Please be seated. Would you please state and spell your first and last name for the record.

THE WITNESS: Am I doing that as me or as the witness?

THE CLERK: As yourself.

THE WITNESS: Okay. Benjamin J. Miller, B-E-N-J-A-M-I-N M-I-L-L-E-R.

THE COURT: Okay. You want to start, please.

(Deposition of JOHN MCCOURT read as follows.)

Q Good morning. Could you please state your full name and your professional address for the record.

A My name is John D. McCourt, MD. Home address is 9436 Steeple Hill Drive, Las Vegas, Nevada, 89117.

Q Doctor, can you tell me a little bit about your educational background?

A Undergrad in Northern Illinois. I did medical school at Chicago Medical School, graduated in 1989. Did an internship here at Michael Reese Hospital in internal medicine

and completed a three-year emergency medicine residency at University of Chicago.

MR. MICHALEK: Page 9.

Q Did it look to you like anything that you would have expected to be in those records was missing when you were reviewing them to prepare for today?

A No, they seem to be complete.

Q Now, when you are keeping records and making records, is it one of your goals to make sure that they are correct and accurate?

A Yes.

Q Because you understand that sometimes other doctors have to rely on these records; is that true?

A That is correct.

Q So you've taken steps in your habits and practices to make sure that the records you're making as near as possible are accurate and correct?

A Yes.

Q And nothing stuck out as you were reviewing these records that would make you think that they are inaccurate in any way; is that true?

A That is true.

Q You saw both of these patients as emergency room patients; is that true?

A Yes.

Q Typically --

MR. MICHALEK: Oh, sorry. Is that a --

MR. MILLER: That's -- that's a question.

Q Typically you see them in an emergency basis and then they are expected, either by your referral or their own referral, to find a doctor to handle whatever can't be handled in the emergency room?

A That is correct.

Q As a contractor with UMC, do you have any input or understanding as to how the amounts that are charged for your services are determined?

A No. I don't know how the amounts are determined by the hospital.

Q You tell them what you've done and then they take over the billing; is that a fair statement?

A The hospital charges a facility fee based on the medical record, and how they determine that fee is purely determined by the hospital. However, the emergency medicine group that I work for also sends a separate bill for services rendered by the emergency physicians.

Q Have you had a role in setting the amounts that are billed for your services as a part of this emergency medical group?

A No, I have not.

Q And do you know the process by which they

arrived at the fees that they charge?

A I would be guessing, but I would assume it's based on standard, fair, and competitive pricing.

Q But as far as where the charges for your -- well, as far as the charges for either UMC or your emergency medicine group, you wouldn't know where they sit as far as what percentile of the average in this --

A No, I wouldn't.

Q When you perform services at UMC, University Medical Center, do you enter in a CPT code or do you write a description of your services and someone else turns it into a code?

A We do not -- we document the medical record. The chart that goes to a medical coder codes the chart, and then it's billed based on that coder.

Q Then I would assume that you don't have any involvement in collections either for UMC or for your medical group?

A That's correct.

Q But regardless, were you given by them any information about how the car accident happened or what was involved in this car accident?

A On my review of the medical record, and specifically this recollection is coming based on my review of my medical record documentation, the specifics of the car

accident was a t-bone car accident with a speed of 35 miles per hour. And I believe, based on my review of my documentation, the vehicle that -- again, you've informed me that they were both in the same car -- the two patients then, based on my review, were in the car that t-boned another car.

Q Did they tell you whether they were seat-belted?

A I believe in my documentations they were both restrained.

Q Did their bodies strike anything on the interior of the vehicle, steering wheel, window, things like that over the course of the accident?

A The documentation I have for Cervantes-Lopez, no, it was not documented he struck anything. Again, the other patient is Abarca, on this I will also mention that I supervised. I saw this patient also in conjunction with an emergency medicine resident. That physician's documentation and mine, the resident document did not -- what was the question again?

Q Did any part of her body strike the interior of the vehicle over the course of the accident?

A Again, in the history of the mechanism present illness, it is not documented in either the resident's documentation or my supervisory note.

Q Did the airbags deploy in this accident, do you know?

A I believe from my recollection of the review, no airbags deployed. Again, that can be found in several instances. I'm just reviewing both charts. The resident didn't document the airbag deployment on the Abarca. On mine, on Cervantes, let me just -- yeah, I -- I have documented no airbag deployment.

Q Were either of them rendered unconscious?

A Per the history of the documentation that I have for Cervantes, patient mentioned possible loss of consciousness. And my documentation specifically states patient had questionable loss of consciousness. Again, that's -- I do need to refer also to the nurse's note, who documented no. A lot of times people will confuse loss of consciousness for being dazed.

Q Were Maria's records, did they show whether she had lost consciousness?

A The nurse's notes document no loss of consciousness, and there's a document there, there was no loss of consciousness.

Q With Mr. Cervantes-Lopez, did you perform any test to evaluate him for a head injury based on him reporting a possible loss of consciousness?

A Yes. He had a CT scan of the brain that was performed. The reason that was done was more specifically for the headache and the nausea that the patient complained of

after the accident. That's sometimes more of a red flag.

Q Was there a Glascow coma score taken as well?

A It was, I believe, 15.

Q That's a perfect score, right?

A Yes.

Q So you mentioned that sometimes someone will misinterpret a loss of consciousness as being dazed or stunned. Did either patient report being dazed or stunned?

A There's no documentation of that.

Q Did it note where they were?

A I'm trying to get the exact documentation from the resident. It's noted per the resident, she had a positive seatbelt sign on the midline cervical spine. Oh, I'm sorry, positive seatbelt sign in midline cervical spine tenderness.

Q So that would be a mark from the seatbelt, and then she had tenderness in her neck area?

A Right.

Q With respect to Maria Abarca, what was your diagnosis for her?

A The clinical impression was abdominal wall pain, motor vehicle crash, cervical strain.

Q And this is -- let's talk about Mr. Cervantes-Lopez. What were your diagnosis for him?

A Nausea, vomiting. Again, I use the term clinical impression, which was nausea, vomiting. And No. 2,

motor vehicle crash.

Q What was the physiological cause of what you -- of your clinical impression for these two patients? Let's start with Maria. In your examination of her, did you identify a pathology, this is where it's coming from, or was it that this -- was she reported this trauma, and you inferred that the trauma caused what she reported or presented?

A Based on my documentation, the clinical impression was -- the clinical impression was due to a motor vehicle crash.

Q Now, with respect to the abdominal wall pain, was there any objective evidence of abdominal wall pain?

A I have to go to mine, because the resident is somewhat -- okay. So my documentation, GI and Maria, it's noted that the patient had abdominal wall tenderness over the rectus abdominus muscle. So that's, again, it was our assumption that that was due to the seatbelt, which is a -- is a finding that will bring up some concern on any patient in a car accident. That's why she in her workup received a CT scan of the abdomen.

Q So based on her reporting pain, you performed these tests and arrived at that clinical impression?

A Yes.

Q With respect to Mr. Cervantes-Lopez, was there objective evidence to support -- oh, wait, wait. Now, with

Maria, you also had an extra cervical strain, right?

A Uh-huh.

Q Was there any objective evidence of a cervical strain, or did you just have to rely on her reporting to you?

A This is common practice to -- just for clarification, our role is to rule out any spinal injuries, spinal fractures. Many patients are left with neck pain and it's based -- it's a clinical diagnose based on mechanism and complaints. And in this patient, the documentation does note on the initial exam she had tenderness palpated by the resident on the neck. She also received a CT scan of the neck to rule out any fractures or spinal injury. Once negative, most -- most patients will get that diagnosis of cervical strain. And that appears per the documentation of what happened here.

Q Is it fair to characterize that then, as her being objectively normal but subjectively complaining of pain in conjunction with an event that can cause injury, and so with those two combined, you said, Well, this is a cervical strain?

A Could you repeat it or clarify that?

Q Yes. So objectively, she was normal. The CT scan and the x-ray, all the measurements were normal for her?

A Yes.

Q But she complained of neck pain and tenderness,

correct?

A Yes.

Q And then she was in a car accident, which, in your experience, a lot of people in car accidents complain of neck pain, correct?

A It depends on the mechanism.

Q But it's something you're familiar with?

A Yes.

Q It's not an uncommon occurrence?

A No, it's not an uncommon complaint after a car accident.

Q And so since it was something that was not uncommon to cause people to complain of neck pain and she complained of neck pain, you had to make the diagnosis of cervical strain based on subjective rather than the objective evidence; is that a fair statement?

A Yes.

Q So moving onto Christian, was there -- the clinical impression for him was nausea and vomiting. Was he actually vomiting in the emergency room or did he just report that he had?

A I'll have to refer to the nurse's note. I can't find any documentation. Well, again, my documentation really only specifically notes headache and nausea. The nurse did write chief complaint, she wrote vomiting, dizzy, nausea. And

again, I can't find documentation that I was aware that he actually -- that the patient actually vomited.

Q So it could have been he was just feeling sick rather than actually --

A Yes.

Q When someone presents to the emergency room, you want to make sure there's nothing bad going on even if the patient might not be reporting any specific symptom; is that a fair statement?

A Our job is to consider and identify potential life threats or -- or occult injuries that may be lurking that we need to diagnosis.

Q So it is your practice, then, to follow up and to document all complaints that a patient makes?

A Well, we need to take a history, take all the complaints, add it together with the history, the mechanism, and then based on that come up with a risk of potential injuries and then to pursue them.

Q Doctor, it's happened before that sometimes a patient may say, Well, I was feeling this in the emergency room, they must not have written it down. Do you do things to try and make sure that you document all of the complaints that a patient makes?

A Yes.

Q So neither of these patients complained of any

lumbar complaints; is that true?

A So for Cervantes-Lopez's nursing documentation, I cannot find any documentation of that. There is -- there is some scribble on back on the nurse's note there that I can't -- I don't know what is written there. Then in my documentation on Cervantes-Lopez, I don't have any documentation that there was any tenderness, back tenderness.

Q What was your recommendation for Ms. Abarca for care after she left the emergency room?

A She was given -- per the documentation, she was given discharge instructions. However, I would have to find out what the exact discharge instructions were. We have standardized written discharge instructions for motor vehicle crash, musculoskeletal strain, cervical strain. Based on my past practice, that's what would have been given. Exactly what was given, I can't comment on that, though.

Q Let's just talk about the typical treatment for abdominal wall pain. Is the treatment that you would give to someone who had abdominal wall pain from a car accident different from that that you would give to someone who wasn't in a car accident?

A No. Again, abdominal wall strain is -- falls into the musculoskeletal strain, contusion, injury group. The discharge instructions are usually the same, antiinflammatory, ice, rest.

Q Could the same be said for the cervical strain?
A Yes.
Q So you give the same treatment to people who even haven't sustained a trauma, but have a cervical strain; is that a fair statement?
A Yes, that's correct.
Q How about for Mr. Cervantes-Lopez; what were his orders or recommendations for follow-up care?
A Per the documentation that I have for Mr. Cervantes, patient was discharged home and instructed to follow up with his doctor as needed and come back if worse. Again, it's not documented, although the -- I believe the full medical record would have a form where the patient signed what instruction they were given. Again, in this patient, since there was some questionable concern for a head injury, although no clinical findings, a CAT scan was performed. And patient would have most likely been given head injury instructions, and then that's probably what have occurred in this case.
Q Does your clinical impression include an opinion as to what caused the conditions that you diagnosed?
A Based on my documentation, yes.
Q And what is that?
A It was my impression that Mr. Cervantes was in a car accident. Based on my documentation and presented with

the complaint of headache, nausea, and vomiting, and based on the fact that he stated he was in a car accident, it was my impression that his symptoms were related to the car accident, and the workup and physical exam were very minimal. I didn't find anything.

MR. MICHALEK: Is 32 -- we have 32?

MR. MILLER: Yeah.

Q Did you make any recommendations to either of these patients with respect to limitations on their work or activities?

A Based on my documentation, no.

Q Were the findings of that physical exam consistent with their complaints that they were reporting?

A Again, based on the documentation, Cervantes-Lopez's physical exam was essentially, from my review of my documentation, unremarkable. His complaints were more symptomatic, nausea and headache.

Q Can patients have symptoms such as nausea or headache without having something showing up on the CT scan?

A Yes.

Q How about with Ms. Abarca, were her physical exam findings consistent with her complaints?

A Yes.

Q You talked a little bit about recommendations and some standard discharge instructions. Do those standard

instructions include recommendations for patients to follow up if they need additional care?

A Yes. Most of our -- standard practice in our emergency department is all patients, the emergency department is just a preliminary evaluation. It's not -- it's not considered a complete evaluation. All patients require a follow-up visit.

Q So is it fair to say that you wouldn't expect patients you see in the emergency room to return to you, but to go to a specific or their own doctor or somebody like that?

A That is correct.

Q I just want to be clear, Doctor, based on the information you have in your records, is it most likely that their complaints are in relation to a car accident?

A The documentation of these two patients?

Q Yes.

A Based on the documentation, it appears of their symptoms and reason for being in the UMC trauma department was due to a car accident.

Q And then, Doctor, is it reasonable that sometimes patients in car accidents with soft-tissue injuries may develop pain or complaints later, such as 24 hours later?

A It does occur.

Q Doctor, in your experience, would you agree that adrenaline can sometimes cause a patient to not recognize pain

or complaints they may have until a later period?

A I can't say that. I'm not aware of any literature that describes adrenaline as something that would cover up significant injuries.

MR. MICHALEK: Mercifully, Your Honor, we're done with that deposition.

THE COURT: All right. Are you going to move to Dr. McCourt?

MR. MILLER: Coppel now.

THE COURT: Coppel, I'm sorry.

MR. MILLER: Yes.

MR. MICHALEK: Does he need to be sworn in again?

THE COURT: No, I think we're fine.

MR. SIMON: Your Honor, we'll call Dr. Coppel to the stand.

(Deposition of DR. COPPEL read as follows.)

Q Doctor, tell me a little bit about your educational background.

A Sure. Medical school at University of Arizona. I did my residency in anesthesia with the critical care at the University of Chicago, my fellowship in interventional pain management at Johns Hopkins, and I finished all of my training in 2006. 2006 I moved to Las Vegas to start practicing as an interventional pain physician. I was originally working with the group Centennial Spine and Pain Center, and then started

my own practice in 2009. And then I'm the owner of Nevada Comprehensive Pain Center.

Q And did you start Nevada Comprehensive Pain in 2009?

A Yes.

Q Are you board-certified?

A Yes.

Q That's in anesthesiology or is that pain management?

A Anesthesiology as well as pain management.

Q Do you have any hospital privileges?

A I have hospital privileges at North Vista Hospital, but we do not do any hospital work.

Q Did you check with Mr. Cervantes-Lopez's records and see if it's the same?

A So I have for him -- or so -- for him I have lumbar MRI on 2/7/12 at Advantage Diagnostic Imaging. I have looks like it's hospital records, doesn't say what hospital it's from. Says Trauma Center Report -- oh, it's from University Medical Center. Looks like a CT of the brain from University Medical Center, a referral from Dr. Adair. Looks like what's their intake, and the same thing, a couple of clinic from him or her. And then he's got three clinic notes of theirs, which is just handwritten notes.

Q Have you seen any expert reports from either

side in this case?

A No.

Q Have you reviewed any photos of the accident, incident reports, or traffic accident reports?

A No.

Q Have you ever testified in trial?

A Yes. I think twice. And the last one I can't remember, but it was, like, over a year ago.

Q Were you testifying for a plaintiff in each of those trials?

A It was for a patient I treated, but it was -- it was as a treating physician. It wasn't as an expert witness.

Q You've never testified as an expert for a person who is being sued in a lawsuit; is that true?

A Not that I know of. I don't know if somebody might have designated as an expert, but to my knowledge, I've always treated the patients that they ask me to have the depos on or court cases or arbitrations.

Q Do you know who referred Ms. Abarca and Mr. Cervantes-Lopez to your office?

A Dr. Adair.

Q So when did you first see Maria?

A So the initial visit was on February 22nd of 2012.

Q When did you last see Maria?

A Her last visit with me was on May 18th, 2012.
Q Doctor, do you know what the customary charge in the Las Vegas area code is for, for example, CPT code 99242?
A Which one is that one?
Q Office consultation.
A I'd say in range anywhere from -- well, it depends, what specialty, I guess, are you talking about?
Q Yours.
A I'm not privy to other peoples' billing, necessarily. I've seen them in depos when I've been asked to review records. And I've seen them go anywhere from $300 as high as $7-$800. But those are usually proprietary information to each practice, so we can't just call up somebody and say, Hey, listen, I want to know what you charge for X, Y, and Z.
Q Do you believe you charge above, below, or at the community average for that type of procedure?
A I think we're about average.
Q And do you feel the same with all of your charges?
A Yes.
Q Who told you that your charges were average or reasonable?
A So reasonable is depending on what you see fit, as you decide what you want to charge for your charges. So

you may say, I went to Harvard Law School, so I deserve to charge much higher than somebody who went to Eastern Tennessee Law School. Reasonable is whatever you decide to do and whatever, in a capitalistic society where people are willing to pay one. But the average itself, we're about average. I've seen -- once again, I used to work at Centennial Spine and Pain Center. Our billing charges are almost identical. So I kind of set it up that way when I left.

And then with what I've seen in the community, there's people that charge higher than we charge and also lower than we charge. So we're pretty much on average, on par with what the Las Vegas community is.

Q Now, you've testified that you believe your charges are about average. Do you know specifically in what percentile your rates are?

A You can give me the information. I'll be happy to point it out to you.

Q But you don't have it?

A It's not available. It doesn't exist and it's not published.

Q When you were billing for your services in this office, do you enter in a description of the service and someone assigns a CPT code to that, or do you enter the CPT code in yourself, and then someone just generates an invoice using that code?

A I select the CPT code.

Q So there's no extra person or other person in the chain between the service and the bill who has to interpret what you've done and assign a charge to it; it just goes by the code?

A Yes.

Q Have you had training in the use of CPT codes?

A How does this -- because I'm not going to answer any other further questions unless you're going to ask me about the treatment of the patient. If you want to ask me about the way we practice, the way we practice is set up, about the billing, I'm happy to go in there with the discovery commissioner, present your questions in person, and we'll answer those.

So once again, somebody comes, I see the patient. I assign the appropriate CPT code to where the billing has already been decided because it's a master charge sheet. So whatever that gets cross-referenced to, that's what the billing is. It's a computerized system. That is it. I decided what the billing rates were set back when I started my practice in 2006 here. It was comparable to what it was at Centennial Spine and Pain Center. And from what records that I've been privy to by reviewing them with other depositions, I've been able to say, yeah, my charges are about reasonable and average for the community. There's nothing published out

there that I can compare myself to, because it's not available for Las Vegas for the specialty that I'm in.

So I'm willing to answer all the questions you want to ask specifically about this patient. But if you're asking me general questions about the practice, it's irrelevant to what I'm here for. And if you want to set up a whole different deposition for that, I'm happy to go in front of the discovery commissioner. We already did do that because we got depo'd for a person most knowledgeable.

MR. MICHALEK: Your Honor, can we approach for a second?

THE COURT: Yes.

THE WITNESS: Yeah.

(Bench conference.)

MR. MICHALEK: There's a reference to --

THE COURT: What -- where did you start?

MR. MICHALEK: He had gotten to -- right here. So then... So I think this would be all this going into the next question.

THE COURT: Yeah. You want to just confirm that Danny's okay --

MR. MICHALEK: Right.

THE COURT: -- with you skipping that.

MR. MICHALEK: Yeah.

(End of bench conference.)

THE COURT: You going to just show him which line you're going to skip?

MR. MICHALEK: We're on the same.

THE COURT: Okay.

MR. MICHALEK: Yeah.

Q So did you answer my question as to whether you have training in the use of CPT codes?

A We all do. Every physician is trained to do it. Every physician is responsible for their own coding at the end of the day, and that's per Medicare guidelines, physician guidelines, AMA guidelines. So the answer is whether you had training or didn't have training, you're responsible for it, simple as that. So my training, if you want to call up Johns Hopkins and University of Chicago and see if there was a specific module that is recognized by the AMA as training, the answer is you'll have to get that from them. Do we know how to train and to code? Absolutely. We have to or else we won't be able to bill.

Q Do you agree with the general proposition that the likelihood of injury is proportional to the force of the trauma?

A That's one of the factors, yes. But there's also a couple other factors that may go along with it.

Q What are those other factors?

A Could be the -- basically, the force of the

injury, vectors of the injury, positioning, type of injury, twisting versus blunt force versus a variety of other things, gunshot wounds. The age of the patient could do something with it. Medical history of the patient can also be associated with it. So there's a variety of factors that go into it.

Q Have you ever testified in a personal injury case that your patient's complaints were not caused by the accident that generated a lawsuit?

A Yes.

Q And what situation was that?

MR. MILLER: That -- that part's out.

MR. MICHALEK: Is it?

MR. MILLER: Yeah. Down to 23.

Q So large gaps in care or gaps in complaints are things that you also think are significant when determining the causation?

A Well, no. I mean, gaps in care, no. Because, I mean, you could be injured and not seek out medical attention. But if you've been seeing a physician and all of a sudden the symptom pops up a year and a half later that had nothing to do with anything you've ever described before, then that obviously has nothing to do with it.

But if you have, let's say, back pain, I saw a lady today, back pain, she had left the country, went to Thailand,

came back three months later, still had the same back pain. There's a three-month gap in treatment, but it was still the same symptoms.

At that point you would have to ask, Did you have any other instigating events in those three months, yes or no? Is the pain that you're having in the location with the same quality as it was before, yes or no? If it is, then it's the same type of pain. If it's something completely different, then you have to investigate why it's different or what else it could be.

Q What about a patient who has no gap in care, but has a gap in symptoms?

A Can be. Symptoms can come and go. I mean, we don't cure everybody we see. There's plenty of people that we see that we'll do an injection on, get better, and the symptoms come back a year later or six months later or what have you.

Q Is there a threshold to you as far as a gap in symptoms where you would start to question whether it's still related to the initial event?

A It depends on the symptoms, the location. The treatments that were done for that.

Q What do you know about the motor vehicle accident at issue in this case?

A So the way it was described to us, I did not

have police reports, obviously, verifying this, this is what the patient told us. So the restrained passenger was Maria Abarca, driver was Christian. So they were driving a 2001 Chevrolet Impala that collided with another Chevrolet Impala. They're saying they were -- that the other Chevrolet Impala failed to yield while he was attempting to make a left-hand turn. Driver wasn't able to stop in time and collided with the other vehicle.

She lost consciousness for a brief moment, I don't think he did. Airbags did not deploy. The police did show up to the scene of the accident and made a report. An ambulance came to the scene of the accident and took Maria to the hospital, University Medical Hospital, but not Christian. She was treated in the emergency department, discharged in stable condition.

And then he, when he showed up to the emergency department, not by ambulance, started to have symptoms that were significant at that point. Then he was seen in the emergency department. So he didn't actually go by ambulance. He went there because I'm assuming they're husband and wife. And then his symptoms started then and he was at -- he was seen at the emergency department.

Q All right. What diagnosis have you made with relation to Ms. Abarca?

A So, basically, she came in complaining of back

pain that was going to into the bilateral lower extremities. Complaining of intermittent numbness down the legs. Pain score was 4 out of 10. Can go from 2 to 6 out of 10. MRI finding showed disc bulge at L4-L5, 1 millimeter, a disc bulge a L5-S1, a protrusion at L5-S1, 2 to 3 millimeters, with an annular fissure. So given her symptoms, the diagnosis I gave her was a lumbar disc displacement, according to the MRI, and lumbar facet syndrome, and lumbar radiculitis/radiculopathy.

Q Were those preliminary diagnoses or did those end up being the same diagnoses that were carried through her treatment?

A Well, they're preliminary. So the facet syndrome is presumed, because you're having axial pain. The only way you could really tell whether that's a true diagnosis or not is by doing procedures for it. The disc displacement is based 100 percent on the MRI. You can have no symptoms but have an MRI that has a disc displacement. So that could be a diagnosis.

The radiculitis/radiculopathy is because she was complaining of radicular symptoms going down the legs. So that could be independent of basically a physical examination. That can also be independent of an MRI.

Q For how long had she had radicular symptoms?

A I don't know. The visit with us, which was -- the accident was on 11/12/11, she saw us on 2/22/2012. So

that's three and a half months afterwards. So that point is when I gave the diagnosis.

Q All right. So with respect to the facet diagnosis, what was the physiological cause of the symptoms?

A So you could have sudden acceleration/deceleration injuries to the facet joints. She also had straight-leg raised test that was equivocal. And she had concordant pain which was on extension and rotation, which could be facet loading that could cause reproduced pain.

Q Tell me what the injury to the facet is. Nothing is broken, correct?

A No. It could be like small tears of the -- and inflammation of the joints. So it's just like if I grabbed your knee and then suddenly jerked it forward and backwards, there may not be any bony injury to it, but you can have inflammation because of the sudden motion that you get, micro tears of the ligaments and the joint capsules in that area.

Q How about the radicular diagnosis, what was the physiological issue there?

A So, basically, you could have a disc bulge that could mechanically press up against the nerve and give you shooting pains down the leg or neuropathic pains down the leg. You could also have an annular fissure if the material inside the disc leaks out. It can chemically irritate a nerve root even without a disc bulge or protrusion there, and that can

give you similar symptoms.

So the fact that she was describing to me symptoms that were traveling down her legs, that's why she gets the radiculitis/radiculopathy diagnosis.

Q So it's your understanding that the bulge and the fissure that were identified on MRI were causing -- these are the physical abnormalities that were causing some of these symptoms?

A That could be causing the symptoms, yes. You don't really ever know until you actually do an interventional procedure, which is diagnostic and therapeutic.

Q Okay. Did you perform any such procedures?

A Yeah. We recommended to her that -- to her that may benefit from bilateral transforaminal epidural injections at L5-S1. We recommended the single level, because I think that's where the majority of the pathology was, despite the fact that she had a small disc bulge above that at L4-L5. That was performed on 5/4/12. She pretty much got significant improvement of her symptoms and she never came back after that.

Q So was that a diagnostic as well as a therapeutic injection?

A Yes.

Q So what diagnosis or diagnoses did it support?

A That the issue that was causing her symptoms was

the disc bulge with annular fissure.

Q Now, did the MRI show that the disc, the bulging disc, was actually impinging on any nerves?

A It showed a protrusion, and then the annular fissure. You'd have to ask the radiologist to look specifically at the MRI for that. But like I said, you can still have chemical irritation even if you don't have a disc bulge or a protrusion. It could be on a normal disc that has an annular fissure and you get similar symptoms.

Q What's the timeframe if -- well, let me ask you this. Is it your assumption, then, that this car accident caused the annular fissure?

A No. It's my assumption that the car accident caused her symptoms. And that's what we were treating. So if she would have come in to me and said, Right now my pain levels are 2 out of 10 and it's very mild, very intermittent, really then there's nothing for me to do. So even if I would have seen a 15-millimeter protrusion with an annular fissure, I wouldn't have done anything about it. So what we're trying to do is treat her symptoms as opposed to treating the fissure or the disc bulge.

Q So whether or not -- so you don't have an opinion as to whether it was the bulge or the fissure that were causing the symptoms?

A No, you can't tell, because the medication would

work for both. There's not a specific injection that could separate those two pain sources.

Q And then you don't have any opinion as to when the fissure was created?

A No.

Q Or how it was created?

A No.

Q And how about for the disc bulge?

A Same.

Q Do you have an opinion on how soon after trauma you would expect symptoms to begin if the bulge or the fissure were causing the symptoms?

A It could be immediate or it could be a couple of months down the road.

Q That's even for the chemical irritation from the leaking disc?

A Yeah. Because you can have a small fissure and then slowly it starts to expand. And that's why you can get symptoms that can come back a month or two months after that. But it's typical to say -- but, basically, the way pain management works is you come in with specific symptoms. We get the MRI to try to hopefully pare down our diagnosis. But that MRI is just a moment in time. Can't really say that disc bulge was probably 1 millimeter a month ago and now it's 2, and next month it'll be 3. It is and what it is. And that's

what we use to help guide her treatment along with physical examination, and also along the way with the patient describes her symptoms.

Q Did Ms. Abarca describe to you any other events that could have instigated her symptoms other than the car accident?

A We asked her and she says she denies a history of low-back pain prior to the accident.

Q What about subsequent?

A Basically, that's what it is. So we basically say when somebody comes in, I'll ask them to give me the history of the car accident. We document it and say, Has there ever been any other sports injuries, work injuries, other motor vehicle accidents? And if the answer's no, then there's no history. If the answer's yes within the last five years, then we'll document it.

Q Do you ever treat patients who in doing just mundane things, everyday chores or everyday activities, suffer an injury that requires your type of medical care?

A Yes.

Q And when those people come in, do you ever have to help them distinguish between an injury that occurred from a mundane incident as opposed to something more traumatic, like a car accident or a slip-and-fall?

A Kind of a confusing question, because if they

just have mundane, that's what -- what it is. But if they had a car accident, they had it. But at the end of the day, it's what we're treating the symptoms that are present in front of us. Sometimes you never know why something happens. People want to say why this -- did this happen to me -- why did this happen to me? I have no idea. And it's, to be honest with you, kind of irrelevant, because we're going to treat it the exact same way.

Whether this was a car accident that caused her back pain with her legs, picking up a box, or going to work, that is more important in terms of assigning for you guys medical legal purposes. For a physician, it's irrelevant. I'm treating the symptoms that are there.

Q Your job and your training focus on treating symptoms and conditions to improve the lives of your patients; is that a fair statement?

A Yes.

Q And so whether pain is caused by something traumatic, like a car accident, or something degenerative, while that may be clinically interesting or legally noteworthy, it doesn't really have an effect on how you treat those conditions, fair statement?

A Yes.

Q Did you get significant training in how to determine whether a particular diagnosis was caused by trauma,

one trauma versus another trauma?

A No. Once again, it's basically common-sense stuff. So if somebody says, you know, I was pain free until I was assaulted outside a casino and hit in the head with a baseball bat, I developed headache after this, most common-sense people say it's probably coming from the trauma.

In terms of somebody who comes in with symptoms and they say, Doc, you know, I do this for a living, I play sports, I do repetitive motions, I did have this injury at work six years ago and now I'm having these symptoms, why? Once again, it's difficult to say, but the fact is you're having these symptoms and you're here because they're bothersome to you. And we'll say, Look, this is what we think it's coming from, not why it's occurred. And this is what your treatment options are. If you want to do something about it, these are what they are. If you decide not to do anything about it, we're okay with that.

Q If a patient who is treating with you, say, a car accident, and symptoms resolve, and then a mundane activity seems to cause new symptoms or an exacerbation or a reoccurrence of the symptoms, do you try to determine whether that exacerbation is because of the original accident or something independent from that?

A I mean, you can. But the best way to really -- and it's happened to me before -- are these the exact same

symptoms you had before in the same location? If the answer is yes, then we treat it as it was the same injury until otherwise proven -- until proven otherwise. But we would not ever say, you know, I -- I do an injection on you, your symptoms go away, you come back at five months later, the symptoms are the same. I'm not going to see -- say, Look, I need to get another MRI. If the symptoms are identical, we treat it the exact same way. We assumed, with more-reasonable-than-not diagnosis, that it's going to be the same thing.

Q Does the MRI show any degenerative conditions?

A She had desiccation at L5-S1, which could be either degenerative or if you have a traumatic annular fissure, it can cause significant degeneration. It would be kind of weird that somebody who was 27 years old to have a severe desiccation of a disc without a traumatic injury. But it could happen. Not likely.

Disc protrusion, 3 millimeters, once again, the likelihood that a 27-year-old is much less likely than me or you having it, but it's there. Annular fissure, once again, it's also less likely when you're young as opposed to when you're older.

Q Are there any conditions, any physical conditions you identified in Ms. Abarca that could have been caused by something other than this car accident?

A So once again, like I said, the degeneration can happen. But it's unlikely at somebody who's 27 years old. And once again, we're not really treating the MRI findings. We're treating more the symptomatology. Then unless I'm presenting with some evidence saying yes, she sought out treatments for these symptoms beforehand, or she had it and they were significant enough for her to seek out treatment, and then you have to -- a normal person would assume that if she says it began after this injury, then it began after the injury.

Q Now, it sounds like -- and you wouldn't be the only doctor that I think does this -- it sounds like you operate generally. There's probably expectations to everything. But you operate generally under the assumption that if a person has significant symptoms, they will probably get treatment; is that a fair statement?

A Yes.

Q And then you do operate on the opposite of that, as well, where if someone has no symptoms, then they typically do not seek treatment?

A It's typical for most patients.

Q And your opinion is that the car accident caused the onset of these symptoms?

A According to the way she described it, yes.

Q Did you perform any test to assess the validity

of Ms. Abarca's complaints or symptoms?

A I mean, the symptoms is basically what she described, so she -- we can't really test the validity of that, obviously. But the physical examination, we did Waddell's testing, and that was negative. And that typically tries to tease out somebody who might be overly embellishing their symptoms.

Q And are you aware of any physiological problems that she has had or had?

A Not that I'm aware.

Q And so in Ms. Abarca's case in her reporting on the subsequent follow-up visit, so that it was not -- these were not false results that she gave you?

A Right. It's an 80-percent benefit she reported. I mean, we typically always ask people right before the procedure what their pain score is and the like as they're being wheeled out. We do that simply because we have to, but it's sort of irrelevant, to be honest with you. It's mostly we base everything on about two weeks afterwards, what your response was at that point. And that's what bases our further treatment or nontreatment.

Q As far as you know, is Maria Abarca's pain better today than it was the day you met her?

A As far as I know, from my last office visit compared to the first, it was better. I haven't seen her.

Obviously, it's been almost been two years now. So I'm not sure -- I'm not sure how it is at this point.

Q Did she have any atrophy or decreased muscle tone?

A Not that I noted. So the pertinent abnormals were decreased lordosis, tenderness over the spinous process, tenderness over the ligaments and facet column, decreased range of motion, equivocal straight-leg raised test, meaning that when you raise a leg up and put it back down, it actually replicates axial pain, but nothing that shoots down the legs. Normal reflexes, normal strength, and normal sensation.

Q Did the MRI show any evidence of nerve root compression?

A Once again, you have to ask the radiologist. They describe it as a protrusion, 2 to 3 millimeters.

Q Could a patient present to you and bring you an identical MRI report and not have the same symptoms that Ms. Abarca reported to you?

A Yes.

Q And in this case, you didn't get the films to read, or did you?

A Not that I documented. But once again, what we document is the actual report itself. So even if I see the MRIs, we document the actual report, because that's the official reading.

Q So you don't have an opinion as whether any radiologist may have over-read the MRI in this case?

A Correct.

Q Do you know whether Dr. Duke is a competent neurosurgeon?

A It's not me to opine. He's either board-certified or not board-certified. Like any physician, I'm sure he has people that love him and other people that hate him. It always depends on the outcomes, unfortunately.

Q I believe you testified you haven't seen any of the expert reports in this case, true?

A Yes.

Q So I guess you're not really in a position to offer any criticisms of any of those reports?

A Correct.

Q Did you ever tell Ms. Abarca that she should limit her activities in any way?

A No.

Q And was she pain-free at the last visit?

A No. I think she was pretty mild and intermittent. I think she had discontinued the oral -- oral medications, so we basically told her just come back as needed. There was nothing further we wanted to do at that time.

Q So you don't have a formal future treatment plan

for Ms. Abarca, true?

A Correct.

Q Are your opinions today to a reasonable degree of medical probability?

A Yes.

Q What does that mean to you? What does that term, reasonable degree of medical probability, mean to you?

A I guess what it means, it's reasonable, it's pretty much middle of the road, and it's probable.

Q He said that he -- and I'm paraphrasing, but he said, basically, while patients' symptoms can wax and wane, he never really expects them -- or I guess it's unusual for a patient to have a long-term trend in one direction then have a sudden, drastic reversal in another direction after something new happening. Do you generally -- generally agree with that statement?

A Yeah, in general. But, I mean, there's also exceptions to that. Most people, let's say what we normally see with people that come to us that have failed therapies in medication management, and time is either the therapies were beneficial, then they plateaued and they failed to be any further beneficial, or they were never beneficial at all, or they were beneficial, but as soon as they stopped, then their symptoms came back. So I'm sure he would attest to it.

As a pain management physician, he gives people

medications. It's beneficial. If he stops their medications, their pain levels can dramatically increase with the exact same conditions.

Q Do you have any indication as to how well the chiropractic care that Ms. Abarca received functioned for her?

A So it's 4 out of 10 pain score. I don't know what the original pain score was. I'm assuming it was significant enough to go to the hospital. It was high up there. So at the time she saw me, she was doing therapies just once a week. And I typically tell my patients usually after two to three months of any particular therapy that you're going to probably maximize that therapy out. So more of the same isn't going to give you any further benefit.

Q Do you know or have you made an assumption as to what the trends were for Ms. Abarca's symptoms from the time of the accident to the time she came to see you?

A I'm assuming she got, once again, some benefit. Because a 4 out of 10 score, I wouldn't expect somebody to seek out medical attention by ambulance to a hospital for that. I mean, you'd have to trend more of the chiropractic pain levels. But by the time she got to us, she was a 4 out of 10 pain score, varying between the two to a 6. But it was significant enough for her to want to do something about it.

Q So with respect to his version of how the accident happened, was he wearing a seatbelt?

A Yeah. He said he was the restrained driver of the Impala.

Q Do you know if his body struck anything on the inside of the car?

A Not that I'm aware of.

Q Did he say he lost consciousness?

A He did not lose consciousness. Once again, the airbags did not deploy.

Q Did he tell you whether he was dazed or stunned as a result?

A He did not indicate that.

Q Did he indicate whether he was bleeding at the scene of the accident?

A We do not have that documented.

Q Is it documented whether he had any cuts, bruises, or swelling?

A No.

Q Did he tell you what his symptoms were at the scene of the accident?

A I don't think he had -- I think he said -- basically, the patient report says he was with his passenger at UMC Hospital, he began to feel pain and was evaluated at the emergency department. So I'm assuming at least the significant symptoms started when he was at the hospital. I'm not sure how long it -- how long it took him to go from the

scene of the accident to the hospital.

Q So what diagnosis did you make for Mr. Cervantes-Lopez?

A So, basically, he had just low-back pain that was going to in the paralumbar area. The diagnosis for him at that time, according to the description of the pain and the physical exam and the MRI findings, was facet syndrome and disc displacement. The facet syndrome, once again, because he had the axial low-back pain, the mechanism of injury could lead to a facet syndrome. The disc displacement was based on the MRI findings.

Q And so what disc or discs were displaced?

A So at L4-L5, he had a 1- to 2-millimeter bulge, and then at L5-S1, he had a 4-millimeter protrusion. He also had foraminal narrowing.

Q Did you ever form an opinion as to whether it was one or both of these discs that were causing symptoms?

A No. I thought it was more the L5-S1 is I think 1 or 2 millimeters. The likelihood of that being symptomatic is pretty small.

Q Were there any degenerative conditions present in the MRI reports?

A Severe desiccation at L5-S1, that could be degenerative. Once again, 24-year-old male, so severe degeneration or severe desiccation is pretty -- so severe

desiccation could lead to -- could be degenerative, but it's highly unlikely at 24 years old, but still a possibility. Once again, disc bulges can be degenerative in nature, as well. Anything 24, less likely than a bit older. I think those are the only two abnormalities that they saw.

Q So mostly based on his age is the reason you suspect that the positive on the MRI are traumatic versus degenerative?

A Yes.

Q Now, did you provide injections to Christian, as well?

A Yes. I think he originally underwent bilateral transforaminal epidural injections at L5-S1. He had those performed on 3/2/2012. He had reported some 70-percent benefit from the procedures. The pain after those were mild and intermittent, so he diminished the frequency of therapies. He discontinued the oral medications that we had provided him, which was a muscle relaxer and an antiinflammatory.

At that visit, which was on March 20th of 2012, which is basically we told him to come back as needed, because he was feeling better. And then he came back on May 2nd of 2012, so about two months later, complaining of the same symptoms, saying that the injection, basically, had worn off. So we recommended to him symptoms at same location, same quality, so recommended a repeat injection at the same levels. He had the

repeat injection on 5/18/2012, 80-percent benefit. Pain, again, was mild and intermittent. So we told him to just come back as needed, and that was the last time we saw him.

Q Did you give him the same type of injection that you did to Maria?

A Yes. It was bilateral transforaminal at L5-S1.

Q So that was at a different level, same type?

A No, same level, L5-S1, and then the same type of injection.

Q Now, the 4-millimeter disc bulge that you believe would be very -- sounds like you're saying it would be unlikely for that to be degenerative because of his age?

A Correct.

Q That bulge could be caused by repetitive actions or a singular traumatic event; is that a fair statement?

A Yeah. I mean, it could be a variety of things, but yeah.

Q Did you ever tell Christian that he should not be working or should be altering his activities?

A No. Not that I recall.

Q Do you know anything about Christian's job duties?

A So the time that he saw us, he was working for -- full-time for DL Denman as a -- looks like a machinist. Machine work.

Q Do you know what his job duties included?
A No.
Q So as far as you know, he's been able to work today, is that true?
A Well, the last time I saw him, his pain was very mild and intermittent. So I'm not sure why he would not be able to work.
Q And what were his symptoms on his last visit?
A Pain level at the last visit was described as a 2.
Q Do you have a future treatment plan for Christian?
A No. He hasn't come in what, two years or so, so I'm assuming he's pain-free.
Q Do you know when Christian first complained of back pain?
A I do not. But I'm assuming it was at the emergency department. And then he said he saw the chiropractic about three days after the accident. So I would kind of look at the chiropractor's records to see when the first time he complained of that.
Q Did you know how effective the chiropractic treatments were for Christian?
A I think similar to her. It must have provided some benefit, but not complete benefit. He was still having

issues that were bothersome to him, so I'm assuming that's why they got the MRI. And then he continued to have symptoms that were bothersome, and I'm assuming that's when they were referred over to our practice.

Q Do you believe that the information you used to select at what level to give the injections to Christian was appropriate was the same thing as any management doctor would do in your position?

A Yeah. I think the question at that point would be -- is the disc. So between the two discs, you know, there's two disc bulges, really. The one on top I think was pretty small, so most likely not contributing any symptoms. Then you have a 4-millimeter disc bulge that can cause symptoms. But the question is whether the symptoms are coming from the disc or maybe from the facet joints. Really don't know.

And then clinical experience and, basically, usually plays into that. I thought it was more at the point a disc, but I wasn't 100 percent sure. So we do that procedure. He got, I think, 70-percent benefit with the original one and 80 percent with the next one. So to me that would indicate that that's the main cause of pain versus the joints. If we would have done that and he would have said, I didn't get any real benefit from it, then I would have said, Look, it's probably not the disc, even though it's there. It's probably going to

be more of the facet joints.

Q Well, was there any period of time where Mr. -- well, where either Ms. Abarca or Christian were using medications as attempt to manage their pain?

A Yes. They both came in on Tylenol. And then we prescribed him the initial visit. For him we prescribed a Naproxen and soma. I think it was the same medications for her. What we typically tell people is when they come in, is if they haven't tried medications, we'll say, Look, these are the procedures that we could do, but we're going to prescribe these medications. If the medications take care of symptoms, obviously, don't get the procedure done. If you try the medication and the symptoms continue, then proceed with the recommended injections.

Q So, in this case, the medications didn't resolve their symptoms, and so you proceeded with injections?

A Correct. I'm assuming that, obviously, we did the injections before we can ask them whether the medications are working or not. So, you know, you can't -- you know what I'm saying, we always assume that they're not going to make the appointment if they're feeling better.

Q In this case, with the patients Christian and Maria, did you -- during your treatment of them, did you have any indications that either of them were showing signs of malingering?

A No.

Q Do you have -- during your treatment of these two patients, did you have any indications that either of them were not being truthful with you?

A No.

Q Did anybody today present to you any medical records or evidence indicating that they had symptoms or complaints of pain prior to the subject accident?

A No.

Q In terms of the treatment you provided to Christian or Maria, is the treatment related to the subject accident?

A Yes. Because they reported the symptoms began after the subject accident.

Q And know there was some talk about your understanding of the concept reasonable degree of medical probability. Would you understanding of that include the phrase more likely than not?

A Yes. Absolutely. That's a disc bulge. Most likely than not, it's A and then B and C. So every physician, whether they use that specific word, has that in their mentality.

Q And so are your opinions today regarding your treatment and the relation to the subject accident to a reasonable degree of medical probability?

A Yes.

Q In terms of the charges assessed for your treatment for Christian and Maria, are those reasonable and customary for this community?

A Yes.

Q And are those charges, is that opinion to a reasonable degree of medical probability?

A Yes.

Q Is it your understanding that an MRI can correlate symptoms to complaints related to by a patient?

A Yeah. It's a tool that we use to kind of correlate what they're reporting subjective with something that's objective.

Q Did the MRIs for Christian and Maria correlate the symptoms and complaints they related to you?

A Yes.

Q I asked you some questions with respect to Maria, but I didn't ask those same questions with respect to Christian, about the bulges or the protrusion and the bulge that you saw on the MRI. But if those were caused by this accident, do you believe there's a timeframe in which they're more likely to demonstrate symptoms?

A Once again, it's difficult to say. I've seen symptoms start out once again immediately after an accident. They can appear up to a couple of months afterwards. Most

reasonable physicians, pain management physicians, say at about six weeks is you're going to show the symptoms that you can have from that specific injury.

MR. MICHALEK: And that's finished with that deposition, Your Honor.

THE COURT: All right. So counsel for the plaintiff, do you have any other witnesses in your case?

MR. SIMON: No, Your Honor.

THE COURT: All right. And by the defense, do you have any additional witnesses in your case?

MR. BAIRD: No. There's no witnesses, Your Honor. There's one exhibit issue that maybe we should approach and address.

THE COURT: Sure. That's fine. Actually, you know what, we're going to have to give the jury a break --

MR. BAIRD: Oh, yeah. Let's do that.

THE COURT: -- anyways, because of the jury instructions.

MR. BAIRD: Sure.

THE COURT: Why don't we do this. This is what's going to happen, ladies and gentlemen of the jury. At this point both the plaintiff and the defense, they have rested. They have no other witnesses to present to you. We're going to give you a little bit longer of a break. Let's going to come back when -- what's going to happen when you come back

from the break is I'm going to give you jury instructions. That's what we told you at the very beginning of the case, that's going to be the law that's going to guide you in your deliberations. After I have an opportunity to give you the jury instructions, the law, the plaintiff will have an opportunity -- opportunity to present closing argument and the defense will have an opportunity to present their closing argument, and the State -- I'm sorry, the plaintiff may choose to do a rebuttal.

So why don't you come back at 2:40. And again, remember, you cannot converse amongst yourselves, you cannot do any research, and you cannot form or express an opinion.

I'll see you soon.

(Jury recessed at 2:26 p.m.)

THE COURT: All right. Let's just address the jury instruction real quick. The Klietz, I read that case. That case deals with joint and several liability. If we're looking -- if I'm looking at the right case, Klietz versus -- make sure I've got the right one. Isn't that the joint and several case?

MR. MICHALEK: Yes, Your Honor.

THE COURT: I don't really see the applicability.

MR. BAIRD: We have the -- hopefully, I asked my office to fax over the Giglio case, that is one of the cases I was talking about.

THE COURT: Do you have the cite? I'm on Westlaw right now.

MR. BAIRD: Oh. Let me pull it up here.

THE COURT: Is it FGA vs. Giglio?

MR. BAIRD: That's the one, Your Honor.

THE COURT: G-I-G-L-I-O?

MR. BAIRD: Correct.

THE COURT: So that's 278 P.3D 490. And why am I looking at this case?

MR. BAIRD: As you go down, Your Honor, it talks about whether sufficient evidence was presented to present to the jury alternative causes. And before the Supreme Court arrived at their decision on that issue, they talked about how the standard for admitting medical testimony and -- and it is clear in their decision there that the defendants are not obligated to provide alternative causes. The --

THE COURT: I don't think you're obligated to provide alternative causes.

MR. BAIRD: Well, that was our concern [indiscernible]. It sounds like he's saying if they get -- if they present evidence on a cause, then we have to present an alternative cause, when that's not true. We just -- we can rebut and say it's not what they say. And that's all we have to do. And we're allowed to end it there, as well.

MR. SIMON: And I don't disagree with that. I don't

think that they have to present an alternative cause. But if they do get up and argue some alternative causes that don't exist in the record, I don't think they can do that, either. And if they do, then that's what this jury instruction tells the jury what they need to do with it.

MR. BAIRD: So it seems to me that in any case, that this jury instruction at issue doesn't apply. Because it isn't a joint and several situation.

THE COURT: It isn't -- again, I kind of agree with defense counsel, I don't think it applies. That case talks about joint and several liability when there's two motor vehicle accidents.

MR. SIMON: And it talks about apportionment of damages. And that rests -- the burden of that rests on the defense. That's what the ultimate --

THE COURT: In a joint and several setting. I didn't -- it -- look, I'll pull it up again. But when I looked at it, it looked like it talks about apportionment of damages when there's joint and several liability, which is not at issue.

MR. SIMON: Well, that is -- yeah, that is the facts of that case.

THE COURT: Yeah.

MR. SIMON: But any time there is an apportionment of damages, whether it's with joint tortfeasors, or whether

they're -- they're apportioning to a preexisting condition of one plaintiff, there's still an apportionment issue. And that burden of apportionment is on the defense if they choose to do that.

And in this case, I mean, if they're not going to argue any other alternative causes, because there aren't any in the records, then, you know, that's fine. I just want to make sure we're all on the same page going forward, and Your Honor's aware of it.

THE COURT: And I think that I asked that specifically. Because, like I said, I think there's three possible ways this could go down, but it sounds like you're -- it's an all or nothing for the defendant, right? Basically, our accident did not cause these injuries and our accident did not cause them to be symptomatic, even if they had them before.

MR. BAIRD: We will comment on lack of evidence, but we aren't going to say it was caused by any alternative method.

THE COURT: Okay. Then I think that's Mr. Simon's concern. Mr. Simon?

MR. SIMON: I'm sorry, what?

THE COURT: Tell him again what you said.

MR. BAIRD: Oh. We are going to comment on the paucity of evidence, but we aren't going to offer alternative

cause.

MR. SIMON: I don't know what that means.

MR. BAIRD: The lack of evidence. We're going to say, Look, they didn't give us the sentence, this sentence was presented --

THE COURT: Their accident did not cause your client's injuries.

MR. SIMON: Oh, okay. Yeah. I was --

THE COURT: Your client's disc tear.

MR. SIMON: That's fair game for them. Sure.

THE COURT: Other than the injuries articulated by Dr. Duke.

MR. SIMON: As long as they don't ask the jury to speculate outside the record, that's fine.

MR. BAIRD: Yeah.

THE COURT: They said they're not.

MR. SIMON: Okay.

MR. MICHALEK: We have one other agreed instruction, Your Honor.

THE COURT: You have one other agreed?

MR. BAIRD: Oh, yeah. We've had [indiscernible] typewritten, but yes, we've got the text agreed to.

THE COURT: Okay.

MR. SIMON: We're happy to do that back at the office, or if your staff wants to do it, we sent word

instructions.

THE COURT: We can print it out. But we try not to type it up, because if there's an error, then it's on us.

MR. BAIRD: Sure.

THE COURT: The parties have stipulated that the net present value for the costs of future medical treatments, the figures presented to the jury during the course of this trial. Works for me. You want to print it up and e-mail it to us?

MR. SIMON: Sure.

THE COURT: Print it? And then this is what I'm going to do. And there's a reason I do this, believe it or not. These are the jury instructions without citations. I'm going to have you guys go through and make sure -- I think there's one that I should have taken out that I did not. I'm going to have you guys go through, number them, and make sure these are the entirety of the jury instructions you agreed upon. Because believe it or not I had a case where an attorney accused me of slipping in a jury instruction. And this way you guys know that they're the ones you agreed upon and which were settled.

MR. BAIRD: It's the big sleaze, Your Honor. I think that there's --

THE COURT: Because I care so much.

MR. MICHALEK: One thing, Your Honor. They're -- what was the set of records? There's health insurance.

MR. BAIRD: Oh, right, right. At the end of Dr. Coppel's records, so those are exhibits -- Exhibits 8 and 18, and I think we actually had discussed this once before with plaintiff's counsel. And I think -- I think the parties actually intended to get it out. And we -- we ended up not. But let me tell you what page number.

THE COURT: Are you talking about those EMG studies?

MR. MICHALEK: Pardon?

THE COURT: Are we talking about the EMG studies again?

MR. MICHALEK: No, no. This is that insurance. It's the -- it's the lack of --

MR. BAIRD: There's a document signed by the plaintiffs that says I don't have any health insurance. Seems like that should come out.

THE COURT: Yeah, it probably should.

MR. BAIRD: And I think that they actually agree. We just forgot to get it done. I'm looking for it here.

Okay. Page 18 of Exhibit 8.

MR. SIMON: Yeah, no objection to that, Your Honor.

THE COURT: Okay. So take it out.

MR. BAIRD: There's another one. Then that was in his. And then --

THE CLERK: Counsel approach. Does this look like the [indiscernible].

MR. SIMON: Yep, looks like it.

MR. MICHALEK: Yes, correct.

THE CLERK: Okay.

MR. BAIRD: And I think there's another one in the other -- Christian's.

THE CLERK: Is that 18, Exhibit 18?

MR. BAIRD: Yeah. I think page 12.

(Pause in proceedings.)

MR. BAIRD: So 12 and 16 from Exhibit 18.

MR. SIMON: Yeah, that's fine. 12 and 16? Okay.

MR. BAIRD: Okay. So that takes care of that.

THE CLERK: Is that the financial responsibility acknowledgement?

MR. BAIRD: Yes. So now we can talk about the --

(Pause in proceedings.)

MR. BAIRD: So the -- the issue yesterday with respect to the EMG that was originally with Dr. Lanzkowsky's records. So this is what we would propose be added. Can I approach?

THE COURT: This is the one Dr. Duke was referencing?

MR. BAIRD: Yes.

THE COURT: So this is defense exhibit?

MR. BAIRD: Yes.

THE COURT: And we already had discussion on this. I allowed it, because it appears that it was produced. And it

was just inadvertently left out of the stipulated exhibit. I allowed it. So this should be a defense exhibit.

THE CLERK: So it's admitted?

THE COURT: Yeah, it's admitted. We previously had argument.

MR. BAIRD: Our other exhibits are just -- should we finalize the exhibits at this point? Because there are a number that are --

THE COURT: You need to make sure they're moved into evidence before I read the instructions.

MR. BAIRD: All right. So --

MR. SIMON: I thought we -- we were concluded. My -- my only issue is this, is a custodian of records affidavit. I don't know why we need that. This is our report of somebody else's records.

THE COURT: Doesn't really matter.

MR. BAIRD: Yeah, it doesn't matter. You can take that off.

(Pause in proceedings.)

THE COURT: Okay. Go through the instructions.

(Pause in proceedings.)

MR. SIMON: Judge, I think we both have a mutual request.

THE COURT: Sure.

MR. SIMON: Okay.

THE COURT: Makes me a little nervous.

MR. SIMON: Your Honor, we are both stipulating to a mistrial.

THE COURT: Seriously?

MR. SIMON: No.

THE COURT: Oh, my gosh.

MR. BAIRD: I didn't put him up to that, but that was a good one.

MR. SIMON: No, just kidding. But what we are both requesting, because we think by the time we get the final jury instructions to you and after you read them and we finally get to argument, we're going to be cut off and jury's going to go home anyway. And we're not going to want to keep people here. My understanding is you might have a light calender tomorrow where we could start earlier?

THE COURT: I do.

MR. SIMON: And then the jury could have a full day to deliberate. And they're going to have to come back anyway.

MR. BAIRD: So we're comfortable starting closings tomorrow, both of us.

THE COURT: Okay. After I read the instructions?

MR. SIMON: Sure.

THE COURT: Okay. Sounds good. All right. Number your jury instructions, please.

MR. SIMON: Oh, you want to read them now? I don't

know that --

THE COURT: I want you to go through and make sure that those are correct.

MR. MICHALEK: Our objections were all already on the record, we don't need to make that again, correct?

THE COURT: Please don't.

MR. MICHALEK: I want this done as fast -- as much as you do, Your Honor.

THE COURT: I heard you the first time. I do listen to you.

(Court recessed at 2:39 p.m., until 3:03 p.m.)

(In the presence of the jury.)

THE COURT: All right. Welcome back. Counsel, you want to make yourself comfortable, please. All right. Welcome back, ladies and gentlemen of the jury. Again, as I previously indicated, I'm going to give you the jury instructions that apply to this case, which is the law that you'll -- that you will use when you go back to deliberate.

(Jury instructions read.)

THE COURT: Ladies and gentlemen, those are the entirety of the jury instructions. Unfortunately, because of timing issues, we are going to have to start closing tomorrow.

Now, we wanted to start earlier in the day, that way we know it will go to you guys tomorrow. We had originally told you tomorrow it would be 1:00 start. Can you guys come

earlier? Can you come in at 10:30 start, does that work with your work?

THE MARSHAL: They weren't given a time, Judge.

THE COURT: Oh, they weren't? I'm sorry. Well, 10:30.

All right. So if you could be here tomorrow at 10:30, what's going to happen, again, the plaintiff's going to do their closing, the defense will do their closing, the plaintiff will do their rebuttal, and then the case will go to all of you for deliberation. So we'll see you tomorrow.

Thank you. Oh, again -- sorry. Again, you're admonished not to converse amongst yourselves, do not do any research, and do not form or express an opinion. Thank you.

(Jury recessed at 3:22 p.m.)

MR. BAIRD: So 10:30, Your Honor. We'll be here.

THE COURT: See you then.

(Court recessed for the evening at 3:23 p.m.)

CERTIFICATION

I CERTIFY THAT THE FOREGOING IS A CORRECT TRANSCRIPT FROM THE AUDIO-VISUAL RECORDING OF THE PROCEEDINGS IN THE ABOVE-ENTITLED MATTER.

AFFIRMATION

I AFFIRM THAT THIS TRANSCRIPT DOES NOT CONTAIN THE SOCIAL SECURITY OR TAX IDENTIFICATION NUMBER OF ANY PERSON OR ENTITY.

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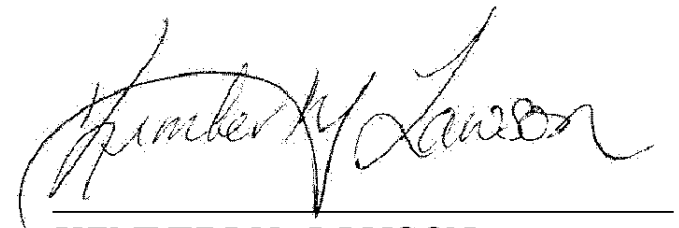

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