No. 71348

IN THE SUPREME COURT OF THE STATE OF NEVADA

EMILIA GARCIA,
Appellant,

v.

ANDREA AWERBACH,
Respondent.

APPELLANT'S APPENDIX
VOLUME XIII, BATES NUMBERS 3001 TO 3250

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healing process is sort of ramping back up slowly into your activity. That's why she was saying I would -- she would take another pain pill or be more likely to take a pain pill when she was more active. So I don't think it would interfere with the healing, but it might -- she might feel it.

Q. More activity, more pain at this time.

A. Generally, yes.

Q. Okay. I would ask you to move to your May notes.

Is the next appointment on May 22nd of 2013?

A. Got it.

Q. Okay. What was Ms. Garcia's status at this time?

A. She was happy because she had gone back to work and she could stand all day. Although she had some more lower back soreness at the end of the day, she would then just go home and lie down. And she was trying to become more tolerant of her work duties. She was tired. And she was having to use some more medications because she was getting back into her work duties and activities.

Q. Did she indicate whether she was pleased or displeased to be back at work?

A. She said she was happy that she had been able

to get back to work.

Q. Did she indicate whether she was pleased or displeased with her decision to have the surgery?

A. She said she was happy she had the surgery.

Q. Thank you, Doctor.

When did you see her next?

A. July 24th, 2013.

Q. Okay. And what were your clinical impressions at that time?

A. She was doing well. She's switched to a lower dose of pain medication called tramadol. She had some elevated pain around the time of her menses, and then some more pain at the end of the day at work and she stood all day at work. Her feet were better. She was doing some stretches. My impression was she was coming along well. I use the word "nicely." Sorry. She was coming along nicely.

Q. Now, at this time, has the fusion healed, in your opinion? We're about half a year post-op.

A. We had done some X-rays that showed everything looked good and she's healing good. So I would say it's -- the majority of it's healed.

Q. Since you'd done the surgery, which was your recommendation, and it healed, why didn't you tell her, You don't have to come back to see me, Ms. Garcia; my

work's done here?

A. Well, because, you know, I develop a relationship with my patients. I want to make sure they're as happy as possible. I said she could see me if she had a reason on an as-needed basis. If she had a flare-up or a problem, she would come back and see me. And then later, there was some pains we were dealing with, separate from her fusion site, that needed my attention.

Q. Okay. At any point, did you feel a visit with her was not medically reasonable or necessary?

A. No.

Q. You mentioned that you set aside an hour for your initial consult with your patients.

How much time do you continue to talk with your patients directly in each one of your follow-up visits?

A. Twenty to 30 minutes, depending on how much there is to say or do. I mean, if we review some additional films and tests since I have some decisions to make, it's more likely the follow-up is 30 minutes. If it's an after-surgery checkup just to tell me how things are going and have a few questions answered, it's more likely 20 minutes.

Q. Was she still seeing Dr. Kidwell at this

time?
A. Yes.
Q. And were you getting copies of his medical reports?
A. Yes.
Q. And were you reviewing them with her?
A. I don't know if I did it with her, but I was looking at them at some point.
Q. Were you helping manage her total medical care at this point?
A. I was.
Q. I'm going to ask you to skip a few appointments and go to April 1st of 2014.
A. Okay.
Q. Now, at this point in time, did Ms. Garcia show any signs of deterioration in her relief from pain?
A. She had what we call a flare-up of lower back pain at that time.
Q. And did you make -- have any note in your record as to what level of improvement you felt she was still showing since her surgery?
A. She said she was still 80 percent better since the surgery.
Q. Was she able to continue increasing her

physical activities?

A. She told me she could do more around the house. So I suppose in a way, yes.

Q. Was she doing any physical therapy at that time?

A. Yes. She had -- I noted she had seen Dr. Kidwell and started a course of therapy for her flare-up, and she was seeing me at that time also to have a look at her.

Q. Okay. At that time, did you have any opinion as to the cause of her flare-up in low back pain?

A. Well, she specifically said there was no specific provocation, meaning nothing provoked it. So I don't know that there was a cause. It was simply a flare-up in pain.

Q. Following this visit, did Ms. Garcia have a spinal cord stimulator trial?

A. Yes.

Q. Could you explain what a spinal cord stimulator is, Doctor, and the purpose?

A. A spinal cord stimulator is an electrical electrode device that is placed, at least by the trial or the test, through a needle by a pain specialist generally up along the spine. And it's connected to a little device that gives it different amounts of power.

And one can adjust the settings in terms of the amperage and the pulse width and -- and things you would do on an oscilloscope to give a small electrical current up along the spine where the pain nerves ascend or go up to the brain along the spinal cord. And this device can provide a buzzing or stimulation or short circuiting of some of those sensations, so the pain someone's having may not reach the brain fully.

It is sometimes used for patients with chronic or persistent pain who want to reduce their medication use. It's used in some cases of a failed spinal surgery or a failed problem or someone who cannot have surgery or for which the surgery's too massive, like seven-level fusion or something. So there are many reasons they might be tried. It's something a pain specialist might endeavor.

Q. Did either you or Dr. Kidwell make recommendations resulting from her spinal cord stimulator trial?

A. Yes.

Q. And are you at your September 15, 2014, appointment?

A. I am.

Q. Very good, Doctor.

What -- what were those recommendations?

A. Recommendation at that time was that we discussed putting a permanent stimulator in her as an option for pain she was having at that time. Because one of her main goals was to get off pain medicines. And she -- when she would have flare-ups and at other times had to return to the ...

Q. Explain how the permanent stimulator would have been different from the trial stimulator that Ms. Garcia tried for a few days.

A. Well, the first difference is the permanent one's put in surgically not through a needle.

Q. Would you -- would you have done that?

A. Yeah, sure.

Q. Okay.

A. And the -- the controlling device is a small pacemaker-like computer about half the size of a standard iPhone that -- that would be inserted under the skin, usually in the upper buttock area. And there are wires going down to it. And so it's this implanted device. A patient once having it cannot have an MRI scan generally. And the battery runs out every five to seven years and you got to do a surgery to remove it and replace it, just like you might with a pacemaker.

Q. And other than replacing the battery, would that stimulator have lasted her lifetime?

A. Sometimes the electrodes need to be changed out. There's some planning that goes into that.
Q. But it's surgery every time you need to change the battery?
A. Yes.
Q. Did you have discussions with Ms. Garcia about that as an option?
A. Yes.
Q. And what did you recommend?
A. At that point, I said, Before you do that, let's check an MRI to make sure there's no other source of pain because, also, you can't have an MRI after you have this thing implanted. So let me make sure.
Q. Okay. And then you saw her again on October 28th of 2014?
A. One second. I'm so sorry. Yes.
Q. Okay. Great. Thank you, Doctor.
So we're at October 28th of 2014?
A. Yes.
Q. She's had the trial stimulator.
Did she indicate that the trial stimulator resolved some portion of her pain?
A. She had the trial stimulator prior to my September visit. It was on September 15th, 2014, where we discussed her benefit from the stimulator.

Q. Okay. And what was that benefit?
A. She said she had 70 percent improvement in her back and right leg and was able to curtail medications during that time and was more functional, and she was interested in pursuing this permanent stimulator.
Q. Now let's go to October 28th.
What are her clinical symptoms at that time?
A. Low back pain. Now, remember the trial stimulator is taken out. It only lasts for about five or seven days. So she has more lower back pain, using more medications which exhausts her. The lower back pain was at the upper aspect of her incision and in the right SI joint area. The -- she was still taking medications, but not smoking.
Q. Okay. The SI joint, we haven't talked about that much before now.
Did Ms. Garcia have SI joint pain, to your recollection, prior to the fusion?
A. May I look back just for a minute?
Q. Sure.
A. I don't believe so, but I want to make sure.
Well, she had some mild tenderness is the only thing I noted in the SI joints prior to the fusion until this October visit.

Q. Of 2014?
A. Yes.
Q. Is it unusual for patients to either develop or have an increase in SI joint pain after a two-level fusion?
A. It's not unusual.
Q. Okay. And could I hand you back our model, Bruce, here? Maybe you could point out to the jury where the SI joint is and why that sometimes develops painfulness after a lumbar fusion.
A. Sure. SI stands for sacroiliac. Sacro is the sacrum bone. Iliac is this big broad hip bone on either side called the ilium that houses the hip joint. And where the sacrum meets the ilium is a joint on either side. We call that the sacroiliac joint or, for short, the SI joint. It doesn't move much as far as joints go. But it is a stress point.
And when you -- when you lock together the lower lumbar bones, in this case L4 to L5 to S1 in a fusion, the body's weight and stress now gets enhanced at the SI joint. Sort of like it's the next mobile part to be affected. So she was starting to have what we call post fusion or after fusion sacroiliitis as one of her sources of pain. And I wanted to investigate that before we did a permanent stimulator.

Q. Okay. You also make reference to the 3-4, the Lumbar 3-4 segment?

A. Yes, only to the facet joints. And -- and this -- if I may, for two reasons. One is you might recall I said she had pain at the upper aspect of her incision. And what's above the incision is the L3-4 level. And secondly, I ordered an MRI on it, and it was done on October 11, 2014. And it showed the fusion looked good, but there was a -- some facet joint inflammation at L3-4 above the fusion. So, again, the next mobile part up and the next mobile part down would be the L3-4 level and the SI joints, respectfully.

Q. And is the fusion going to cause more or less stress to -- to go on those joints above and below the fusion level?

A. There would be more stress at the next or what's called the adjacent segment above, which is L3-4, and more stress at the SI joints below.

Q. Thank you, Doctor.

So what were your recommendations at that time in October of 2014 for continued treatment?

A. It was at this point I suggested a combined right SI joint and L3-4 facet joint injection and some hardware injection, meaning numb up the area along the hardware because sometimes there can be pain in that

area. Basically, hit all of what I think is hurting her and see if we can get some benefit.

Q. Very good.

And who did you refer her to for the injections that you were recommending?

A. Back to her pain specialist, Dr. Kidwell.

Q. Thank you.

And did you evaluate Ms. Garcia again on January 22nd, 2015, after she had received those injections?

A. Yes.

Q. Okay. What were your impressions at that time, Doctor?

A. She had significant benefit to the lower back and right thigh after the combined injection. So to be clear, those weren't all separate. They were all done at the same time. They lasted about a month. So I was happy for her because if we can get a month of benefit, maybe we can get two. If we can get two, maybe we can get four. So I -- so I suggested we do it again.

Q. And during that time, did she show any change in the amount of medications that she was requiring for her pain?

A. She went back to needing the medications.

Q. And what were your recommendations moving

forward?

A. I wanted her to do it again in anticipation of what's called a rhizotomy.

Q. Okay. And could you explain -- what's the long time name for a rhizotomy that the jury might see in some of the exhibits?

A. There are lots of names. But there is a burning procedure that can be done for certain types of nerves, specifically nerves that -- that supply joints with pain, joints like the SI joint, joints like the facet joint, and also nerves that might be dealing with the hardware area. These aren't important nerves to go down the leg and move the foot. They're just little sensory nerves. And we can burn and damage them, and that can sometimes last three to six months at a time. But before we burn anything, we want to make sure that's the nerve that's causing it. That's why I recommended a repeat injection before the burning.

But when we do the burning, it's called a rhizotomy, which is a fancy term for making a hole in a nerve. The other term is an ablation because we're burning something. And -- and the long term is an RFTC, or radiofrequency thermal coagulation which basically means we use a radiofrequency wire. We have it vibrate at the tip and it causes some thermal

release or burning of energy that -- that can cook those little nerve endings.

Q. And who -- who does that type of procedure, the rhizotomy? Is that a neurosurgeon or a pain management doctor?

A. Generally, a pain management doctor like Dr. Kidwell would do that.

Q. Did she report any benefit from these repeat injections that you recommended?

A. Yes. She again had the same combined SI joint, L3-4 facet, and hardware block, and then she came back and had one to two months of benefit, somewhat similar to the benefit she had with the prior one in 2014. And it was based upon that, that I said we should do this rhizotomy. Maybe we can put off the stimulator.

Q. Excellent. And did you see her next on June 17th of 2015?

A. Yes. That was after the second injection, Counsel.

Q. And that's when she again reported the relief that you had just told the jury about; right?

A. Yes.

Q. Did she also discuss a pain in her thigh at that time?

A. Yes.
Q. And some trouble lying on her right side?
A. Yes.
Q. To what did you attribute those complaints?
A. Still -- still not 100 percent certain. She had thigh symptoms, little numbness in the front of her thigh right after the surgery. Sometimes that's from lying on -- on the table. There are pads on the thigh for a long periods. But that should have gone away. It can be related to the L3-4 level. I think one of the injections may have helped the thigh of these more recent ones and one did not. So I'm still sort of looking in on the thigh. The thigh is not her biggest complaint.
Q. So at that time, would you say she was satisfied with continuing that course of treatment, Lortabs for the pain, continued periodic injections?
A. She wasn't satisfied with Lortab. She wanted not to have to take them. They really made her tired and affected her quality of life in a way she did not prefer to function. So she was satisfied with the injections, enough that she was willing to try this rhizotomy procedure and burn those nerves to see if we can get it to last longer.
Q. So what course of treatment did you recommend

at that point?

A. At that point, I recommended she go ahead and have the rhizotomy of the L3-4 facets, the sacroiliac joint, and along the hardware. And she did that in September of 2015.

Q. And did you see her on November 11th of 2015 after the rhizotomies?

A. I did.

Q. And what were your clinical impressions when you saw her in November of 2015?

A. She reported significant benefit to the lower back area and the right thigh cramps. She was able to be more active, more motivated, had more energy, could do more household chores and activities which she had not done for quite some time. She had some upper back pain and foot symptom we looked at, but seems like she was doing quite well. She was down to two pain pills a day and it was only tramadol. Before the rhizotomy was six tramadols a day.

Q. And the tramadol, does that have the same level of side effects as Lortab?

A. No. Tramadol is less potent and Lortabs or Norcos.

Q. Based on your discussions with Ms. Garcia, your review of the medical records from the other

doctors, and your own evaluation, did you believe the rhizotomy had been a success?

A. Yes.

Q. Okay. Could you explain to the jury why?

A. Because she was doing quite nicely. After the rhizotomy was helping those leftover symptoms that she had that had, you know, become apparent in maybe the year after surgery or so.

Q. Did she report a significant increase in her pain?

A. Did you say "increase in her pain"?

Q. Yes.

A. After the procedure, she had a significant decrease in her pain.

Q. Sometimes I have to be silly since I can't lead.

A. That's fine.

Q. So, Doctor, did she indicate whether she was able to -- to do more activities?

A. Yes.

Q. Did she report a general increase or decrease in her quality of life?

A. Quality of life seemed to be improving.

Q. All right. At that point, did you recommend future rhizotomies?

A. Yes.
Q. When, how often, and why?
A. At that point, I recommended them twice a year based upon custom and experience that they last up to about six months at a time. And why? Because it would be a great way to manage her pain and keep her quality of life good.
Q. Now, we just discussed that the few months before -- before some of the injections that you wanted to try before you recommended that she proceed with the spinal cord stimulator. You've now tried the injections. You've had success. You moved on to the rhizotomies with success.
Do you still consider the spinal cord stimulator to be an option at this point?
A. It's an option.
Q. An immediate option?
A. No, not right now. I mean, unless the rhizotomies stop working, I would try to put off the stimulator.
Q. Does it sometimes happen that rhizotomies stop being as effective in controlling pain after repeated ones?
A. It does sometimes.
Q. But more likely than not, will repeated

rhizotomies on a regular basis provide relief to her over her lifetime?

A. Yes. We know that.

Q. Thank you, Doctor.

You talked to the jury using the spine model about the adjacent segments, and one of those was at L3-4. You told the jury that there's additional stresses now on the adjacent segments.

Does that more likely than not eventually result in additional medical problems requiring treatment?

A. Yes.

Q. Can you explain that to the jury?

A. Yes. In 2012, there were some consensus articles published in a journal called *Spine* that I subscribe to. And this was published by a guy named Dr. Lawrence Brandon and others. And they looked at every eligible study that had ever been done on the topic of does someone else have stress and problems at the next level after the fusion? And they came up with this consensus conclusion that there is a rate of accelerated degeneration at the adjacent disk. In our case, it would be the L3-4 disk, because there's no disk below the sacrum. And the rate is from .6 percent per year to .39 percent per year. The average, I

believe, is 2.25 percent per year. And if you add it up every year, you're eventually going to get to over 50 percent, and I think it's at 22.22 years, if I recall correctly, that that next disk will need treatment.

Q. So just over 22 years is when it becomes more likely than not that she will have needed an additional fusion surgery on her prior to that time.

A. Right. Measured from the date of the first surgery.

Q. Okay. And the surgery -- is that going to -- more likely than not going to require a fusion surgery?

A. Yes.

Q. When you have adjacent segmental breakdown, does she wake up one morning after 22 years and the pain is back and she needs a surgery?

A. No.

Q. Explain how that process would work leading up to her need for surgery from a -- from a medically-more-likely-than-not standard.

A. It would be expected to be, you know, perhaps in the five or so years leading up to that date, a slow sort of insidious increase in her pain, maybe the rhizotomies become less effective and she needs more medications. Maybe we try some -- some different

injections like epidurals at L3-4, and we do an MRI. She'll need more MRIs to see what the L3-4 disk begins to look like. Just like it's a new problem.

Q. And more likely than not, after 22 years, she's going to, after going through those things, need that additional fusion.

MR. MAZZEO: Objection. Speculation.

THE COURT: I think he's already stated it once. Overruled.

THE WITNESS: Yes. The L3-4 segment, we'd have to extend the fusion to include it.

BY MR. ROBERTS:

Q. More likely than not, Doctor, is Ms. Garcia going to require annual and repeated medical treatment through her entire life as a result of the injuries sustained in the January 2011 accident?

MR. MAZZEO: Objection. Speculation. Foundation.

THE COURT: I don't think so. Overruled.

THE WITNESS: Yes, it will differ. Some years will be not much treatment and some years will be more treatment.

BY MR. ROBERTS:

Q. But we know at least according to your recommendation, she's going to need one to two

rhizotomies per year for her lifetime?

A. Correct.

Q. Let me ask you about some criticisms that -- that you might hear about your treatment of Ms. Garcia.

First of all, did you do a diskogram before your surgery?

A. No.

Q. Was one necessary for you to know whether the surgery was medically advisable?

A. I am going to answer your question as if it's two questions. One, one was not necessary. Two, even if we did one, it doesn't have the ability to tell us if surgery is medically advisable.

Q. What is a diskogram?

A. A diskogram is a confirmatory test that surgeons sometimes use, including me sometimes, when we're trying to determine or confirm a source of pain from a disk or disks that are perhaps in question based upon an MRI or to look at a questionable segment. For example, we could tell from the MRI that L4-5 and L5-S1 were shot. I didn't need a diskogram to tell me that, when correlated with her pain and symptoms, needed to be repaired. L3-4 looked really good.

But if L3-4, hypothetically, looked questionable, wasn't fully blown out but maybe was a

little bulged or something, we might have done a diskogram to evaluate L3-4 so that when we do the surgery, we might include L3-4 while we're there. But L3-4 looked gorgeous and wasn't causing her the type of pain I would expect from L3-4. So we didn't go there.

Q. Thank you, Doctor.

Ms. Garcia didn't report any pain within the first day of the accident; therefore, the accident couldn't have caused these things you treated; is that correct?

A. No, that's not correct, for many reasons.

Q. Could you explain?

A. First, I see a great many patients who are injured. Some don't have pain immediately. Sometimes it take hours, days, and even weeks or more, especially when it's a disk problem. Patients are also initially in shock. They can't believe what happened. They try to go back into their normal life and go to work and take care of their kids. And -- and having been injured myself, I can tell you that's exactly what I did too. You don't have to have immediate pain for there to be a structural problem.

Additionally, a problem like this one slowly worsened with time, meaning her pain worsened. Also worsened with time was her slippage, her

spondylolisthesis. It went from 4 millimeters to 7-point-something millimeters to 10.2 millimeters with time, indicating a worsening structural problem with a worsening clinical picture of pain. One does not have to have immediate pain at the time of the injury to do that.

Plus, the spine stiffens in response to pain and structural problems. And patients might say, I didn't have a lot of pain right away, but I felt stiff within a few hours.

Q. The mechanical forces in the car accident were simply too low to cause Ms. Garcia's injuries and need for treatment that you've described.

Do you agree?

MR. MAZZEO: Objection. Speculation. Foundation. Beyond the scope.

THE COURT: No. I'm going to allow it. Overruled.

THE WITNESS: I disagree. First, we cannot fake the type of progression in the spondylolisthesis and her symptoms that -- that developed. That clinical correlation is -- is significantly supported by all the medical evidence.

Two, we have to remember she was susceptible. She wasn't held together by solid bone at the pars.

She was held together by gristle. Gristle can get pulled apart. That gristle does not heal well. I laid that out quite nicely on that last page of my first report where I had the diagram. There's a discussion about that which might be a salient answer to your question now.

Q. Your very first report?

A. Yes. You were so kind to put it up earlier. For the diagram, but the -- the actual discussion there is, I think, crucial knowledge for -- for anyone that's looking at this treatment and for the jury. It's page 16 of 17, actually.

Q. Okay. And I have got that out.

And rather than show that to the jury, can you refresh your recollection and then review with them the findings that you made on May 25th, 2011, with regard to that very point?

A. Yes. Well, I described the tough fibrous tissue that's holding the pars together and how Ms. Garcia and people like her would be more susceptible to injury. And -- and I say that, Without trauma, only a small percentage of such patients become symptomatic or present for surgical treatment. And once the fibrotic tissue is disrupted, i.e., through trauma, the chance of spontaneous healing is slim as

such scar-like tissue tends not to form a reasonable union. Thus, trauma is typically the reason that causes the anomaly and weakness to become surgical. And I said --

Q. When you say "typically," do you mean more often than not?

A. I do.

Q. Thank you, Doctor.

A. I said, Absent the injury, there would have been no apparent need or expected need for such treatment.

So attempting to revisit the vehicular forces is simply an exercise in attempted revisionism. It's interesting, but just doesn't fit the facts and evidence of the case.

Q. What is your foundation, the information upon which you base the opinion you just gave the jury that only a small percentage of patients with spondylolisthesis become symptomatic?

A. Well, first, I have a background and training in the area of spine and spinal biomechanics by virtue of my fellowship and my practice with experience. Second, I have written a couple textbook chapters and articles on the topic of what's called lumbosacral junction biomechanics. The lumbosacral junction is the

lower lumbar spine and the sacrum, the things we're talking about here. In fact, that diagram that you put up earlier today was from my chapter.

So this is my area or at least one of my areas where I have researched and written and understand the nature of the problems and the epidemiology. Epidemiology meaning what happens in patients walking around out there not knowing about this and how they get into trouble like trauma.

Q. Emily is over -- Emilia is overweight and, therefore, she would have eventually had these same problems and need for surgery anyway.

Do you agree?

A. I don't agree. I think she's been large for the majority of her life and hasn't had any problems with her low back. So it would be more likely than not that that history of not having symptoms would have continued absent the trauma, meaning unless the trauma occurred.

Q. Okay. The spondylolisthesis was a preexisting condition and, therefore, she would have needed a surgery anyway.

A. It's not a condition whatsoever. It is an anomaly. Again, from my own research and writing and experience and her own history of not having trouble,

she would have not needed the surgery had she had not had a progressive slip in symptoms related to it. She was symptom free in her lower back prior to the injury.

Q. Explain to the jury how your -- how and why you're drawing a distinction between an anomaly and a condition.

A. Well, a condition is defined as a -- a problem, in this sense, a medical problem. That can be a symptom. It could be a -- it could be something wrong with a body part that's causing a symptom. But just because she has a freckle or a sixth finger on her right hand doesn't mean she's having a condition or a problem. It's an anomaly, meaning it's a different anatomy that's unexpected or -- or not the typical. Doesn't mean it's a problem or condition. A condition is a problem. She did not have a problem prior to this injury. She had an anomaly.

Q. Ms. Garcia is out of shape or deconditioned, and, therefore, she would have had these problems anyway.

Do you agree?

A. I can't agree. They -- that would require speculation. She wasn't having these problems for the first three decades of her life, and she was not fully conditioned then either. Certainly the injury's

deconditioning and the surgery's deconditioning. But those are after the fact of the surgery.

Q. Ms. Garcia might be misrepresenting whether she had symptoms before this incident.

Any opinion on more likely than not whether that's true?

A. Well, I've come to know Emilia. I've seen her, except for surgery, I believe 19 times in the office. She has always been forthright with me as far as I can tell. And I do have a sense of people, since I see 15 or 20 people every day in some way. I've never found to be misrepresenting herself. I mean, she's certainly come in when she was feeling good and tell me how good she was doing. And when she was hurting, I could tell by how she sits and how she carries herself. I thought she was always appropriate in her responses. I found no evidence to even consider an idea that she would be feigning or faking or making anything up.

Q. Thank you, Doctor.

One to two days of relief is not a positive indicator for a diagnostic nerve root block and, therefore, Emilia's doctors, including you, never really figured out what was causing her pain.

Do you agree with that?

A. No, that's silly.

Q. Explain why you think that's silly, Doctor.

A. The diagnostic component is usually known within hours to days. So one to two days is perfectly diagnostic.

In terms of your comment that we never figured out the pain, I think we continue to be very diligent in our attack upon figuring out her pain. The selective injections, the correlation with imaging tests. I mean, we've handled this actually quite strategically to make sure we figure out what's wrong with her and treat it.

Q. Doctor, are you treating Emilia on a lien?

A. Yes, I have a lien for her treatment.

Q. And could you -- could you explain to the jury what that means?

A. Sure. A lien is a contract that I have with patients who perhaps are unable to pay at the present moment and have said to me, Hey, I'm going through a legal proceeding or a lawsuit, and I will pay you at the end. So the contract is sort of my security instrument, like signing a credit card application. So that when this is done, then we'll start the payment process. It allows me to delay her payment while she sorts things out.

Q. Okay. Regardless of the outcome of the lawsuit, will she still owe you for your services?
A. Yes.
Q. Does the fact that -- that you have a lien, has that altered any of the medical opinions you've expressed here today?
A. Not at all.
Q. Has that affected your treatment plan for Emilia in any way, Doctor?
A. No.
Q. As Emilia's case has progressed, did you receive all the records from all of her other treating physicians, chiropractor, therapists? Have you reviewed the costs associated with those treatments?
A. I have.
Q. And have you formed an opinion as to whether her complete care that she's been receiving has been reasonable, appropriate, and necessary for her condition?
A. I have.
Q. Are there a few exceptions?
A. Well, there was one item. I'll just give it to you. I felt that the hardware costs for the surgery were a little inflated. But other than that, all the treating doctors, hospital charges, aside from what I

just said, care delivered was within what we call the usual and customary range for similar services in the community, both here and in California, because they're a quite similar.

MR. MAZZEO: Objection, Your Honor. Sidebar, please.

THE COURT: Come on up.

(A discussion was held at the bench, not reported.)

THE COURT: Objection sustained as to relates to the foundation for the last statement.

MR. MAZZEO: Move to strike the last response from the doctor.

THE COURT: I can't strike the whole thing because part of it was responsive to the question that didn't deal with usual and customary bills. I'll strike the portion of the statement where he offered a general blanket statement as to usual and customary in nature of all the bills until there's a proper foundation laid.

MR. MAZZEO: Thank you, Judge.

MR. ROBERTS: Thank you, Your Honor.

BY MR. ROBERTS:

Q. Before we go to that bigger point, let's focus on what you were just saying, which is not

struck, and that is you thought the hardware charge was excessive.

A. Yes.

Q. Okay. And the hardware charge, do you select out of a catalog one piece at a time, or does that come in some sort of a kit?

A. Well, I usually ask for a certain system which is as opposed to a kit. And they bring lots of different screws and rods and sizes and extras, and I use what I need to use. And then I imagine the company bills the hospital, and the hospital usually passes that bill back on in their bill.

Q. Okay. And when you say "they bring" it, you mean the hospital brings it?

A. Well, the company or representative or distributor brings it into the hospital through their rules and sterile processing and -- and then their economic relationship, meaning purchase orders, what have you.

Q. Okay. And the -- the package or the -- the hardware, does that include just what pieces are left in Ms. Garcia, or does that include instrumentation or tools of some kind?

A. Usually, it's two or three large metal trays of the -- not only the parts we insert and extra parts,

but all the necessary insertion tools, the crowbars I was mentioning, the distraction elements, the screwdrivers, all kinds of tools we might need to help get the job done.

Q. And you mentioned that -- that one screw that's not there that broke off, how -- how much pressure are you putting on that screw when you're torquing it down?

A. Well, probably over 100 pounds of torque. Maybe more. Crowbar, threshold torque.

Q. The jury has seen a breakdown including a bill from Pacific Hospital of just north of $280,000.

Is the hardware charge within that charge?

A. Yes.

Q. And other than the -- the hardware charge, just looking at the 280-some thousand, is that total charge reasonable and customary based on what you've seen from your hundreds of surgeries?

MR. MAZZEO: Objection, Your Honor. Foundation.

MR. ROBERTS: I can clean it up, Judge.

THE COURT: All right. Go ahead.

BY MR. ROBERTS:

Q. You've told the jury already that you've done about 300 lumbar fusions.

In connection with that, have you seen what the hospitals bill for the lumbar fusions in some or all of them?

A. Many times.

Q. Okay. And is the charge that you've seen from Pacific Hospital within the range of charges you've seen from other hospitals in Nevada or California for a lumbar fusion?

A. Yes, to the total charge.

Q. So the total charge is reasonable and customary even though you had a nitpick with a charge within it.

A. That's right.

Q. Okay. Thank you, Doctor.

In the process of, I guess, serving as not only a treating physician but an expert, as an expert, the lawyers made sure they sent you all of the medical reports from all of the other treating physicians involved in the case; correct? Well, you don't know if it was all.

Did you receive medical records from the lawyers?

A. Yes.

Q. And did you also receive the bills associated with those records?

A. Yes.
Q. In the process of reviewing the case periodically, did you review the billings?
A. Yes.
Q. Did you sometimes make tables and add up all the billings and come up with grand totals?
A. I did.
Q. As you looked at the records and looked at the associated bills, do you have the foundation through your practice and your expert work to -- to determine whether a bill is reasonable and customary for the service being provided?
A. Yes.
Q. Explain to the jury what that foundation is.
How would you know if a bill was high or low or just not right?
A. Few different reasons. First, I have a multidisciplinary spine and orthopedic center in California. We have different types of doctors, pain doctors, orthopedic doctors, a neurosurgeon, me, physical therapist, chiropractors, all in one place. And I've been the medical director of the facility since we opened in 2006. And we went to great pains to make sure that our charges were constructed properly. We had them looked at by a billing consultant. We --

we base them on what's called the MGMA surveys at that time. MGMA stands for Medical Group Management Association, and they look at surveys in the -- in our case, in the western region, which includes both Clark County and Orange County. And we made sure we were within the --

(Clarification by the Reporter.)

THE WITNESS: -- two standard deviations of the mean. Sorry. I was doing so well until then. We raised them by -- for -- for procedures, no more than 1 to 2 percent per year just with the Consumer Price Index.

So our prices for all of these services are right in the ballpark. And part of that involves me knowing what surgery center and hospital charges are in addition to looking at some of my own patients' cases where I'm asked to be an expert, because part of being an expert is understanding the costs of care. And good care, costs money.

And it occurred to me when I started taking on cases in Nevada that the charges were largely similar. And whatever work we've done in California, since the charges are similar in Nevada, carries my foundation from -- across state lines. So my foundation and knowledge is based upon looking at other

cases also where I'm asked to be an expert. And there's a large consistency in the cost of care, within a range. So that's the foundation for my knowledge in this area.

BY MR. ROBERTS:

Q. And of the medical records and associated bills that you reviewed, did you see any that did not appear to be reasonable and customary to you other than the hardware charge?

A. No.

Q. Did you see any that did not appear to be causally related to the motor vehicle accident of January 2nd, 2011?

A. There may have been some treatments that were unrelated, but there were no bills given to me to review like for a cold or flu or something. That's unrelated to the injury, and -- and its cost is unrelated to the injury.

Q. Very good, Doctor. Okay.

MR. ROBERTS: Your Honor, we're right at noon. I will conclude my examination at this time.

THE COURT: Okay.

MR. ROBERTS: Thank you.

THE COURT: Thank you. Go ahead and wait and do cross-examine when we come back from lunch, folks.

During our break, you're instructed not to talk with each other or with anyone else about any subject or issue connected with this trial. You are not to read, watch, or listen to any report of or commentary on the trial by any person connected with this case or by any medium of information, including, without limitation, newspapers, television, the Internet, or radio. You are not to conduct any research on your own, which means you cannot talk with others, Tweet others, text others, Google issues, or conduct any other kind of book or computer research with regard to any issue, party, witness, or attorney involved in this case. You're not to form or express any opinion on any subject connected with this trial until the case is finally submitted to you.

Take till about 1:15. See you back then.

(The following proceedings were held outside the presence of the jury.)

THE COURT: All right. We're outside the presence of the jury.

Anything we need to put on the record, Counsel?

MR. MAZZEO: Your Honor, just one matter. If -- if you don't mind, I know during Dr. Gross's testimony, he was up close to the -- with the spine

model speaking with the jurors. One of the jurors wanted to help him and give him a pen. I just ask you to ask the jurors not to assist witnesses in their course of their examination.

MR. ROBERTS: I think offering a pencil when he had asked me for one and I was having trouble digging one out really wouldn't -- it's not inappropriate.

MR. MAZZEO: You know, it's -- it gives a suggestion -- appearance of impropriety if -- if they have a liking for Dr. Gross, he's a likeable guy, and -- but I don't need them helping out the plaintiff's witnesses.

THE COURT: I think if -- if Dr. Gross had asked the jurors, Does anybody have a pencil, I think that would be inappropriate. The fact that a juror just offered it because nobody else was finding one, if it happens again -- I don't know. Let's try not to let that happen again, I agree. But I don't think we want to make somebody feel bad for offering a pen or a pencil, so I'm not going to make a big deal about it with the jurors.

MR. ROBERTS: And the record will reflect that I did have one, so he would have been able to do it. I was just not as quick as the juror.

THE COURT: What else?
MR. MAZZEO: That's it, Judge.
Oh, I have a copy for the Court of Defendant Andrea Awerbach's trial memorandum regarding Stan Smith.
THE COURT: Okay. We don't need to do that right away, though, right?
MR. MAZZEO: We do not.
THE COURT: Okay.
MR. ROBERTS: Otherwise titled the "Motion to Reconsider Motion in Limine Excluding Part of His Testimony."
THE COURT: Anything else right now on the record, guys?
MR. ROBERTS: No.
MR. MAZZEO: No, Judge.
MR. ROBERTS: Not from us.
THE COURT: Off the record.
(Whereupon a lunch recess was taken.)
THE MARSHAL: Jury entering.
(The following proceedings were held in the presence of the jury.)
THE MARSHAL: Jury is present, Judge.
THE COURT: Thank you. Go ahead and be seated. Welcome back, ladies and gentlemen. We're

back on the record, Case No. A637772.

Parties stipulate to the presence of the jury?

MR. ROBERTS: Yes, Your Honor.

MR. MAZZEO: Yes, Your Honor.

THE COURT: I was only three minutes late today. I just want to you guys to notice that.

All right. Let's bring Dr. Gross back in. Tom, can you grab him?

Mr. Mazzeo, are you going to go first?

MR. MAZZEO: Yes.

THE COURT: Okay. Come back in, Doctor. Go ahead and retake the stand. Just be reminded you're still under oath. I'm not going to swear you in again.

THE WITNESS: Thank you, Your Honor.

THE COURT: Mr. Mazzeo, cross-exam.

MR. MAZZEO: Thank you, Judge.

CROSS-EXAMINATION

BY MR. MAZZEO:

Q. Good afternoon, Dr. Gross.

A. Good afternoon.

Q. How was your lunch?

A. It was well. Thank you.

Q. Dr. Gross, how much are you getting paid for

your testimony today?

A. Testimony is free. It's the time away from my office that's being compensated.

Q. Thank you. That's what I meant.

How much are you getting paid for the time you're in court today to testify?

A. Well, half a day is 4,500. So depends on how long you keep me.

Q. If you're here for the day, how much do you charge?

A. Two half days is $9,000.

Q. Thank you.

Now, Doctor, you are the principal doctor at Comprehensive Injury Institute; is that correct?

A. Yes.

Q. And is -- are you also the principal owner or sole owner of that facility?

A. I am.

Q. And you're also -- I believe you're also associated with Medical Strategy Management, Inc.; is that correct?

A. Yes.

Q. You are -- that's a Nevada Corporation that does billing for you?

A. Yes.

Q. And you're also the sole principal owner of that facility?

A. It's not a facility. But I'm the owner of that company.

Q. Okay. And you had mentioned earlier during direct examination, you made reference to a company by the name of Medical Group Management Association.

Do you recall that?

A. Yes.

Q. And is that a company that's incorporated in California?

A. I have no idea.

Q. Is that -- you've done business with that company, though, in California?

A. The only business I've done is look at their annual survey and their data as a member during that time. I don't have any specific business with them. They're sort of a support group for medical offices.

Q. Okay. And you -- you provide neurological -- neurosurgical consultation and follow-up consultations at the -- at the Comprehensive Injury Institute; is that correct?

A. Yes.

Q. Okay. Now, with Ms. Garcia in this case, you had -- you -- as you testified on direct examination,

your initial neurosurgical consultation, which was a second opinion, was on May 25th, 2011; correct?

A. I believe so, yes.

Q. And then after that, I believe you had an additional 18 neurosurgical follow-up consults?

A. That sounds right.

Q. Okay. And including -- and I believe you had 3 neurosurgical post-op consults with Ms. Garcia after the surgery on December 26th; is that correct?

A. Yes.

Q. Now, the total bill that I have for you from the records for Comprehensive Injury Institute, which doesn't include the surgery services you provided, so for those 19 or 20 neurosurgical consultations, it comes out to be $9,970; correct?

A. Yes.

Q. And then in addition to the follow-up consultations you've had with Ms. Garcia, between 2011 and 2015, you've also had, as you testified to on direct, reviewed various medical records pertaining to Ms. Garcia's treatment. And as a result of that, you've drafted, I believe -- my count may be off, but, I believe, four expert reports, otherwise referred to as a Neurosurgical Supplemental Report?

A. I have a few more than that. I have eight in

total. Sorry, nine.

Q. Nine. Okay. And your bill for the surgery that you had performed on December 26th of 2012 was for $70,662; correct?

A. For the surgery itself, I have 69,952. I don't know if you're adding in some of the hospital visits or something.

Q. Oh, well, I'm just looking at one of the bills from Comprehensive Injury Institute for 70,662, but -- so your total is 69,952?

A. Comprehensive Injury Institute bills do not include the surgery.

Q. Oh, okay. So the bill for -- maybe that's from Medical Strategy Management.

That's where it's from?

A. The surgery bill is, yes, that company.

Q. Thank you.

And that's for $69,952.

A. And 35 cents.

Q. And 35 cents.

For the five-hour surgery that you performed on December 26th of 2012; correct?

A. That's right.

Q. And then you also billed -- from Medical Strategy Management, you provided a bill for the

assistant surgical nurse, Ron Filmore; is that correct?
A. No.
Q. Okay.
A. That bill is through a different company.
Q. Okay. For which company did you bill for Ron Filmore, the RN, to assist you at the surgery?
A. Ron Filmore is RNFA, to be clear, which is a surgical assistant credential. And it -- we bill for him under Jeffrey D. Gross M.D., Inc.
Q. Okay. Also through your company, though; right?
A. It's a company of mine, yes.
Q. Okay. And his -- his -- the amount you -- you billed for the services provided by Ron Filmore, RNFA, was $33,924.44?
A. Yes.
Q. Okay. So -- and is it -- is it still a fact that you perform approximately 25 lumbar fusion surgeries a year?
A. Close to that, if not that, yes.
Q. Okay. Possibly more at this point?
A. I don't think more. If -- if -- it would be closer to 20.
Q. So closer to 20 now?
A. No. I just don't think I'm doing more. I

think I'm doing less slowly.

Q. Okay. And so at the time that you were -- do you recall being deposed in relation to the -- to the -- to this litigation?

A. Well, I recall because I reviewed the deposition transcript.

Q. Okay. And -- and the deposition that you appeared for was September 24th of 2013; correct?

A. One second, please.

Q. Sure.

A. That sounds right, but I wanted to check.

Q. Sure. So surgeries if you're billing at approximately 6 -- 69,000 and change or 70,000, let's round it up, for 20 to 25 surgeries per year, that's anywhere from --

MR. ROBERTS: Objection. Irrelevant.

THE COURT: Overruled.

MR. MAZZEO: Thanks, Judge.

BY MR. MAZZEO:

Q. That's anywhere from about 1,400,000 to 1,750,000.

And that's just for the lumbar fusions surgeries per year; correct?

A. What am I answering to?

Q. To my question; is that correct?

A. I don't understand your question, I guess, is what I was trying to say.
Q. So if you're performing between 20 -- 20 and 25 fusion surgeries per year at approximately 70,000 per fusion surgery, that comes out to about 1,400,000 to 1,750,000 per year?
A. That does.
Q. Okay. Thank you.
And approximately how many surgeries do you currently perform per month at Pacific Hospital?
A. None.
Q. Okay. But back in 2013, you were averaging about two to three surgeries per month at Pacific Hospital; correct?
A. Yes.
Q. And one of the codes that you had submitted for billing was, and you may recall, that 999 code?
A. Yes.
Q. That's -- that's a code for an unlisted procedure. And that's for $1,500, correct?
A. $1,500.
Q. Okay. And it's my understanding that that $1,500 charge covers the increased charge of buying malpractice insurance for surgeons?
A. Correct.

Q. Okay. And that charge is for the greater risk of liability for surgery to surgical patients; correct?

A. No. It's because of the malpractice insurance liability crisis that occurred in the early 2000s, and all the prices of insurance went up. So the surgeons had to pass through the cost.

Q. Don't you agree that that's built into all the other fees you charge for this surgery -- surgery performed which totals 70,000?

A. No.

Q. Now, also, isn't it a fact that with regard to your surgical fee, is it fair to say that you believe that you fall at the higher end of what would be reasonable and customary?

A. Yes.

Q. Doctor, when in 2011 did you obtain your Nevada's -- Nevada medical license?

A. I think March.

Q. Okay.

A. But the license would speak for itself.

Q. And -- so when did you open up your office here in Nevada?

A. March of 2011.

Q. Okay. And -- now, with this particular case,

Ms. Garcia's, is it correct that she was referred to you by plaintiff's counsel, Glen Lerner & Associates?

A. I don't know that. I think she was a second opinion for treatment.

Q. A second opinion.

How did she come to go to you for a second opinion?

A. I'm not sure, actually.

Q. Okay. So it's possible that Ms. Garcia was referred to you by Glen Lerner's office?

A. I'm certain that almost anything is possible, Counsel.

Q. Well, you can take a minute, look at your records, and let us know.

You would have an indication in your file, would you not, as to where this patient came from?

A. I might.

Q. Thank you.

A. I don't see in the medical records if I can answer your question any better.

Q. Okay.

A. If there's something in my file you have that I didn't print out for my binder, I'm happy to look at that it for you.

Q. Okay. Fair enough.

Now, aside from this case, this patient, Ms. Garcia, you -- is it a fact that you have had -- you have a -- you have a -- a -- a relationship of sorts with Glen Lerner's office where you have -- you are the treating physician for a number of their clients; is that correct?

A. Well, I don't know that I can answer based on the way you phrase the question because it implies there's some type of relationship, which is no different than a relationship I have with you here today in that I'm treating someone and you're a party or a representative for a party litigant.

Q. So, Doctor, let me ask it this way: Have you treated -- since March of 2011 and today, have you treated any patient -- any of -- any clients that would have been -- or any -- let me rephrase that.

Since March of 2011 and today, have you treated any patients who are also clients of Glen Lerner's office?

A. Yes.

Q. Okay. And how many open cases do you currently have with Glen Lerner's office with -- with clients of theirs that are also your patients?

A. I probably have a dozen or dozen and a half cases at this time.

Q. Okay.
A. Where there's such overlap.
Q. All right. And can you tell us and tell the jury how you came to market yourself to Glen Lerner's office. How you -- how you developed a relationship with Glen Lerner's office to treat their -- their clients.
A. Well, again, you -- you keep embedding this concept of relationship. I'm a doctor in the community. I don't know that I have any relationship with them any more than I have one with you. Your question also implies I do some type of marketing to attorneys, which I do not. I've met some of the attorneys along the way. I treat spine problems. A lot of spine problems are injuries. A lot of patients have injuries sometimes have to file a lawsuit because of the way they're damaged or the way they're suffering. That doesn't mean I'm marketing to them.
Q. Doctor, do you and I have a relationship outside of this courtroom?
A. No. That's exactly my point.
Q. Okay. But you do have some sort of connection with Glen Lerner's office, insofar as you treat patients who are also clients of Glen Lerner's office; correct?

A. I don't have a relationship with the Glen Lerner office, except for that overlap. And that overlap extends the same way it does to you in that you might defend patients or people who caused injuries to clients I might be treating who happen to be represented by Glen Lerner. It's no different.

Q. I asked you about a connection, Doctor, in that question not a relationship.

Do you have some connection with Glen Lerner's office, whereby you receive -- whereby clients of theirs are -- are directed to you for an evaluation? Yes or no?

A. Not that I know of.

Q. Well, if not yourself, then who would know? Someone else in your office?

A. I don't think so.

Q. Okay. So you seem uncertain about that, so --

A. No. I just want to be accurate for the jury.

Q. Okay.

A. And I'm happy to answer further, but I don't want to get outside the color of your question.

Q. So you -- you obtained your license in March of 2011, and within two months, you have Emilia Garcia who is a client of Glen Lerner's office; correct?

A. Yes.
Q. Okay. And would she have been the first client referred to you or the first client who you treated as a patient who's a client of Glen Lerner's office?
A. I don't know.
Q. Okay. And isn't it a fact that you had -- at the time in September of 2013, you had about five to ten open cases with clients of Glen Lerner's office?
A. Probably.
Q. And -- and then you've also worked on -- you've also had patients where they have been clients of Glen Lerner's office whose claims have resolved; is that correct?
A. Yes.
Q. Okay. And back in 2013, you -- you believed at the time of your deposition there were about 10 to 15 other cases; correct?
A. Yes.
Q. Would you agree this is a pretty financially profitable relationship between your office and Glen Lerner's office?
MR. ROBERTS: Objection. Form.
THE COURT: I'm going to allow the question. Overruled.

You can answer.

THE WITNESS: For whom, counsel?

BY MR. MAZZEO:

Q. For -- well, for you, Doctor.

A. Not for you?

Q. Doctor, for yourself -- why -- I don't work on any clients of Glen Lerner's office. I'm asking about -- you understand you're in here as an expert, a neurosurgeon; right?

A. I understand that.

Q. And you've provided treatment to Emilia Garcia who is a client of Glen Lerner's office? Yes?

A. Indeed.

Q. And you have provided treatment to at least -- at least 30 other patients who are also clients of Glen Lerner's office?

A. I have.

Q. And you know that; right?

A. I know that I have.

Q. Okay. Good. So -- so my question, then, getting back to the question I asked you before, that this is a financially profitable relationship between yourself and Glen Lerner's office; correct?

A. Any source of a patient, chiropractor, physician, friend, Internet, Glen Lerner's office, even

if it's not sent by them but they happen to represent the client, benefits me financially, I suppose, because I'm a doctor in business taking care of patients.

Q. What other plaintiff's firms do you obtain patients from who are also clients of a -- with a medical-legal claim?

A. Well, I do some expert work in the community where I'm not treating, and I have had some clients from the Harris firm. I can't name many others with any frequency more than maybe one case a year to look at. Also some defense firms.

Q. Okay. And is it fair to say that since you obtained your license in March of 2011 that the patients who have had medical-legal claims in this community, most of the patients that have worked on with medical-legal claims have been also clients of Glen Lerner's office?

A. I don't think so.

Q. So is it possible that you have more clients from another plaintiff's firm in town?

A. No.

Q. Or patients, I should say.

A. Not necessarily.

Q. Okay. Now, you also testified that you had -- on direct examination earlier this morning, you

treated on a lien; correct? You said that?

A. The treatment, yes.

Q. The treatment, yes.

And -- and is it -- it's common to typically take third-party claims on a lien as you did in this case; correct?

A. I have made that part of my practice, yes.

Q. And you understand what I -- what I mean when I say "third-party claims"; right?

A. I believe I do.

Q. And that's where there's been a claim asserted against by a -- another individual or company who might be responsible for the injuries sustained by a patient.

A. That's my understanding.

Q. Okay. And is it fair to say that you would typically never take an average walk-in patient on a lien, you'd never treat them on a lien?

A. Well, your question uses the word "typically" and "never," so I'm confused.

Q. Okay. Well, let me just ask you: Have you ever treated a patient who does not have a third-party claim, who is otherwise just a "walk-in" patient, have you ever provided them treatment such as with Ms. Garcia in this case, a $70,000 surgery on a lien?

A. Well, I don't know about surgery. But yes, I see patients who are, we'll say, not represented, or on a lien for other reasons, yes.

Q. With respect to a claim of some sort?

A. I have many patients I treat early after, let's say, an injury who haven't even filed a claim. But we -- we have them sign a lien as a matter of security instrument against my billing.

Q. Okay. And with those patients that you're referring to, those are patients who may have -- who may anticipate filing a claim for an industrial claim or third-party claim of some sort.

A. Well, I can't speak to what someone anticipates. I think that would be speculation on my part.

Q. Okay, Doctor. What I'm asking about is: You understand the -- when you sign a patient up and have -- have a patient actually sign a lien with your office, it's with the knowledge, you understand the circumstances giving rise to the alleged injuries; correct?

A. Well, they usually sign a lien when they fill out their initial paperwork before they come back and see me. I don't know anything yet. So they might talk to my front office about how they're going to pay.

And -- and that might be part of the equation.

Q. And part of the equation is if it's an industrial claim or a third-party claim where there's an accident and there's potentially a third party that's responsible, those are the ones that you would consider having sign a lien; correct?

A. Probably.

Q. Okay. And that's typically only where there's a -- a potential third-party payee as in a case like this or in a workers' compensation type case.

A. I suppose.

Q. And isn't it true, Doctor, that they charge for your services whether it's for a follow-up neurosurgical consultation or for a fusion surgery as you performed in this case, that there's a difference in -- in the amount that you bill on a lien as opposed to a private patient who's paying for themselves?

A. You're incorrect on two parts there in your question, so I can't answer affirmatively.

Q. The -- is it correct, Doctor, that this lien that you have the patient sign gives you an interest in the outcome of the litigation?

A. No.

Q. Well, you certainly have an interest in -- in wanting to get paid for the services you provided in

this case; correct?

A. Well, I'm in business to provide medical services, and that business is hopefully not losing money.

Q. And if you can't tell the jury that all of the treatment that Ms. Garcia's received is related to this accident, including your surgery and all your follow-up consultations, then there's the chance that you may not get recompensated, at least by way of a verdict, for the service you provided.

A. Well, first, anything is possible based upon the way you phrased your question as to "chance." So I'm certain that's of no interest from an expert.

Secondly, there's nothing I've said medically here or in the past or will answer that has anything to do with the outcome of this trial. My services are on a lien as a delay contract. It's not a contingency. I want to make that absolutely crystal clear to you and everyone in the room.

Q. But, Doctor, my question was: Having the medical lien where you have not been paid yet for your services, that gives you -- you -- you have -- you have an interest, then, in getting paid, obviously? Yes?

A. I have an interest in justice. I have an interest in my business succeeding, but I don't have an

interest -- a financial interest in the outcome of this proceeding.

Q. You don't have any?

A. Correct.

Q. So if the jury determines at some point that your fusion surgery and all your consultations are not related to this accident, then you realize as you're sitting there testifying that you may not get paid for anything that you have performed, done in this case, except for the expert services you provided to plaintiff's counsel.

A. That's not correct.

Q. Okay. Now, Doctor, moving on. Is it -- would you agree with me that nearly everyone in their life will experience low back pain? I'm not saying everyone, but nearly everyone will experience low back pain at some point in their life?

A. Transiently, temporarily, yes, that's common.

Q. And is it -- would it be correct to say that low back pain is the second most common cause of missed days of work in the U.S.; only the common cold is -- precedes that?

A. I believe that's true.

Q. Okay. And is it correct to say that some well-known factors that contribute to low back pain

include poor conditioning?
A. Yes.
Q. Poor physical condition?
A. Yes.
Q. And including smoking?
A. Yes.
Q. And then also improper use of lift techniques and proper use of the back and lifting?
A. Yes. Those are risk factors for back pain.
Q. Would obesity be another factor that might contribute to low back pain?
A. Yes, it might.
Q. And is it correct to say that obesity can have an impact on -- in causing spondylolisthesis?
A. Obesity itself is not a cause of spondylolisthesis.
Q. Not a cause -- let me -- let me rephrase that.
Is it -- is it correct to say that obesity -- obesity can contribute to symptoms related to spondylolisthesis?
A. In the face of spondylolisthesis being caused by something else, obesity can accelerate the problem.
Q. Is it correct to say that obesity can alter the normal body mechanics to prematurely wear out

joints in the back and either cause or -- or -- or progress a pars defect to -- to worsen?

A. It can, possibly.

Q. Okay. And with respect to this case and your -- your patient, Emilia Garcia, would you agree that she was not in the best of physical conditioning?

A. At what point?

Q. Well, when you first evaluated her on May 25th of 2011.

A. Yes, she -- she doesn't have a perfect, ideal body size.

Q. And that wasn't my question, Doctor. I wasn't being critical of the plaintiff. I wasn't saying that she didn't have an ideal, perfect body size. You interpreted it that way.

My question was -- my -- to you was: Would you agree that Ms. Garcia, at the time that you evaluated her on May 25th of 2011, excuse me, that she was of poor physical conditioning?

A. Well, then I'm going to have to say your -- if -- if I look at this generally, you're vague because I'm not sure what part of her conditioning. I mean, her arms were strong. Her leg muscles were good. Those were well conditioned. Her back was, as I recall, tight muscles responding to her injury by the

time I saw her. She was overweight, Counsel, if that's what you are headed towards.

Q. Well, that's what -- I think I was referring to that by the word "obesity," Doctor.

A. I'm sorry. Then the question had to do with conditioning, so maybe you can be more specific.

Q. So the conditioning meaning muscle strength in the core -- core muscle strength in her body?

A. Well, again, her back muscles were tightened and had increased tone. And the only two reasons for increased tone are muscle spasm and contracting a muscle or having a -- a super strong physique. So she either had a really strong core or was in spasm when I saw her at the initial visit for her back muscles. I did not study her abdominal muscles, to speak of.

Q. Fair enough.

She was also an active smoker at the time of your consultation?

A. She was.

Q. And would you -- would you consider her -- her size when you saw her in May of 2011, five-foot at approximately 170 pounds, to be obese or overweight?

A. Yes.

Q. And were you familiar with her work duties at her job at Aliante as a assistant cage cashier?

A. Yes.
Q. And her work duties included lifting weighted bags from the floor to the lower shelf?
A. I'm not familiar with that part. I was familiar with her standing most of the day.
Q. Okay. Now, would you agree that as we age, we, people -- this is a generalization I'm asking you for -- that spinal disks break down and deteriorate?
A. Our disks deteriorate. Break down, I think might be somewhat prejudicial. They deteriorate as the normal part of aging. I think that's fair. I can't speak to the other aspect of your question.
Q. That -- fair enough.
So you agree that as we age, the spinal disks deteriorate?
A. Yes.
Q. And that can be seen in the form of desiccation?
A. That's one form of it or one finding.
Q. Thinning of a disk is another condition?
A. Yes.
Q. Okay. Drying and dehydration is another?
A. Well, that's the same as desiccation.
Q. Desiccation. Thank you.
And so these conditions are known as

degenerative disk disease?

A. I'm sorry?

Q. These conditions, the desiccation, the thinning of a disk, is that known as degenerative disk disease?

A. I'm sorry. I thought we established earlier today that conditions are problems, and certainly aging is not a condition. So now you're -- you're -- the preface of your question is confusing and alternative to my prior testimony.

So can you break that down a bit, please?

Q. So I guess from your perspective, you would refer to it as a normal age-related changes, dehydration, the desiccation, the thinning of a disk?

A. Yes. With age, we expect to see these things happen in our disks.

Q. And that includes -- age-related changes will include bulges occurring; correct?

A. Yes, bulging but not herniations.

Q. Okay. And now, herniation is where there's a disruption -- there's a tear in the annulus fibrosis; correct?

A. That's one of the elements, yes.

Q. And are you -- but herniations can occur from a -- a number of factors. From an acute injury;

correct?

A. Yes, acute injury.

Q. Also, from sneezing, herniations can occur where there's a -- there's a tear in the annulus fibrosis.

A. It's an -- extremely rare, but a forceful enough sneeze is an acute injury.

Q. Okay. And would you agree that these age-related changes in the spine as we age occur in people who smoke cigarettes?

A. They age too.

Q. Okay. Well, they age too, but they age also in an accelerated fashion than people who don't smoke cigarettes.

A. Well, there's a risk for that. It's not mandated or guaranteed that someone who smokes, that that person's spine will age faster than someone else's. It is simply an observation in epidemiology. It does not necessarily apply to an individual.

Q. Fair enough.

And -- and these age-related changes that occurred to the disks in the spine start occurring in -- in -- as we age in the 30s and 40s; correct?

A. Well, it varies. And we -- we believe that to vary based upon both genetics and lifestyle. For

example, a construction worker might have more degeneration earlier than someone who sits at a desk.

Q. And -- and just according to your record of May 25th, 2011, I believe you had indicated or Ms. Garcia indicated to you at the time of the consult that she was a smoker for 27 years of her life; is that correct?

A. If it's in my consult, then it's correct.

Q. Okay. And you can take a moment to look at your consult just to confirm that what I said was accurate, Doctor.

A. Thank you.

Yes, you read it properly.

Q. Okay. And is it fair to say that people who are overweight or obese are more likely to have symptoms of degeneration disk disease and/or conditions than people who are not?

A. You used the phrase "disease." Can you help me understand that so I can answer accurately?

Q. If I take the word -- oh, I said disease or conditions, so if I take disease out -- why don't you like the word "disease"?

A. Because it's inaccurate --

Q. Why?

A. -- it's improper and unjust.

Because aging isn't a disease, otherwise we're all in trouble.

Q. Well, we're not talking about our age -- we're talking about the disks that break down; right?

A. I'm just trying to answer your question. And I don't want to make the wrong judgment from the words you were using.

Q. Fair enough. Fair enough. Okay.

So a disk -- a bulge, a disk bulge, would you consider that to be a normal, healthy disk?

A. It depends on the context.

Q. Well, a normal, healthy disk, am I not correct to say that a normal, healthy disk stays within the confines of the edges of the vertebrae?

A. Well, bulging, by definition, is a diffuse relaxing of the annulus. Not nucleus material coming out beyond the edges of the vertebra. So one can have some age-related changes of the spine, if I can help you ask your question, by which there is bulging, and that person can be perfectly healthy. So it's not the perfect disk as if someone's 18 years old, but it still could be a healthy disk.

Q. When you say the person can be healthy, you're talking about the overall condition of a person?

A. No. I was answering the question that you

used because I think you used the word "healthy," "healthy disk." I wasn't speaking to the person necessarily. I was speaking to the disk by virtue of your own question, Counsel.

Q. Okay. So --

A. Bless you.

Q. -- you would classify a bulging disk that is maybe flattening or protruding beyond the edge of the sides of the vertebrae, would that be considered a healthy disk?

A. There's a difference between bulging and protruding. So your question uses both words and mixing them. I can't answer that question.

Q. Let me separate it.

So protruding bulging disk.

A. I'm sorry. You didn't separate them. You put them back together.

Q. Well --

A. Those are different things.

Q. No, I understand they can be different things, but they can also be one and the same.

A. No, they can't. Actually, there's consensus literature on this topic. A bulge is very different than a protrusion.

Q. So a protrusion, then, in your terminology,

would -- would be a disk that protrudes beyond the edge of the vertebrae.

A. It's not my definition. It's the consensus definition published in *Spine* in 2001 by Milette and Fardon, initially. And a bulge is a diffuse relaxing of the annulus greater than 50 percent of the circumference of a disk. A herniation, of which protrusion is the form that does not burst through the ligament, is tearing in the annulus with herniated nuclear material going outside of the borders of the bone less than 50 percent of the circumference of the disk. It can be focal. It can be broad based. It can be both sides.

Q. Posteriorly?

A. Posteriorly is one area, yes.

Q. Okay. All right. Now, let's move on to what you testified to earlier.

The condition that Ms. Garcia had spondylolisthesis, which is --

A. Can I ask for clarification as to at what time?

Q. You testified to that earlier this morning.

A. I'm sorry. You're being vague as to what time. You mean after the injury or before the injury?

Q. Well, no, after -- after the injury.

A. I'm just being clear.
Q. Okay. So it's -- it's what you identified from your review of the January 26th, 2011, MRI of Ms. Garcia's lumbar spine. You had identified at the time of that consult a spondylolytic spondylolisthesis.
A. Yes.
Q. Okay. So is it correct that causes of spondylolisthesis, a slipped vertebrae, can be due to trauma, degeneration, tumor, and/or birth defects?
A. They can possibly be those things.
Q. Okay. And -- and an isthmic, i-s-t-h-m-i-c, spondylolisthesis would be a defect in the pars interarticularis of the vertebrae; correct?
A. Yes.
Q. And a traumatic spondylolisthesis would be due to direct trauma to the vertebrae.
A. Yes.
Q. And a traumatic spondylolisthesis could be caused by a fracture of the pedicel, the lamina, or facet joints?
A. It could be possibly caused that way.
Q. Which, as you've testified earlier today, when there's a -- a defect in -- in the -- in the pars interarticularis, it allows the portion of the vertebrae to slip forward on top of the one below it;

correct?

A. Correct.

Q. Typically occurring, as you said, at the L5 -- with the L5 disk on top of the S1.

A. Most commonly, yes.

Q. And the surgery that you had performed on Ms. Garcia, you said that was not an emergency surgery or an urgent surgery.

That was an elective surgery for her; correct?

A. Correct.

Q. And have you ever performed a -- an emergent or urgent surgery on a patient of this nature where they had a spondylolisthesis and pars defect?

A. Yes.

Q. Okay. And what would be considered, from your own experience, an emergent or -- or an urgent situation where you would have to get that patient in from time of consult to surgery?

A. The urgent part would be, and was in my patient where I did this in the last few years, progressive neurological deficit. She was getting a foot that stopped moving, called a drop foot, and was losing control of the nerves to her bladder because she had a Grade V, IV becoming V, spondylolisthesis. So I

had to get her in to free up her nerves quickly.
Q. Okay. And what -- what period of time did you perform the surgery after your consultation with the patient?
A. I think within 12 hours.
Q. Very quickly. Very soon.
A. Yes.
Q. Okay. And have you ever performed a surgery on what -- what -- what would be considered an acute Grade II spondylolisthesis?
A. Yes.
Q. Okay. And would symptoms associated with an acute Grade II spondylolisthesis include immediate onset of pain?
A. It could.
Q. And would it also include severe low back pain and leg pain?
A. It could.
Q. Okay. And -- and I believe you testified earlier that symptoms associated with a -- with a spondylolytic spondylolisthesis include pain symptoms in the legs; correct?
A. They can, yes.
Q. Well, not just can, but would -- would you agree that it's more often than not you're going to

have pain symptoms in the legs?

A. At some point with progression, yes, I agree with that.

Q. Typically, it's going to be about -- if we -- if we proportion it, it's going to be about 20 percent in the pain in the back and about the 80 percent pain in the legs.

Would you agree with that?

A. In what setting?

Q. With a -- with an acute Grade II spondylolisthesis.

A. Immediately acute to Grade II? I don't know that I know that necessarily. Different patients present differently.

Q. Okay. And would you also agree that a patient who has sustained an acute injury to a Grade II spondylolisthesis will have significant decrease in functionality?

A. Probably developing that as a progression, yes.

Q. You -- you referred to this word "progression."

But would you agree that if there was an acute injury to a preexisting spondylolytic spondylolisthesis where there's actually the L5 slips

forward to such a point where there's actual pressure on the nerve as a result of the traumatic injury, not as a result of progression, but immediately, contemporaneous with the event, that there would be an immediate onset of pain?

A. It doesn't have to be immediate, but I would expect symptoms in the back and leg within days or weeks.

Q. Well, more likely you're going to expect symptoms within a few hours. If not immediately, then within a few hours on the day of the traumatic event.

A. That's not my experience.

Q. Is that not your experience or that's just not -- doesn't fit into your evaluation of Ms. Garcia in this case because her pain symptoms didn't start until three days after the motor vehicle accident?

A. I'm not sure that's 100 percent true. But Ms. Garcia aside, it's my experience that we treat the facts and the patients. And patients come in with symptoms, and then we have to figure out what caused those symptoms. So trying to reverse engineer it your way is illogical from a medical view. So I'm not sure I can answer your question as an expert physician or treating doctor.

Q. Would you agree that treatment of an acute

injury to a preexisting Grade II spondylolisthesis would include building up stomach and back muscles, in other words, core strengthening?

A. Are you asking is that a potential treatment?

Q. Yes.

A. Yes.

Q. And in -- in patients that had this condition who are overweight, the recommendation would be for them to lose weight; correct?

A. Yes. Regardless of injury.

Q. And would you agree that surgery for a symptomatic surgery for a -- let me rephrase that.

Would you agree that fusion surgery for a Grade II spondylolisthesis should only be performed where you have an unstable spondylolytic spondylolisthesis?

A. Not necessarily. But that's a good reason.

Q. Okay. Now, in this case -- actually, let me -- just give me a moment. So let me just back up for a minute, Doctor.

So in addition to what you're charging for your time to testify here in court today for the -- it's going to end up to be a full day, I believe, $9,000, for the 35 to 40 hours that you performed or for your services that you performed -- rendered for

reviewing all the medical records and drafting these reports, that comes out to about 15 to $20,000?

A. Yes.

Q. Yes? Okay.

Now, on May 25th of 2011, I believe you -- the only film you actually reviewed on that date was -- was the MRI of the lumbar spine that was performed on May -- or, I'm sorry, performed on January 26th of 2011; correct?

A. That's the only film I had. I did have other reports of X-rays and things, but that's the only film.

Q. Okay. And you had the X-ray report for the lumbar spine that was taken on February 8th of 2011?

A. Yes.

Q. Well, let's talk about that for a moment.

Since you didn't review this X-ray at the time of your consultation, is it fair to say that you had no reason to dispute the radiologist's findings that are contained in the report for this study?

A. Correct. I wouldn't have a reason to or a way to dispute it.

Q. Of course. And according to the radiologist, this X-ray of the lumbar spine that was taken on this day showed a Grade II anterolisthesis of L5 upon S1; correct?

A. It did.
Q. And it also showed L5-S1 disk space narrowing?
A. Yes.
Q. And I believe the radiologist noted a 50 percent slippage of the superior vertebrae over the inferior vertebrae?
A. I'm sorry. Give me one second, please.
Q. Doctor, if you would, just tell me what report and page you're looking at.
A. I'm looking at the actual document from February 8th, 2011. You said something about 50 percent, but I don't see that here. So I don't know where you got that.
Q. Grade II/III spondylolisthesis would be a 25 to 50 percent slippage; is that correct?
A. Where did you get /III? That's nowhere on here.
Q. I'm asking you, Doctor. That was a question. I'm not referring to that.
My question to you is -- listen to the question -- a Grade II/III spondylolisthesis would be a 25 to 50 percent slippage; is that correct?
A. It's incorrect as phrased.
Q. What would that be?

A. What would what be?
Q. What would be the slippage of a Grade II/III -- actually, a Grade II/III spondylolisthesis, Doctor, and I -- I stand corrected here --
A. You asked me to listen to your question, and I did, Counsel.
Q. -- would be a 50 to 75 percent slippage?
A. Grade III --
Q. Grade III.
A. -- is 50 to 75 percent. Grade II is 25 to 50 percent.
Q. Okay. Thank you.
The report -- the X-ray report from -- of the lumbar spine taken on 2/8 of 2011, was that Las Vegas Radiology or Nevada Imaging Center?
A. I have a report from Las Vegas Radiology.
Q. Okay. And based on the radiologist's impressions on that report, is it fair to say that the radiologist did not identify or -- did not identify any -- any acute or traumatic injury to any of what he observed on the film?
A. The radiologist fell silent on the presence and/or absence of cause -- of traumatic causation. He simply reported what he saw in terms of the anatomy.

Q. And based on what the radiologist saw in terms of anatomy, is it fair to say that the conditions that the radiologist noted from that 2/8/11 X-ray study showed only preexisting conditions?

A. Not at all. He doesn't say that at all.

Q. No, I'm not saying what the -- Doctor, I'm not saying what the radiologist --

A. Then, I'm sorry. Can you ask again?

Q. Yeah. So -- yeah, I'm not -- I know that the radiologist didn't actually come out and say, These are all preexisting conditions.

But based on what the radiologist noted in his report for the X-ray of 2/8 of 2011, those findings that the radiologist noted would be indicative of preexisting conditions, more likely than not.

A. By -- by "conditions," are we just speaking of the anatomy? Just so we don't keep fighting about the word "condition."

Q. Yes.

A. Not a patient's symptoms or lack thereof?

Q. Correct.

A. Thank you.

So the anatomic condition as described by the radiologist, he -- he falls silent, and the items discussed could possibly be from multiple things. One

thing it could be is something that was there already or a preexisting anatomic condition possibly.

Q. Okay. Now, directing your attention to the -- the film that you actually did review, that would be the 1/26/11 MRI of the lumbar spine.

And is it correct to say that this MRI was the only test that you used to correlate your clinical findings, meaning it's the only film that you had reviewed to correlate your clinical findings?

A. At the first visit, yes. Later I had other films for further correlation.

Q. Okay. And -- and what this -- what this film showed was a 4-millimeter anterior subluxation of L5 in relation to S1 secondary to bilateral pars interarticularis defects; correct?

A. Yes.

Q. And what's meant by anterior subluxation is basically just a structural displacement of two vertebrae; correct?

A. Yes.

Q. And just -- just so I heard you correctly on your direct exam this morning, it's your opinion that this pars interarticularis defect was most likely developed congenitally or in early childhood.

A. Yes.

Q. And is it correct to say that based on the radiologist's findings as well as your own interpretation of this MRI, that there were no significant disk abnormalities to L1-2, L2-3, and L3-4?

A. I would agree with that.

Q. And is it correct to say that the L4-L5 disk showed presence of disk desiccation?

A. That's one thing that was shown in the disk.

Q. And as you said earlier, this disk desiccation represents a dehydration or drying of the disk.

A. I do. Or did and still do.

Q. And did this MRI also show what's referred to as a central hyperintense T2 signal, which could be a subligamentous annular fissure?

A. Yes.

Q. And as well as a 2-millimeter posterior annular bulge central and lateral aspects?

A. Yes.

Q. Let's talk about annular fissure for a moment.

An annular fissure would be a deficiency in the layers of the annulus fibrosis; correct?

A. Yes.

Q. And it could be any sort of -- strike that.

An annulus fissure doesn't necessarily mean that there's a tear from the inner layer of the annulus fibrosis to the outer layer.

A. Tear and fissure are often synonymous, meaning the same thing. As to the locations, inner layers, outer layers, depends on what is actually shown on the film.

Q. Is it correct to say that annular fissures are very common with -- with age-related changes?

A. Fissures are common with age-related changes. That is one reason.

Q. And -- and annular fissures occur as part of the age-related degenerative process.

A. Yes.

Q. Now, this -- this MRI on 1/26 of 2011 also had a -- showed an AP spinal canal of 1.4-centimeters.

Did you see that?

A. At L4-5, yes.

Q. At L4-L5, yeah.

And would you agree that that would be considered a normal space?

A. It's within the range of normal.

Q. Okay. And at this location, the L4-L5, there was no significant neural foraminal narrowing; is that correct?

A. Correct.
Q. Okay. Now, moving on to the L5-S1 disk.
That also showed disk desiccation with a 2-millimeter posterior annular bulge.
A. My report says 2.2 millimeters.
Q. Okay. And -- and as you testified earlier with regard to the slippage from one MRI, the 1/26/2011 MRI, to the November 2012 MRI, you yourself didn't measure the progressive change in slippage; correct?
A. Well, I can see the progression as eyeballing it, but I didn't get out, you know, a measuring device and actually measure it myself.
Q. Okay. Because we can't really distinguish on an MRI imaging study the difference between a 1 millimeter or a 1 millimeter and a -- and a 3 millimeter; is that correct?
A. No, that's incorrect. The radiologists have very high-resolution monitors and can zoom in such that each pixel represents a fraction of a millimeter. And they can actually give us a measurement.
Q. And what I meant to say -- what I meant to say is we can't -- you can't as a neurosurgeon, nor can I, I certainly can't read films, so -- but the layperson can't eyeball it, eyeball a film and say, Okay, this -- this slippage is -- is so many

millimeters, can you?

A. Well, after learning how to look at a few films, you might be able to eyeball it.

Q. Okay. And this -- this film also showed facet joint hypertrophic changes; correct?

A. Right.

Q. And that's consistent with what the radiologist said in his report?

A. Yes.

Q. Okay. And that -- that term "facet hypertrophy," is a term used to describe degeneration and enlargement of the facet joints.

A. Well, it describes enlargement. The word "hypertrophy" means to enlarge. Like working out would cause you to have hypertrophic bicep muscles, for example. It doesn't necessarily have to be degeneration. It could be caused by degeneration. It also, more probably, is related to the fact that there was a congenital pars defect and the facets had to work harder, so they were hypertrophic, just like a bicep muscle that worked harder would become hypertrophic.

Q. And the facet joints are -- is it a fact that the facet joints could become enlarged as part of the body's response to aging and degeneration?

A. It could be possible.

Q. And the reason for that is it tries to provide additional stability to counteract the instability from the degenerative disk deterioration?

A. Well, I don't want to use the word "instability" or "stability" here. So the way you phrase it is not accurate. There's a better way to phrase it.

Q. Well, let me ask you this: If there is facet hypertrophy from age-related changes, would it be due to the body attempting to provide additional stability to -- to counteract the instability? I'm using the same word --

A. I know.

Q. -- but I'm just asking you to focus on this -- on the facet hypertrophy. Am I saying that correctly?

A. It's fine.

Q. Hypertrophy?

A. Either way.

Q. As a result of age-related changes?

A. I can't answer the question. It assumes that facet joints hypertrophy in relationship to instability as part of some degenerative process. And instability is uncommon as part of degeneration. There's a better way to phrase it.

Q. Tell us, how would you phrase it?
A. Thank you. As disks degenerate with age, they -- they aren't perfect cushions. So then the facet joints take on a stronger role in -- in dealing with the body's stresses, not -- not supporting instability.
Q. Okay. Now, also, according to the radiologist, based on these findings that we were -- we've been discussing, the annular fissures and the facet hypertrophy, he concluded in this report that a combination of these findings causes mild narrowing of the lateral recess and neural foramina.
Do you agree with that?
A. Do I agree with that's what he said?
Q. No. Do you agree with -- I mean, if it's in the report, it's in the report, so --
A. Agreed.
Q. So what I'm asking you is whether you agree with the radiologist's impression that these -- that these conditions caused mild narrowing of the lateral recess in the neural foramina?
A. These anatomic conditions caused, I would call it more moderate narrowing. As I showed the jury earlier when we were looking at the films, I think mild would be an understatement based on what we saw.

Q. The L5-S1 also had a spinal canal of 1.3-centimeters.

Did you see that?

A. Yes.

Q. Would you agree that that's also a normal space?

A. It's within the range of what could be normal.

Q. And what -- when we talk -- use the term "narrowing of the lateral recess," we're talking about a reduced space within the foramen of the spinal canal; correct?

A. Going towards the foramen would be fair.

Q. Okay. And foramen is an opening in the spinal canal?

A. Yes.

Q. And I know stenosis, I don't know if that word was used, but that refers to a constriction?

A. Stenosis does refer to a constriction.

Q. And based on your review of the 1/26 MRI, there was no evidence of any stenosis noted at the foramen?

A. No, I pointed out the elements that contributed to stenosis at the L5-S1 foramina, which is the plural.

Q. That was at the -- I think you -- that was earlier today, you pointed that out on the film. That was at the L5?

A. L5-S1.

Q. S1 level?

A. Yes.

Q. And what's the relationship between having a -- a normal spinal canal space, let's say at the L5 level, of 1.3, the L5-S1 level, and -- and the narrowing of the lateral recess?

A. What's the relationship between the two?

Q. Yes.

A. The -- the -- the relatively normal AP diameter of the canal has to do with the main pipe of nerves. And when that gets really narrowed, you get what's called cauda equina syndrome. That's not relative -- excuse me, relevant to this case. We never got that far. We caught her earlier. When you get into Grade III and Grade IV spondylolisthesis, then we get worried that the canal closes off.

Lateral recess stenosis has to do with the corners of the spinal canal, towards the foramen. So if you have slippage and disk material both, then the nerve has less room to head out the spine, then you start getting leg symptoms.

So the relationship is in the spondylolisthesis case, you're likely to get into some lateral recess stenosis and foraminal stenosis as the spine slips before you get into significant central stenosis or AP diameter stenosis.

Q. And with what the radiologist noted, I know there's a disagreement between yourself and the radiologist, where the radiologist noted a mild narrowing of the lateral recess, and you -- you believe that it might have been more of a moderate narrowing; correct?

A. Yes. More specific to the neural foramina, she says lateral recess and neural foramina at L5-S1.

Q. Okay. And would you agree that mild narrowing of the lateral recess in neural foramina could represent long-standing degenerative conditions? Or if you don't like the word "degenerative," long-standing conditions?

A. It could, possibly.

Q. Okay. Which -- and if it did represent long-standing degenerative conditions, it would have predated this accident that occurred 24 days earlier?

A. Yes. I would have expected such anatomic conditions, if present, to be there before the injury.

Q. So is it correct to say that there was --

based on your review of this 1/26 MRI of the lumbar spine, that there was no evidence of edema on the MRI study?

A. The report does not refer to edema, but we saw it.

Q. When you say "we," you're talking about yourself or you and someone else?

A. Well, I think there's another expert, but I don't want to foreshadow. I'll let you ask that person.

Q. Okay. So you think that you -- as you testified or you're saying, that you may have seen edema on this 1/26/11 film?

A. Your question implies possibility. I did see edema. Certainly.

Q. Oh, you did see it. Okay.

And that's -- that's a -- would you agree that that's a significant finding?

A. Well, it is a finding. A lot of things are significant. I wouldn't just pick one element and say, Oh, that's significant.

Q. Well, would that be significant to -- with regard to whether an acute injury occurred or whether there's a long-standing condition or something else?

A. Possibly.

Q. Okay. Was it -- was it a condition that was not necessarily important to you when you noted it?

A. It's germane. It's interesting. I don't know that it by itself is important, necessarily.

Q. And it's a fact that you didn't make any reference to it in your May 25th, 2011, report, did you?

A. It is a fact that I did not.

Q. Okay. And the fact that you didn't make reference to it might suggest that when you reviewed the film, either, number one, you didn't see or make any note of edema at the time that you initially reviewed the report; or two, you didn't find that any so-called presence to edema would be significant.

A. Are those the only two possibilities?

Q. That's it.

A. Well, then I can't answer your question if you're backing me into that corner because that's an inaccurate corner.

Q. Okay. Well, when did you first come up with this belief that -- that you might have observed edema on the January 26th, 2011, MRI?

A. Well, again, it's not a might observed. I observed it. I observed it here today. I observed it before when looking at all the documents in preparation

for trial. I don't know going back when I first observed it. I didn't realize it was going to be so important to you. I would have observed it much earlier. But it's certainly there.

Q. Okay.

A. I also didn't make note of the exact size of the foramina and certain things like that, but I was aware of it. I didn't put down everything about the film.

Q. And is it your belief that -- that you observed edema at the lower portion of the L5, top portion of the S1?

A. At what time?

Q. Today in court when you were looking at the film.

A. I did observe it.

Q. Today?

A. Yes. Not only today, but also today.

Q. Okay. Well, other than today, did you ever make note of it in any report of your -- in any of your treatment records or any of your nine expert reports that you -- that you drafted in this case?

A. Well, I'd have to go back and look at the expert reports. But in answering the portion of your question deals with my clinical reports, I think I fell

silent on the topic. I didn't say edema was present, nor did I say it was absent.

Q. You didn't make any reference to it whatsoever.

A. In those reports.

Q. In -- in any reports.

A. Again, if my testimony is not clear, there are treatment reports where I fell silent. I mean, I didn't talk about it --

Q. Yes.

A. -- either way. In my expert reports, I have to go back through them. And I don't want to take all the jury's time, but I will if you think it's important.

Q. Okay.

MR. MAZZEO: Judge, just need a moment. Thank you. Appreciate it. You work with so many pages, it's easy to get lost here.

BY MR. MAZZEO:

Q. So, all right, Doctor, I'm going to show you --

MR. MAZZEO: If we can turn on the ELMO, Judge.

MR. STRASSBURG: It's on.

MR. MAZZEO: Great. I just need to turn the

light on. We have a little glare. Let me see if I can maybe turn it off. That's better. Okay. All right.
BY MR. MAZZEO:
Q. So this is Plaintiff's 40B, Slide 1. So I believe, Doctor, this was one of the slides that we looked at on computer today.
You were actually looking at an imaging study not a photograph of a imaging study; correct?
A. Thank you. Yes.
Q. And I believe that you had noted you -- I think you pointed to it at one point. And it's the whitish color on the S -- top of the S1, the -- the edge or the cusp of the S1.
A. Yes.
Q. And the lower portion here where I'm pointing --
A. Yes.
Q. -- to the L5, you see that?
A. Yes.
Q. Okay. And have you heard of the term "Modic changes"?
A. I have.
Q. What is that? What does that refer to?
A. Dr. Michael Modic is a radiologist at Cleveland Clinic, and he described these changes in the

bone marrow adjacent to disk issues.

Q. Okay. And -- and in describing changes in the bone marrow, we're talking about -- would it be a form of ossification?

A. It depends.

Q. Osteophytic-type changes?

A. Well, I don't see any osteophytes here, but it depends.

Q. Okay. And would you agree that this -- this whitish appearance on the top of the S1 and bottom of the L5 could be indicative of Modic changes?

A. Could possibly.

Q. Okay. And, in fact, in your expert opinion, to a reasonable degree of medical probability, more likely than not, it's some form of -- given that the study was taken 24 days after the subject accident, that this discoloration and this whitish appearance is more likely than not a form of ossification indication or bone growth on top of or from within the L5 and S1; would you agree?

A. Not necessarily. I mean, I suppose it's possible. But in the -- in the -- in concert with the disk protrusions, the high-intensity zone at L4-5, the pars defect and, more importantly, the clinical problems, pain and leg symptoms starting after the

injury, I think it's more probable than not that the findings in the bone marrow here are in response to the disk stress as part of injury.

Q. But these -- these changes in the bone marrow, would not occur within 24 days and represent themselves as they are depicted on the film and in this photograph; would you agree?

A. Not necessarily.

Q. Let's talk about -- let's talk about these procedures that you had performed on Ms. Garcia on January -- December, actually, 26th of 2012. I just want to -- and also want to refer to some structures in the back.

When we refer to the term "spinal stenosis," we're talking about a narrowing of the spinal canal that can cause chronic pain, numbness, and muscle weakness in your arms and legs; correct?

A. Well, you're somewhat compound. Not only in to the different -- different part of the body, but also, arms pertains to the cervical spine, meaning the neck. So I think you're speaking somewhat overbroadly. But if I'm allowed to answer overbroadly, then sure.

Q. And you -- you can because I was purposefully being overly broad. I was talking about spinal stenosis in the spine, the cervical, thoracic, and

lumbar. Certainly in the cervical, if you have spinal stenosis, the -- the pain, numbness, and muscle weakness would go into the arms. And the spinal stenosis in the lumbar spine would produce pain, numbness -- chronic pain, numbness, and muscle weakness into the legs; correct?

A. Correct to a degree. It's not 100 percent correct because you're speaking about the diagnosis of stenosis, not stenosis related to a spondylolytic spondylolisthesis with no onset pain.

Q. That's correct, I was not. I was just speaking -- I was just asking specifically about the term "spinal stenosis."

A. Okay. Then very generically, you're correct.

Q. And when we speak of foramina, we're talking about openings where the nerve roots normally exit the spinal canal?

A. Yes.

Q. And if the foramina become narrowed, painful nerve compression can result from that?

A. It can, yes.

Q. Laminectomy, as you talked about, removes the entire bony lamina in the back portion of the vertebrae?

A. It does.

Q. A portion of the enlarged facet joints and ligaments overlying the spinal cord and nerves?
A. Well, the facet joints, it's called a facetectomy, but otherwise, yes.
Q. Okay. And in this case, you did both the laminectomy and a facetectomy --
A. Correct.
Q. -- at the same time.
And -- and a laminotomy you also performed in this case in addition to the laminectomy.
A. Yes.
Q. The laminotomy is the removal of a small part of the lamina and ligaments, usually on one side in order to decompress the corresponding spinal cord and the -- and/or the spinal nerve root.
A. Well, I don't know that it's usually on one side, but in this case, it was both sides as it applies to the L4 and S1 levels.
Q. Have you ever performed a lamin -- sorry, a laminotomy where you removed a small part of the lamina and ligaments on one side as opposed to both?
A. Probably.
Q. Okay. And -- and there's a reason -- isn't there a reason for -- for doing a laminotomy on one side as opposed to both because it allows for the

natural support of the lamina left in place on the other side?

A. That's not the reason.

Q. What -- what do you think is the reason?

A. Because there's no reason to go on the other side in some cases.

Q. But if you only -- but if you do only perform a laminotomy on one side, would you agree that by leaving the other -- the lamina on the other side in place, it allows for support of that structure?

A. The -- the other untouched lamina is not specifically required when one does a laminotomy because a laminotomy means part of the lamina is still intact. So no additional support is really needed.

Q. So -- but -- but a laminotomy can be performed where the lamina is removed from both sides.

A. Then it's a laminectomy not a laminotomy.

Q. Oh, and that's -- so a laminectomy is where you remove the entire lamina.

A. You can do a one-sided laminectomy, I think is what you're really trying to ask me.

Q. Can you do a one-sided laminotomy?

A. Sure. I do them all the time.

Q. That's what I was asking you about.

So -- so you can do a one-sided laminotomy.

A. Not in a case like this.
Q. I wasn't asking you about a case like this one.
A. I just want to make it clear to everybody.
Q. Oh, yeah, yeah. No, I was just asking you in general about surgical terms. That's all.
A. I see. Yeah, one can do a one-sided laminotomy. It's -- it's a common procedure.
Q. And it's a common procedure, and it's -- is it preferred to do a one-sided laminotomy, rather than a two-sided laminotomy because it allows the additional support from the lamina that's left in place?
A. No. The lamina is still in place with a laminotomy. Just -- you're just taking a little piece away.
Q. Now, in this case, you performed bilateral laminotomies; correct?
A. At L4 and S1. But laminectomies at L5.
Q. Okay. At L4 -- at L4 and S1 you performed bilateral laminotomies.
A. I did.
Q. Okay. And by performing bilateral laminotomies at those two locations, would you agree that that would increase postoperative spinal instability?

A. No, not at all.
Q. Facet -- hold on one second.
Now, a facetectomy is a procedure used for decompression of the spinal cord root; correct?
A. In part.
Q. And in part a decompression of the nerves -- of the nerves going through the foramen.
A. Also in part.
Q. Okay. And also -- now, you also did a foraminotomy; correct?
A. Yes.
Q. Which is removal of the bone around the neural foramen.
A. Yes.
Q. And the bone around the neural foramen is the space between the vertebrae or where the nerve root exit the neural foramen.
A. Correct.
Q. Or exits the spinal canal.
A. Both. Both are correct.
Q. Okay. And is it -- is it correct to say that decompression surgery for spinal stenosis is elective surgery as opposed to urgent surgery?
A. There are urgent reasons to do it. I would say it's more commonly elective.

Q. Okay. Now, in this case, you had -- from your review of the operative report -- give me one second. Let's see.

Well, according to the operative report, you had -- you performed an L5 gill type, G-i-l-l, type laminectomy; is that correct?

A. Yes.

Q. And you removed the gill lesion at L5 and removed the facets at each level from L4 to S1; correct?

A. The facets at L4-5 were partially removed, but the gill at L5 takes away the entire L5 facet.

Q. Okay. So then all of the facets removed from L4-L5, S1? No?

A. No. The L5 component is removed and only part of the -- the L4. The part that goes up to L3 is untouched.

Q. Sure. Okay.

And would you agree that extensive removal of the lamina adds to the instability of the spine?

A. It could, yes.

Q. And is it correct to say that you did not use a rod on the right side from L4 to S1?

A. I used it on the -- from L5 to S1. But as you may recall from my earlier testimony, I had trouble

with the right L4 screw, and I had no place to put the rod up there.

Q. Okay. And by not using a longer rod on the right side, is it possible that that could lead to instability, especially after removing the facets and lamina?

A. I didn't remove the facets that high. I didn't remove the lamina that high. I did laminotomies. So, no.

Q. So you used -- you removed a -- a portion of the lamina --

A. Right.

Q. -- at those levels?

A. Correct.

Q. So I should have qualified it, then.

So could the -- could your -- the fact that you didn't use a longer rod on the right side, could that lead to instability after removing a portion of the lamina on the right side?

A. Highly unlikely, but anything's possible, I suppose.

Q. And is it possible, also, that excising these -- these parts, the lamina, the facets, could result in failure of the fusion?

A. No. Excising these parts contribute to

fusion because we use that bone to create the fusion. The excision and the fusion are separate things.

Q. But the -- the procedure that you had performed -- well, strike that.

In your operative report, you referred to a allograph material that you used to support the arthrodeses.

A. Yes.

Q. What allograph material did you use?

A. I didn't specify the type, and I don't have the hospital file with the implant log and biologic log. It would be in there.

Q. Okay. Do you have any recollection as to whether it might be a biologic morphogenic protein?

A. It may have been.

Q. Okay. And -- but would it help if you had the -- oh, go ahead.

A. I'm sorry. I found it. It's on the last page of my operative report. It says Bacterin putty. So it's a demineralized bone putty. It has calcium, magnesium, phosphorus, things that bone cells are looking for to make more bone. Bone food.

Q. Bacterin putty allograph.

A. B-a-c-t-e-r-i-n is the company of the product.

Q. Okay. Does that have any relationship to a morphogenic protein?

A. Not that I'm aware of.

Q. Okay. And are there -- are there complications associated with Bacterin putty allograph?

A. Not when used properly, no.

Q. Okay. What if not used properly? What are some complications?

A. Well, if I opened it or the nurse opened it to give it to me and she sneezed on it before she handed it to me, the patient could get an infection.

Q. Okay. Is that the only complication from using a Bacterin putty allograph?

A. As far as I know.

Q. Doctor, would you -- would you agree that a -- when you -- when a patient comes to you and they -- they give you a history of the present illness and past medical history and -- and -- and they self-report to you regarding an event that might have contributed or caused their -- their pain symptoms, would you agree that a patient's recollection is better closer to the event being described and diminishes over time?

A. Probably.

Q. And in attributing injuries to a specific

traumatic event, is it fair to say that you consider preexisting conditions, onset of symptoms, diagnostic studies, and mechanism of injury?

A. If they exist, yes.

Q. Okay. When we refer to the term "traumatic injuries," we're referring to injuries that are sustained from a traumatic event; fair enough?

A. Yes.

Q. And in diagnosing traumatic injuries, you -- you would expect that the onset of symptoms from a traumatic event would arise in close proximity to the traumatic event.

Is that fair -- fair to say?

A. Usually, but not always.

Q. And symptoms that arise further away from a traumatic event would usually be less likely related to that event; correct?

A. Generally as a trend, yes.

Q. And when we refer to the term "causation," we're referring to an event causing an injury or condition?

A. Yes.

Q. And would you agree that there's a direct correlation between a patient's reporting of past medical history and history of present illness and

causation of injuries?

A. I'm not sure I understand your question.

Q. Okay. When a patient comes to you and self-reports and tells you that -- gives you a report of the past medical history and also the history of the present event or history of present illness or injury, those -- that self-reporting by the patient are significant factors for you as a physician in assisting you to determine causation.

A. They can be.

Q. And would you agree that another factor impacting your determination or a doctor's determination of causation would be onset of pain?

A. Yes.

Q. And would you agree that a patient's reporting of symptoms contemporaneous with an event would be more accurate than a patient recalling symptoms later on as they -- as time becomes -- as -- as we get further away from that event?

A. Generally, yes, as a trend.

Q. And is that the reason why medical doctors such as yourself want to ascertain from the patient's earliest medical records the reporting of symptoms that occurred, when they first reported them following a traumatic event?

A. That's one element we would look to, but not all elements we would look to.

Q. Now, I just want to go over some of the -- some of the information that you had at the time of your initial evaluation on May 25th, 2011.

And when you had first evaluated Ms. Garcia on May 25th, you had testified earlier that you had MountainView Hospital record, the records from Dr. Gulitz, I believe --

A. Yes.

Q. -- maybe as well as a number of reports from imaging studies?

A. Yes. There are few more items, but generally that's most of what I have.

Q. Yes. And I think you also said Primary Care Consultants, that Mr. McGauran --

A. Yes.

Q. -- the PA?

Okay. And so based on your review of the records in addition to your -- well, strike that.

Based on your review of the records at the time of your initial consultation, you knew that Ms. Garcia reported that she was not injured at the scene.

A. I'm sorry. One second, please.

Q. Sure.

A. I don't see from my summary any discussion of the presence or absence of injury in the State of Nevada Traffic Accident Report. But I don't have the actual accident report in front of me.

Q. Okay.

A. So if you -- if you -- I can't answer more accurately without looking at it again. I'm sorry.

Q. Fair enough.

And that's -- I was going to direct your attention to that next because I know that this morning you had indicated that you had reviewed the traffic accident report in this case. Okay.

MR. MAZZEO: Judge, may I approach not the witness, but behind him there are the trial -- the exhibit books, the binders?

THE COURT: That's fine.

MR. MAZZEO: Yeah? Thank you, Judge.

And if I may, I just want to show a -- it's not in evidence, so I just want to show it to the doctor.

THE COURT: That's fine.

MR. MAZZEO: So for the record, I'm showing the doctor Plaintiff's Exhibit 1, page 4.

/////

BY MR. MAZZEO:

Q. And I'm going to direct your attention to the top of that page. Take a moment to look at it --

A. Thank you.

Q. -- and tell me if that indicates to you whether or not injuries were reported at the scene.

A. (Witness reviewing document.)

Q. Doctor, if you stay on that first page.

A. If it's okay with you, I'd like to look at the entire document before I answer any questions.

Q. But before moving on to the second page, did you see the part on the first page of the location of the box that indicates that no injuries were reported at the scene?

A. Well, I'd rather be accurate. There's a box -- there are three boxes that can be checked by, Officer Gibbs -- yeah, Robert Gibbs; is that right?

Q. Well, it's Officer Figueroa, but regardless, that's fine.

A. Sorry. So Officer Figueroa I assume filled out the report. There are three boxes. One says Property, one says Injury, one says Fatal. And only the Property box is checked. I think that's the more accurate answer.

Q. Okay. But the box -- I'm not asking you

about property, Doctor. So stay on that page for a second.

The box which has Fatal and the box that has Injury, neither of those are checked; correct?

A. That is correct.

Q. Okay. Thank you. Okay.

Doctor, we're going to move on. It's a long report. I don't need to ask you about the other portions of that report. Okay?

A. Okay.

Q. Thanks. Thank you.

So does that refresh your recollection as to when -- or as to the fact that Ms. Garcia did not report that she was injured at the scene? Or you have some other understanding?

A. I just want to take a look at my history to see if I do have another understanding.

Q. Sure.

A. She didn't tell me if she knew she was injured or not at the scene. She just said she was in shock.

Q. Okay. And did you know that Ms. Garcia went to work the day after the motor vehicle accident on January 3rd of 2011?

A. I don't know that I knew that on May 2011

when I saw her, but later perhaps in her deposition, I think I came to understand that.

Q. Okay. And you have no reason to dispute that she went to work on May -- or January 3rd of 2011 and worked a full shift at her employment; correct?

A. I wouldn't have a reason to dispute that.

Q. And you have no reason to dispute that she went to work on January 3rd and performed all of her duties.

A. I would have no reason to dispute that either.

Q. And did you know that she had reported that she did not suffer any symptoms whatsoever until three days after the motor vehicle accident?

A. Well, I don't know exactly where that came from. She told me that she felt stiffness in the neck, upper back, and shoulders the following day, meaning the day after. And then had some tingling and discomfort in the lower back. And she just thought she'd be sore from the accident. And it was over the next few days she became more uncomfortable due to low back pain. So I don't know if it's at Day 2 or Day 3, but this is a dynamic experience that she was having.

Q. Okay. Sure. And that's what she told you about five months after this accident; right?

A. Yes.

Q. Okay. And I'm going to direct your attention to Plaintiff's Exhibit 18, page 1, and this is a record from MountainView Hospital Physician Clinical Report. Going to direct your attention to about halfway down the page. And this is additional history. By the way, the historian is the patient. So the information contained on this page came from Ms. Garcia. And she indicates under Additional History paragraph she felt fine after the accident. Patient was pain free after the accident. Patient's symptoms started today.

Today referring to January 5th of 2011; correct?

A. Yes, that's what it says.

Q. Okay. And is it fair to say that you have no reason to question Ms. Garcia's self-report to MountainView Hospital on -- when she reported -- when she appeared at MountainView Hospital on January 5th of 2011 as to when the symptoms started?

A. I have no reason to question it.

Q. Thank you.

And, um, is it possible, Doctor, or do you think -- or it is it likely -- strike that. Let me start over.

Do you agree that a -- that a plaintiff

litigant or a patient litigant could have a motive for attributing injuries to a specific event as a result of a potential interest in a third-party claim?

A. Whether or not the event caused them?

Q. Yes.

A. Anything is possible, I suppose.

Q. Now, when -- when Ms. Garcia presented to you on May 25th of 2011, she came to you, you were the -- you were -- she came to you for a second neurosurgical opinion; correct?

A. Yes.

Q. Essentially, you're her treating physician evaluating her for potential surgery in the future.

A. I'm the second surgeon to look at her for that reason, yes.

Q. That's true. So maybe on May 25th you're not actually her treating physician at that point, but you're a consultant. You're consulting her with regard to a neurosurgical consult.

A. Both. I mean, I am treating her as a second opinion consultant, so both are probably true.

Q. Okay. And as a treating physician, it's correct that you're -- at that point when you're reviewing the medical records and speaking with Ms. Garcia, you're focused more on the diagnosis and

treatment plan at that point than on causation; correct?

A. Well, I'm certainly focused on my patient and -- and getting the right diagnosis and the right treatment plan. But I don't think I skirted the issue of causation. I have a whole page on it with diagram and everything.

Q. Doctor, but you -- you weren't retained as an expert as -- at the time of the initial consultation; correct?

A. That's true.

Q. Okay. And -- and would you agree as a treating physician, your primary focus is to -- when you're evaluating a patient for the first time, it's to diagnose and treat the patient?

A. That is a primary focus.

Q. Because you want to relieve the complaints, the symptoms, whatever they're coming to you for.

A. Yes. I want to try.

Q. And -- and you were not -- as a treating physician, your primary focus is not to determine causation; correct?

A. Well, sometimes to understand the injury and the diagnosis, you have to have some understanding of causation. So I didn't downplay the discussion of

causation, even if it wasn't the primary focus of the evaluation or the reason for which she presented to me.

Q. Today I believe you said that you have special education and training in, did you say biomechanics?

A. I did.

Q. Or biomedical? I think you said biomechanics.

A. Biomechanics of the spine.

Q. Of the spine. That's what you said. Spinal biomechanics. That's what I wrote down. Okay.

But is it correct to say you don't have any training or education in biomechanical engineering?

A. Outside -- as its application to the spine, no, I don't.

Q. Okay. And is it correct to say that with your training in spinal biomechanics that you actually never studied the impact forces on the spine of an occupant in a car which is struck in the rear passenger door?

A. I've treated patients in many types of auto collisions, but I don't think I have done a specific study in that type of environment.

Q. Okay. And -- and I was -- I was very specific with a particular accident, but I'll take

it -- I'll broaden it up some.

Is it a fact that you've never studied the impact forces on the spine of an occupant in any vehicle who's involved in an accident?

A. Not outside of reading studies, both with nonpatients, meaning crash dummies and looking at epidemiologic studies of patients in accidents, I haven't done any specific study of my own or investigating.

Q. Okay. And would you agree that the biggest factor in attributing injuries to a specific accident such as a motor vehicle accident would be the patient's history, it would come from the patient's history?

A. I don't really know if that's the biggest factor, but it's an important starting point.

Q. And is it a fact that you often rely on a patient's self-report with regard to things such as past medical history?

A. Well, I do, but I'm also at the same time making an evaluation of their credibility, consistency, looking at records to see how good of a reliability I have on that history.

Q. Fair enough.

And would you agree that a patient's self-report regarding past medical history is important

in assessing the relatedness of injuries, treatment, and prognosis to a -- to a certain event?

A. It can be.

Q. And would you agree that a patient's self-report regarding both past medical history and history of present illness, it's a subjective appraisal given to you by the patient?

A. I suppose.

Q. Well, I say "subjective" because this self-report typically cannot be verified; is that correct?

A. Well, I think you're somewhat vague as to "it." It depends on the element and the patient and the records in the past and so many variables. Sometimes things are verified. Sometimes the absence of something is -- is -- is at least somewhat supported by the absence of any treatment or records supporting that absentia claim.

Q. Okay. But I'm specifically talking to -- about what the patient tells you regarding history of present illness.

A. My answer was specific to that. Unfortunately, your question was somewhat broad as to it. The word "it."

Q. Well, if you were to -- you made a reference

to reviewing other medical records, correct, in -- in verifying, I guess, a patient's self-report to you when they come in for a consultation?

A. Right.

Q. And -- and so when you review other doctors' records, typically the format is the same. There might be some subtle changes from one doctor's report to another, but typically you have in -- in each treatment record, you'll have an HPI, history of present illness; right?

A. Generally yes.

Q. You'll have a PMH, a past medical history; right?

A. Yes, generally.

Q. You'll have sections for medication, social history, family history.

A. That's typical.

Q. Right?

And would you agree that when you review other doctors' medical records and you're looking at the information from history of present illness or past medical history, that's generally information that the patient self-reported to these other providers? Yes?

A. Yes.

Q. Thank you.

When -- when Ms. Garcia came to you on May 25th of 2011 and you performed a physical examination, your physical examination showed her condition as she appeared on that date, May 25th, not her condition as she appeared on January 2nd or January 3rd of 2011; correct?

A. Correct.

Q. Okay. When we refer to pain, patient comes to you and says, Doctor, I have pain in this part of my body, they might point to a general location on their body, right, as to where the pain's coming from?

A. They might.

Q. And when we talk about pain, we're talking about a -- it's a subjective self-appraisal by the patient; right?

A. Pain is a subjective experience.

Q. Cannot be quantified or measured; correct?

A. Not purely objectively.

Q. Okay. And as opposed to when we talk about objective evidence, we're talking about something that can be quantified or measured such as an MRI, diagnostic imaging study.

A. Generally, yes.

Q. Okay. And would you agree that where a patient's subjective complaints are not supported by

objective medical evidence that you -- in that situation, you might question the accuracy of the patient's reporting of the symptoms?

A. It depends.

Q. Now, in your report that we're still on, the May 25, 2011, report, you had identified the various medical records that you had reviewed in connection with your evaluation; right?

A. At that time, yes.

Q. Yes. And -- and that -- as you testified to already, that included the MountainView Hospital record --

A. Yes.

Q. -- right?

And that's the record I had up on the screen a few minutes ago; right?

A. Yes.

Q. And -- and at the time that she appeared at MountainView Hospital, the doctors there performed a physical examination of Ms. Garcia; correct?

A. Yes.

Q. And is it correct that at the time that they performed the physical examination, that they noted the findings in the record, the MountainView Hospital record?

A. Well, they didn't -- they didn't note very much. I think it was limited. I think they said unremarkable.

Q. Well, I think they said a little bit more than that, Doctor, and I will direct your attention to it. And I'll put it on. It's plaintiff --

THE COURT: Need a break?

MR. STRASSBURG: When you get to a good point. I mean, I just --

MR. MAZZEO: Can I just go through this real quick?

MR. STRASSBURG: Absolutely.

MR. MAZZEO: Thank you. Thank you.

BY MR. MAZZEO:

Q. All right. Doctor, just -- so we're on Plaintiff's 18, 2. It's at the bottom there. And we're on the second page, and I'm going to direct your attention to the physical examination. And specific -- specific findings on the examination, with respect to head, you see it was -- it noted nontender, no swelling of the head; correct?

A. Yes, that's what it says.

Q. They examined Ms. Garcia's neck. No muscle spasm in the neck, painless range of motion, nontender, no vertebral tenderness.

Do you see that?

A. I do.

Q. Let's go down to back. She had no back tenderness, no vertebral point tenderness or muscle spasm.

Do you see that as well?

A. I do.

Q. So these findings under Physical Examination, are all -- I mean, they did perform a -- a head-to-toe physical examination of Ms. Garcia; correct?

A. Emergency room head-to-toe exam, we'll call it.

Q. Okay. And with regard to her extremities, just for the jury when -- when -- when doctors refer to extremities, you're referring to the arms and legs; right?

A. Yes.

Q. Okay. And so extremities would -- were noted normal inspection, pelvis is stable, extremities atraumatic, no lower extremity edema.

Do you see that?

A. I do.

Q. And then they did a neuro exam. No motor deficit, no sensory deficit.

Do you see that as well?

A. I do.
Q. Okay. And then the clinical impression was low back strain, and they put motor vehicle accident.
Do you see that as well?
A. Yes.
Q. Okay. And a sprain, just for the jury, is -- is a stretching or tearing of the ligaments?
A. Yes.
Q. And -- and ligaments are the tough bands of fibrous connective tissue that connect one bone to another in the joints?
A. Yes.
Q. And is it correct that when we -- when the doctors and -- and medical people refer to sprains and strains, they're talking about musculoligamentous injuries?
A. Yes.
Q. Okay. And is it correct that treatment and prognosis for both back strains and strains is essentially the same treatment for a sprain as is the same for a strain?
A. Generally, yes.
Q. Okay.
MR. MAZZEO: Good time to break, Judge.
THE COURT: Okay. Great. All right, folks,

let's take our afternoon break.

During our break, you're instructed not to talk with each other or with anyone else about any subject or issue connected with this trial. You are not to read, watch, or listen to any report of or commentary on the trial by any person connected with this case or by any medium of information, including, without limitation, newspapers, television, the Internet, or radio. You are not to conduct any research on your own, which means you cannot talk with others, Tweet others, text others, Google issues, or conduct any other kind of book or computer research with regard to any issue, party, witness, or attorney involved in this case. You're not to form or express any opinion on any subject connected with this trial until the case is finally submitted to you.

Plan on ten minutes.

(The following proceedings were held outside the presence of the jury.)

THE COURT: We're outside the presence of the jury.

We need to put anything on the record?

MR. MAZZEO: No, Judge.

MR. TINDALL: No, Your Honor.

THE COURT: All right. Off the record.

(Whereupon a short recess was taken.)

THE MARSHAL: Jury entering.

(The following proceedings were held in the presence of the jury.)

THE MARSHAL: Jury is present, Judge.

THE COURT: Thank you. Go ahead and be seated. Welcome back, folks. We're back on the record, Case No. A637772.

Do the parties stipulate to the presence of the jury?

MR. ROBERTS: Yes, Your Honor.

MR. MAZZEO: Yes, Judge.

MR. STRASSBURG: Yes.

THE COURT: Doctor, just be reminded you're still under oath.

Mr. Mazzeo, you may continue.

MR. MAZZEO: Thank you, Judge.

BY MR. MAZZEO:

Q. Doctor, I'm going to now direct your attention to the bills from Pacific Hospital from which you testified earlier on direct examination earlier today you were testifying about them.

So you had indicated, and according to the records, the Pacific bill for the -- Ms. Garcia's fusion on 12/26, and I guess as well as for some of her

stay at the hospital before and after that surgery was $281,351.20; right?

A. I believe that's correct.

Q. And -- and also, I believe it's correct that patients have told you that Pacific Hospital charges are -- are high for the procedures for which they go to the hospital for; is that correct?

A. Patient -- my California patients have said that.

Q. Okay. What about your Nevada patients?

A. No. It's probably the one slight difference between the two states is the hospital charges here in Nevada seem to be higher than in California.

Q. Now, Ms. Garcia stayed at Pacific Hospital for eight days post procedure; right?

A. Something like that, yes.

Q. And Pacific charged 7 -- $1,742 a day for her stay in a hospital bed; right?

A. I would have to look back at the bill, but that's in the realm of what I would expect.

Q. And -- and in the file that you brought with you today, do you have the bill?

A. I just have the summary of the bill. I don't have the full bill with me here. I have it on this flash drive, but I'd have to pull out my laptop to look

at it.

Q. Oh, I see. Okay.

And as far as you know, Ms. Garcia didn't have any complications from the surgery while she recovered in the hospital afterwards; right?

A. Just the chin, kind of like a loss of skin on the chin from lying on her front for a bit. But that -- that was gone within a month or two.

Q. And also, according to my notes, the anesthesia for the surgery was $17,882.

Do you have any reason to dispute that?

A. I'm sorry. Within the hospital bill?

Q. Yes.

A. I wouldn't have a reason to dispute that, specifically.

Q. Okay. And I believe from what you testified to earlier as well as possibly previously, you believe that Pacific Hospital charges high markups for both services and hardware.

Would that be correct or just hardware?

A. I think it's just hardware. And then overall, their bill is higher because of that.

Q. And there was a charge for -- from the Pacific Hospital for devices such as other implants, to Code 278, and Pacific charged $129,694 for that -- for

that code.

Do you have any reason to dispute that?

A. Well, I think that's the hardware charge.

Q. Okay. And as you said, you told us earlier that that hardware covers -- let me get to the page -- that would be the instruments, the trays.

What about the -- the screws and the -- the implants themselves?

A. I think all the hardware, anything metallic or the acrylic I used. And then it's -- it's likely that the biologics, the Bacterin putty allograph material was in one of those charges also.

Q. Okay. And -- and this bill from Pacific hospital for 281,000-plus dollars for this surgery and -- and others like it, is it true that you believe that there -- there's a -- a three times markup for the list price of the hardware?

A. I don't know if I know that for certain. I think the hardware is -- agreed, I think it's -- it's marked up too much. But the overall bill for that stay is certainly in the realm of a -- of a fusion surgery hospital bill here in Clark County.

Q. And -- well, did you previously -- when you previously testified at your deposition, did you indicate and say something to the effect of that, To my

knowledge, they were marked up at -- at three times the list price?

A. I may have.

Q. And I can direct your attention to the page. It's page 30, line -- starting at line 16.

A. I did say that.

Q. And then also there was a charge, Pacific charge for International implants of $115,108; is that correct?

A. Yes, but I think that's part of the 129.

Q. Okay. And -- and is it your understanding that this was marked up -- that the markup was increased greater than 50 percent above the list price?

A. I think so.

Q. Okay. Now, International implants, is that a company that provides the hardware that was used in -- for Ms. Garcia's surgery?

A. That's my understanding.

Q. Okay.

MR. MAZZEO: And, Judge, I'll need a prior ruling on the next topic I need to go into.

THE COURT: Come on up.

MR. MAZZEO: If we can approach.

(A discussion was held at the bench, not reported.)

MR. MAZZEO: Thank you, Judge.
THE COURT: Okay. Go ahead.
MR. MAZZEO: May I continue, Judge?
THE COURT: You may.
MR. MAZZEO: Thank you.
BY MR. MAZZEO:
Q. Okay. Doctor, so you had -- during the course of your work in this case, you served as both -- both a treating physician and you provided expert services as well; right?
A. Yes.
Q. And the expert services you provided was by way of reviewing the -- all the, you know, voluminous medical records and documents in this case and then offering an opinion with regard to other treatment; correct?
A. Yes.
Q. Okay. And so just want to talk to you about those for a moment. Part 1 of the -- directing your attention to -- one second.
So one of the reports that I want to direct your attention to would be the September 23rd, 2013, Neurosurgical Supplemental Report that you authored, and that report includes a review of Dr. Oliveri's Comprehensive Medical Evaluation and Life-Care Plan, as

well as Dr. Stan Smith's forensic report from July 11th of 2013; right?

A. Yes.

Q. And -- and so you reviewed this -- these -- these reports as -- to render an -- an opinion as to whether you are in agreement with the findings and opinions of Dr. Oliveri and Dr. Stan Smith or not; right?

A. I suppose.

Q. Okay. Well, and after -- after reviewing Dr. Oliveri's report and Dr. Stan Smith's report, it's correct that in your supplemental report, you didn't provide any analysis of any of the information you gleaned from the reports that you reviewed; correct?

A. Well, only to the degree that I -- I largely agreed with the opinions set forth, and that's a little bit of an analysis in a way.

Q. Well, let's go to that, then. You actually provided a conclusory statement where you said, "I have reviewed these reports and am largely in agreement with the opinions set forth"; right?

A. I did.

Q. But other than that, you did not provide any analysis of any of the findings, opinions, or conclusions by Dr. Oliveri or Dr. Stan Smith.

A. Notwithstanding the analysis of agreement, there was no other analysis provided.

Q. Okay. And Dr. Stan Smith, as you know, is an economist; right?

A. Yes.

Q. And he provided report regarding economic losses, household services, life care plan, and hedonic damages; right?

A. Yes.

Q. And you're not an economist; right?

A. I'm not.

Q. And is it fair to say that you don't know what household services Ms. Garcia provided before the motor vehicle accident; right?

A. Generally, I have an idea, but I don't know to the degree that Dr. Smith probably evaluated.

Q. Okay. And -- and you have -- you don't know specifically what limitations Ms. Garcia had with regard to household services after the accident?

A. Well, I have some idea since I gave her some of those restrictions, certainly after the surgery, and I've come to see her many times. I certainly am aware of some of the things she has difficulty doing or cause her more pain. But I would -- I would defer to Dr. Smith's expertise in that evaluation and arena.

Q. Well, more specifically, not -- I'm not talking about the surgery. Of course there's going to be certain limitations. But more specifically, after -- from the time that you consulted with -- first consulted Ms. Garcia in May of 2011 up until the time of the -- the surgery, December 26th of 2012, is it fair to say that you don't know what her -- what would be considered her normal household services in terms of cooking, cleaning, mopping, things of that nature, how much she did it per week, how many times per month, what assistance she had; right?

A. Again, I know a few pieces because we did talk about her household activities at times. But not to that degree which, again, I would expect Dr. Smith to handle.

Q. Okay. And by the way, you're not -- is it fair to say you're not educated or skilled in this area of hedonic damages or loss of enjoyment of life feature of the damages?

A. Not outside discussing them in a medical report as to someone's pain or life experience as part of a problem. I don't know how to evaluate or give value to them like an economist can. I think that's the most fair thing I can say.

Q. And also, is it fair to say -- take it one

step further -- that you really had no basis to agree because you lack the education, skill, and experience in evaluating hedonic damages? And even household services, you had no basis to agree with Dr. Smith's economic damages, his findings, opinions, and conclusions in his report, except to say, Generally, I agree, sounds good.

A. I don't have the background skills and training to necessarily evaluate Dr. Smith from an economic perspective.

Q. Okay. And directing your attention to the September 19, 2013, supplemental report.

A. Okay.

Q. Okay. Now, this report identifies several records. These are basically -- I think you received billing charges for various medical providers that had -- are related to the treatment Ms. Garcia received following this accident; right?

A. Both records and bills were reviewed in this document.

Q. Okay. And -- and there's a chart on the second page of your -- it's actually --

A. The 20th page to be accurate.

Q. Yeah, page 20 of 21. Okay. And that's the second-to-last page of the 21-page report. Okay.

A. Yes.
Q. And this page has -- has a chart identifying or listing the summary of the charges for the various providers; right?
A. That's right.
Q. Okay. And there's 21 items that are listed, providers with -- with corresponding bills associated with their services --
A. Yes.
Q. -- that are identified.
And so with regard to your discussion about all these additional medical records and bills that you reviewed, you -- your opinion was essentially reduced to stating that, on page 21, Medical bills listed here represent care that was both reasonable and necessary for the treatment of Ms. Garcia's treatment -- Ms. Garcia's injuries related to the present trauma. Most of the bills are within usual and customary range.
Do you see that?
A. I do.
Q. And so you didn't -- again, in this report, you didn't provide any specific analysis of any specific bills that you reviewed for any of these records from this report; correct?
A. Well, I analyzed them for whether or not they

were in the usual and customary range.

Q. I mean, in print. You didn't identify your analysis. You gave a conclusion about, oh, they're all reasonable and customary, but you did not provide any in-depth analysis as to any specific bills. You didn't identify in your discussion any specific bills. You just gave a conclusory statement that all these bills are reasonable and customary.

A. It says most, not all.

Q. Okay. Well, you said that they -- just to be clear, Medical bills listed here represent the care that was both reasonable and necessary for the treatment of the injuries related to the present trauma. And then the second sentence is, Most of the bills are within the usual and customary range, the exception being with the -- with the Pacific Hospital --

A. The hardware charges, yes.

Q. And -- and so just directing your attention now to your October 28th, 2014 report. And that consists of 37 pages.

A. Okay.

Q. Do you have that, Doctor?

A. I do now, thanks.

Q. And by the way -- and -- and also back --

backing up a second. We talked about two reports, the September 19th report and the September 23rd report; right? And now we're talking about a third report.

The -- the summary -- your reports provide a summary of the information that's contained from the actual medical records; right?

A. Medical records and other documents.

Q. Okay. And is it fair to say that you do not yourself summarize those medical records that -- what you were asked to review? They're summarized by someone in your office at your direction, but you personally don't summarize those.

A. No, this is my summarization. I dictate the summary into my dictation system, and then I'm given a report to edit.

Q. Okay.

A. This is my work.

Q. And so directing your attention to the October 28th, 2014, supplemental report, it's your testimony that you've summarized all of the medical records that are identified in this 37-page report?

A. Yes.

Q. Okay. The reason why I ask is because some doctors have -- the staff -- staff personnel to summarize it, and then they'll review it for accuracy

and correctness. So that's why I was asking you that.

A. I see.

Q. So this report is a -- is -- which provides a summary of all the medical records is based on your own summary based -- through dictation.

A. Yes.

Q. Okay. So -- and then directing your attention to page 36 of 37.

A. Okay.

Q. And under Discussion, the very first sentence, it says that you have -- I have reviewed the above listed documents, including updated medical records which are consistent with my own history from Ms. Garcia from my ongoing treatment of her injuries; right?

A. Yes.

Q. And so -- so then I want to direct your attention to -- so you gave -- first, I'll ask you: You gave a blanket statement in -- on that page 36 of your report that -- that your review of all of these medical records was consistent with your own history of Ms. Garcia from your ongoing treatment of her injuries, which means that you're in agreement with all of the treatment that was rendered by the other medical providers was consistent.

Doctor, okay, I don't know if you're looking for something.

A. I know you don't.

Q. Okay. So if you would, before you flip through it, just want you to -- to focus on the question.

A. I'm highly focused on your question. I think we both know that.

Q. Okay. So are you looking for something in particular?

A. I'm anticipating your question by skimming my record, but just my methods. Don't you worry.

Q. Okay. All right. Good.

So -- so is it fair to say based on the statement, the reference you had on page 36 of your report, that you are in agreement with -- and it's your opinion that the treatment from the treatment records that you reviewed for this report is you're in agreement that it was reasonableness and related to this accident, the subject accident?

A. Yes.

Q. Okay.

A. I think that's largely what I'm saying.

Q. And -- and I -- and I thought -- yeah, I mean in all fairness, I thought that's what I was

summarizing as well, so ...

All right. Doctor, directing your attention to page 27 now, paragraph 14. We have a record that you summarized from Dr. Walter Kidwell's office, which states about in the bottom third of that paragraph, The diagnoses were "chronic pain syndrome, lumbar disk protrusion, failed low back" management -- I'm sorry, "failed low back surgery syndrome" -- I skipped a line -- "low back lumbosacral spine pain, medication management."

Do you see that?

A. I do.

Q. Okay. And so you -- you were essentially in agreement with Dr. Kidwell's appraisal that -- and opinion that the surgery that you performed was -- resulted in a failed low back surgery syndrome for the patient.

A. No. I'm not in agreement with that phrase. I think his evaluation was reasonable -- and it actually wasn't him. It was his PA. But it wasn't unreasonable at the time. But we now know after some additional diagnostic injections and treatment that it wasn't a failed back syndrome. It was actually some L3-4 facet problems, some sacroiliac joint pain, and some hardware pain.

Q. Doctor, earlier today you testified that when you saw Ms. Garcia after the accident, you said -- well, let's -- I'll show you the record. I'll put it on the screen.

This is a record from January 7th of 2013. And you -- you state, Amazingly, her low back -- as you testified earlier -- her lower back pain is improved compared to prior to the surgery; right?

A. Right.

Q. And then if we look at -- and she's telling you that about two weeks after the accident --

A. Yes.

Q. -- approximately?

A. Not even.

Q. Somewhere around there; right? Thirteen -- 12, 13 days.

So -- now, back in December, we know prior to the surgery, December 11th, 2012, she's taking about -- Lortabs about four per day, 10 milligrams; right?

A. Right.

Q. But two weeks after the surgery, she ups that to six Lortabs per day, which are taken -- if you account for about eight hours of sleep, six Lortabs, 10 milligrams, taken within a 16-hour period, that's an increase of what she was taking prior to the surgery;

right? Is that a "yes" or a "no"?
A. I can't answer with a yes or no because it completely bastardizes the truth for me to do so.
Q. Okay.
MR. MAZZEO: Judge, I move to strike the nonresponsive answer given by Dr. Gross.
THE COURT: No. Sorry.
BY MR. MAZZEO:
Q. Doctor, does the January 7th, 2013, report indicate that her medications include Lortabs, 10 milligrams, about six per day?
A. That part is true.
Q. Okay. Does the December 11, 2012, report indicate she takes Lortabs, 10 milligrams, about four per day?
A. That part also is true.
Q. Thank you. And would the -- if she's -- the reference to the six Lortabs, about six per day, referring to Lortabs on January 7th, 2013, would you agree that that can account for some of her diminished pain that she's feeling after your surgery 13 days earlier?
A. Although improbable, possibly would be the answer.
Q. Okay. Now, on 2/8/2013 -- I believe you were

asked about this date by Mr. Roberts. And on 2/8 of 2013, you had indicated that based on Ms. Garcia's report of pain, she had intermittent right leg pain with some numbness in anterior thigh and posterior thigh.

And if you need a moment, you can you can flip to that date.

A. Thank you.

Q. And that would be Plaintiff's 24, 50.

A. Yes. I did say she had that.

Q. And is it correct to say that prior to the surgery, she never complained of any anterior thigh numbness?

A. I believe that's true. That was a new finding after the surgery.

Q. And is it correct to say that -- that the fusion caused perineural fibrosis scarring around the anterior divisional fibers?

A. I doubt it.

Q. Why do you doubt it?

A. Because, first, February 8th is only six weeks after surgery, and it would be way too early for any scarring. And because we use a special table with thigh pads, and I have seen multiple times in the past people with thigh numbness for a while from pressure on

their thighs for many hours of surgery, that's the more likely cause of the thigh symptoms.

Q. Doctor, you said earlier in direct examination that you hope for a -- from performing this type of surgery, you would hope for -- I believe you said 80 percent -- was it 75 to 80 percent improvement?

A. Usually, 70 to 80 percent is what I quote because there's studies that give me those numbers.

Q. And --

A. And that should be after someone's fully healed not six weeks later.

Q. Okay.

A. Thank you.

Q. Okay. And so what is the customary or typical and usual recovery time for a patient after a surgery like this?

A. I would say between three and six months we start to get a picture where they're going to end up.

Q. Okay. And -- and -- and ideally, the reason for doing the surgery, which is what you testified to on direct examination, is -- is to -- for -- for the -- for the patient to wean off of medications. You -- you want to have them improve. Obviously, 100 percent is not -- is -- is not -- is not realistic, but 70 to 80 percent is realistic. And with that sort of

improvement, you would expect that patients can be weaned off of pain medications; correct?

A. Well, medication reduction is not the only reason for the surgery. But it is -- it is one nice one. I would -- do hope they can wean off medications.

Q. Okay. And now, it's been -- since the surgery that you performed in 2012, it's been more than three years since that surgery; correct?

A. Yes.

Q. And -- and it -- and at each -- in looking at your consult -- follow-up consultations with Ms. Garcia from -- from that first post-op consult on 1/7 of 2013 where you recommend that she continue pain medication management with Dr. Kidwell, and then you do that consistently at each and every consult that you have with her through 2013 and then up and through 2014. And then if we look -- if we go to 2015, January -- January 22nd of 2015, same recommendation. You keep using the phrase "She's done nicely, but continue medication management per Dr. Kidwell." You do that with -- in June -- in June of 2015 and then in November, November 11th of 2015 as well; right?

A. That's part of what I do at those visits.

Q. Sure. And not only that -- and now, in addition to the medication management because of her

continuing pain complaints, now you're -- you're making recommendations for injections, for Dr. Kidwell to -- to follow up and perform injections and, as you testified earlier, radiofrequency ablation, both at the sacroiliac joint and at the facet joints in her lower back; right?

A. Yes.

Q. By the way, would you agree that a person who has an asymptomatic spondylolytic spondylolisthesis probably should not have chiropractic -- chiropractic adjustments in the lower spine?

A. I would expect forceful adjustments to the lower back to not be helpful --

Q. And let me phrase it a different way.

A. -- in that setting.

Q. Okay. Let me phrase it a different way.

With -- where a chiropractor performs chiropractic adjustments on the spine, specifically mid and -- and thoracic and lumbar portion of the spine shortly after the accident, where a patient has a previously asymptomatic spondylolytic spondylolisthesis, as in Ms. Garcia's case, is it not just possible but probable that those chiropractic adjustments could actually cause an unstable or disrupt, cause further slippage of the spondylolytic

spondylolisthesis?

A. Your question is compound to thoracic and lumbar spine. So let me separate them. There's no problem with adjusting her thoracic spine here, her mid back, because there were no spondylolisthesis there.

In regards to the lumbar spine, particularly L5 where there is a spondylolytic spondylolisthesis, I could say that forceful adjustments could possibly worsen a spondylolisthesis. I can't say to a degree of probability because I don't think I've ever seen that happen. And a lot of people see chiropractors, even those who have asymptomatic spondylolisthesis. And I have never seen anyone come into my office for care having been made worse by a chiropractor's adjustment who had an unbeknownst or unknown asymptomatic spondylolisthesis before.

Q. Given Ms. Garcia's constellation of symptoms she presented, then, following this accident and then her treatment -- and her treatment 12 -- or 10 days after this accident with Dr. Gulitz who performed spinal manipulation and adjustments on Ms. Garcia, is it -- and this is a hypothetical question, Doctor -- is it likely that if Ms. Garcia had -- after this accident, still had an asymptomatic spondylolytic spondylolisthesis until she received chiropractic

adjustments from Dr. Gulitz, is it possible that that could have caused for the progressive worsening of this spondylolisthesis that's seen in the difference between the January 26th, 2011, film and the November 19th, 2012, film?

A. Well, you've heard it before from me, but anything's possible, although it's improbable given the evidence in this matter.

Q. Okay. So now, as of -- as of May 22nd, Doctor, May 22nd, 2013, you indicate that Ms. Garcia was able to return to work as a cage cashier, was able to stand all day; correct?

A. I did.

Q. Okay. And then on 7/24 of '13, she complains of residual right anterior thigh numbness, deep internal itching; is that correct?

A. Yes.

Q. And that was never present before the surgery; correct?

A. That's right.

Q. Okay. And -- and then with regard to the -- the -- then we talked about the September 19th, 2013, neurosurgical supplemental report; correct?

A. Yes.

Q. And that was addressed -- as was all of your

supplemental reports, that's addressed, To Whom It May Concern --

A. Yes.

Q. -- right?

And that's actually referring to -- when you put To Whom It May Concern, you're actually sending this report to plaintiff's counsel; correct?

A. I'm sending it to plaintiff's counsel.

Q. Right.

A. But "to whom it may concern" might concern all of us here and you and anyone who reads it in this setting.

Q. But you were asked to provide a supplemental report at the request of plaintiff's counsel not by myself; correct?

A. Correct.

Q. And then on 5/24, May 24th -- I'm sorry, May 21st of 2014, Ms. Garcia comes in to you and complains of uncontrolled low back pain with radicular pain in the right lower extremity.

Do you see that?

A. The date again? I'm sorry, Counsel.

Q. That's fine. That's May 21st of 2014. Do I have -- maybe it's -- do I have the right date?

A. I don't have in my notebook a visit from that

date. So either you have something that my staff failed to print or maybe you have your date wrong.

Q. That's possible. Let me just check my record here. Maybe it's the April 1st of 2014 report.

A. Okay. I have that.

Q. But there was a report where there was a reference to uncontrolled low back pain with radicular pain in the right lower extremity. And the April 1st, 2014, report refers to a flare-up of lower back pain. Anyway, in any event, I can't find that particular record right now.

And then January 22nd, Doctor, you note in your report that at that time that Ms. Garcia was not currently working, but that was due to employment issues.

That wasn't related to her physical condition; correct?

A. Yes.

Q. And then in your June 17th, 2015, report, you indicate that -- this is -- it's Plaintiff's 24, page 572. You indicate that she's not currently working and now -- and -- oops, and now cares for her ill mother; right?

A. I did.

Q. And by the way, would you agree that

Ms. Garcia -- Ms. Garcia caring for her ill mother suggests and implies a certain ability to perform household duties?

A. Certain ones, yes.

Q. And by the way, you didn't put it into your report and I would assume that you didn't have a discussion about what household duties Ms. Garcia would have to engage into care for her ill mother; is that correct?

A. I don't remember a material conversation with her about it. I just know I asked her tell me about herself and what's going on in her life. And I gave her the opportunity to talk to me about anything that sets off her back. So whatever care she's delivering apparently is within the realm of what she can do given her back situation.

Q. Following the motor vehicle accident, you know that she had continued working a regular schedule at her job at Aliante; is that correct?

A. Yes.

Q. And -- and that she continued working in this position for -- up until April of 2014.

A. Well, except after the surgery when we -- we took, I think, five or six months off.

Q. Sure, with the exception of that time after

the surgery which I believe was -- I think it was four months, but if you -- we can -- I thought it was less, but ...

A. I just remember she came back to see me in May of 2013 having gone back to work. So I don't know the exact date. You could be right. I'm not disputing it. I'm sure the evidence speaks for itself, but a number of months that we asked her to take off after surgery. And she had to.

Q. Sure. And notwithstanding the time that she took off, whether it was four months, five months, whatever, after the surgery, not withstanding that time, it's correct and it's your understanding that Ms. Garcia continued working in a full-time capacity at Aliante in her position as an assistant cage cashier from actually the day after the accident of January 3rd, 2011, up until April of 2014.

A. That's about right, yes.

Q. Okay. And did you know, though, that -- that Aliante provided what's called reasonable accommodations for employees with injuries and physical conditions and whatnot?

A. I don't know enough to testify about it. I remember discussing it loosely with her at some point, about her -- me wanting her to have certain things,

but -- and although maybe the employer said on paper they would do it, that she wasn't really getting those accommodations. But maybe I'll let her speak to that.

Q. And -- and then she -- and you know, as you testified, that Ms. Garcia returned to work after her recovery period following the surgery sometime, I guess, in May of 2013?

A. Right. And that's when I saw her and was aware she had returned to work.

Q. And is it correct that when she returned to her employment at Aliante, that she returned in full capacity with no restrictions?

A. I don't recall specifically, but that could be the case.

Q. Okay. And -- and do you have any reason to dispute that she was able to perform all of her duties at her job both following this accident and after she returned to work after the recovery period following the surgery?

A. No, but I don't -- I don't know besides standing in the cashier area what else that required, so maybe I'll let her speak to that.

Q. And by the way, directing your attention -- we'll go back to your -- just give me one second here.

So directing your attention to -- from my --

oh, here we go.

Direct your attention to your May 25th, 2011, report, I know the first page indicates May 31st, but it's actually May 25th.

A. The visit date was May 25th. It took me a few days to review all the records and put the report together. So the actual issue date was May 31st.

Q. Oh, for the report. Thank you for that clarification.

So directing your attention to the first page, for the record, Plaintiff's 24, page 14. So this -- this report indicates that -- this report -- if you can see at the bottom, she was dizzy, dazed, confused, nauseated. She was in shock.

And that's what Ms. Garcia reported to you when she came to you for the consultation; right?

A. Yes. In regards to the date of the injury.

Q. Yes. In regards to the date of injury, she was reporting that -- how she felt following the accident was dizzy, dazed, confused, nauseated, and in shock; right?

A. Right.

Q. Okay. And would you agree that she never reported to any of the other providers that she was dizzy, dazed, confused, nauseated, and in shock,

referring to MountainView Hospital, Dr. Gulitz, Mr. McGauran, the PA at Primary Care Consultants?

A. Dr. Gulitz on 1/12/11 documented confusion, nausea, ringing in the ears since the motor vehicle accident.

Q. Okay. So -- but -- but that wasn't indicated when she went to the emergency room three days after the accident, was it?

A. I don't think I saw it in the emergency room record.

Q. As a matter of fact, as we talked about, the emergency room record indicates that she felt fine after the accident, pain free, and basically she didn't have any symptoms because she said symptoms started today; right?

A. Can you show me that whole record before I answer that question for accuracy? Zoom out.

Q. Yeah. I'll have to zoom out.

A. Okay.

Q. There you go.

A. So in terms of patient symptoms started today, I believe that applies to chief complaint of injuries to the head, neck, and lower back, and sacral -- oh, I got the arrow to go.

Q. Oh, it works?

A. Well, a little bit.
Q. Okay. Nowhere on this document she indicates that she was dizzy, dazed, confused, nauseated, or in shock; right?
A. I don't see any complaints of that on that page.
Q. Okay. Okay.
MR. MAZZEO: Judge I need just a moment to look -- look at the records. Thank you.
Your Honor, at this time, I'll pass the witness.
THE COURT: Mr. Strassburg?
MR. STRASSBURG: Yes.
THE COURT: You want to start?
MR. STRASSBURG: I'm happy to let them go right now, Judge, and do it all at once when they're fresh, when I'm fresh, when the witness is fresh.
THE WITNESS: Don't worry about me.
MR. STRASSBURG: Huh?
THE WITNESS: I'm ready to go anytime.
MR. STRASSBURG: Oh, of course you are.
THE COURT: We started early today, folks. Let's go ahead and take an early out. I have a really small calendar tomorrow. Can everybody start early, like, 9:30, 9:45? Let's plan on 9:45.

MR. ROBERTS: First, we -- I can be here. I just don't know if my witness. I'll have to contact him and see if he can come early.

THE COURT: What time was he planning?

MR. ROBERTS: He was planning to come at 10:00.

THE COURT: Let's just start at 10:00 to make sure that we have somebody here. Doesn't make sense to have you guys here and not have a witness.

So we'll go ahead and start at 10:00 in the morning.

During our break this evening, you're instructed not to talk with each other or with anyone else about any subject or issue connected with this trial. You are not to read, watch, or listen to any report of or commentary on the trial by any person connected with this case or by any medium of information, including, without limitation, newspapers, television, the Internet, or radio. You are not to conduct any research on your own, which means you cannot talk with others, Tweet others, text others, Google issues, or conduct any other kind of book or computer research with regard to any issue, party, witness, or attorney involved in this case. You're not to form or express any opinion on any subject connected

with this trial until the case is finally submitted to you.

We'll see you tomorrow at 10:00.

(The following proceedings were held outside the presence of the jury.)

THE COURT: We're outside the presence of the jury.

Did you guys want to make a record on something? It seemed like you wanted to make an offer on something.

MR. STRASSBURG: A proffer on cross about that hospital.

MR. MAZZEO: Can we do it outside the presence of the witness?

THE COURT: That's fine.

MR. ROBERTS: Now might be a good time to do it. Well, I thought you wanted to make a proffer with the witness.

MR. STRASSBURG: Gee, not really.

THE COURT: Okay. That's fine. We can excuse him. Thank you, Doctor. Just work with these guys about when you come back.

THE WITNESS: Very good. Thank you, Your Honor.

THE COURT: It kind of seems like we're

starting a lot of witnesses and not finishing with a lot of people, so we'll get you back on.

THE WITNESS: We'll make it work. Thank you.

THE COURT: Thanks for working with us.

All right. Now we're outside the presence of the jury and the witness. Go ahead, Mr. Strassburg.

MR. STRASSBURG: Thank you, Judge.

THE COURT: Just for the record, there was a bench conference about whether or not I was going to allow questions to this witness about -- apparently, this hospital in California had some issue with fraud, and so was there an indictment. I don't know how you indict a hospital, but there was obviously some individuals involved that were in -- in some trouble. And I said that I wasn't going to allow it based on the fact that I think it's a collateral issue, open up a can of worms, that I don't think there was any -- and correct me if I'm wrong, but I don't think there's any evidence in this case that they were using some kind of fake instruments on the plaintiff, and I think that's what the allegation was at the bench --

(Interruption in proceedings.)

THE COURT: We're back on the record. We're outside the presence: The jury and the witness.

You can make whatever offer or proffer you

would like as it relates to that last issue.

MR. STRASSBURG: Thank you, Judge.

On direct examination, the witness indicated that the billings from Pacific Hospital were reasonable and customary with the exception of the billings for the medical device implant, screws, and rods. The subject matter of the Pacific Hospital billings is the subject of a ruling in limine dated June 1, 2015, deciding Plaintiff's Motion in Limine 29 which granted that motion excluding allegations of improper billing practices against Pacific Hospital Long Beach.

The witness, by his testimony, has opened the door to permit us, despite this in limine ruling, to inquire as to the basis of his knowledge about the inflated prices charged for the medical implants and how long he knew about those inflated prices and whether or not he knew about the inflated prices at the time that he decided to take Ms. Garcia to surgery at Pacific Hospital in preference to Hoag or someplace else that might have accepted a lien.

The -- also, we would be entitled on that basis to inquire as to the basis of the witness's knowledge about Pacific Hospital that he relied upon in deciding to take her there.

There is testimony here that one of the

pedicle screws utilized in the surgery as an -- an implanted device broke during the -- the surgical procedure. On document Bates numbered -- oops. Gee, I don't have a Bates number, but it is a -- it's the surgical procedure form of Dr. Jeffrey Gross dated for the surgery 12/26/12. And it indicates the doctor's selection of the various devices to be utilized on Ms. Garcia's surgery. And he has selected the use of lumbar pedicle screws and PEEK interbody devices International implants, which was the company implicated in the fraud that was reported in the California newspapers in April 2014.

We would, I think, have the right to inquire as to whether he knew about the media report in April of 2014 and whether they reported information about what was really going on at Pacific Hospital, that he knew or suspected prior to that date. There is an article in the Long Beach newspaper indicating that the CEO, a Michael Drobot of Pacific Hospital, had pleaded guilty in federal court to charges brought in connection with this state's largest workers' compensation fraud scheme cheating taxpayers out of hundreds of millions of dollars.

The papers also reported that millions in illegal kickbacks were paid to doctors in connection

with that scheme which led to more than $500 million in bills being fraudulently submitted between 2008 and 2013 to, among other things, the California workers' compensation program. And the article specifically indicated that to finance the kickbacks, Drobot inflated the price of implantable devices used during spinal surgeries knowing that under California law, medical hardware was considered a pass-through cost, blah, blah, blah, blah.

The -- this indicates that there was public information of this fraud scheme involving the implantable medical devices that Pacific Hospital was billing for between 2008 and 2013. The surgery in question performed by the witness was done on December 26th, 2012, and falls within this period of time. The --

THE COURT: So the article you're talking about were 2014; right?

MR. STRASSBURG: Yeah, that's right. And that gives me a various astute observation, Judge. The article provides me the basis to ask the question whether or not he knew about the information reported in the articles before those articles reported. And it also provides the basis to ask whether he received any of those kickbacks for the implantable devices.

The substance of the conspiracy was reflected in a criminal plea that's been produced in this case in which the witness -- I'm sorry, Michael Drobot, the CEO, elocuted to various factual statements in the criminal information. Among those, he admitted certain overt acts involving the payment of kickbacks for -- in connection with spinal surgeries. There's no indication those spinal surgeries were not of the same type as this witness performed on Ms. Garcia.

Having opened the door to the basis of his knowledge that these charges were inflated for the implantable devices that were an instrument of this criminal fraud scheme, we believe that the preclusive effect of the motion in limine is -- should be set aside, and we should be permitted to walk through the door that's now been opened and inquire as to the basis of his knowledge for his statements that these charges were inflated and why or what adjustments, if any, he decided to make in the charges to Ms. Garcia for them. Or did he keep it all for himself?

Thank you, Judge.

THE COURT: I understand the argument. But, first of all, can't believe everything you read in the newspaper or articles.

Second, even if it's true, if he was found

guilty of some criminal fraud and it was a felony, it would come in under the statute. We have a -- we have a good example of that in Las Vegas with Dr. Kabins. If Dr. Kabins testifies in a trial of mine, which he has in several different cases, I allow certain things in about the prior criminal felony conviction.

In this case, unless you've got some criminal conviction against Dr. Gross, I don't think it comes in. I mean, whether or not -- I mean, if he's getting a kickback or not -- if he's getting a kickback, I bet the Feds are looking at him anyway. But that's just -- it's way collateral to come in in this case. I mean, we're going to end up trying the whole case about this -- this hospital and this company in California that has -- has fraud allegations. And whether or not this witness has any knowledge about that or not, I don't think is relevant to the fact of whether or not the treatment is reasonable and necessary and whether the billing charges are usual and customary.

MR. STRASSBURG: But it goes to credibility of the witness, Judge. What he knew and when he knew it, that goes to credibility.

THE COURT: It may, but it's -- it's too collateral. It's too collateral. It's -- if -- I think all it does is confuse the jury, if that issue

comes in because that -- that issue is not before them. The issue of whether or not the treatment is usual and customary or the bills are usual and customary and the treatment's reasonable, that's the issue before them at this point. That's the issue.

And -- and if there's issues with the credibility of the doctor because he says that the treatment's reasonable or usual and customary, you can -- you can explore that. But you just can't explore it by using somebody else's criminal fraud conviction. You just -- you have to have another way to -- to -- to come at his credibility.

MR. STRASSBURG: Thank you, Judge, for considering our proffer.

THE COURT: Sorry. What else? Anything else?

MR. ROBERTS: Yes, Your Honor, couple of things. One, we objected during Mr. Mazzeo's cross-examination while he was asking the doctor to extrapolate his fees per surgery times the number of surgeries he did to come up with a gross number. I objected irrelevant. I just wanted to say for the record that my big problem with that is that he was asking the doctor for a gross number. This is his gross income from performing a surgery.

MR. STRASSBURG: No pun intended.

MR. ROBERTS: So in order to -- yes, of course. And his name is Dr. Gross. Thank you.

But the -- so it was a gross income in two different ways. But in the fundamental way I'm discussing it, it doesn't net out his costs.

So the only way for the jury to understand how much money he makes, which is what they want to do, you make all this money from doing surgeries, is to subtract out his costs and also to discount the -- any collateral discounts that he get -- his -- he's a collateral source on some of his own cases. He doesn't receive that full billing. He discounts it.

So now I'm in the position where I can't show, well, you don't really make 1.4 million a year from these surgeries. You only make 700,000 a year because you got to take out your cost, you got to take out the discounts that you give. But I don't want to talk about discounts and collateral sources. So now I'm kind of in a bind where to avoid the things that have been excluded and I don't want to talk about, I've got to leave the jury with the erroneous impression that 1.4 million is his income from these surgeries that he gets to put in his pocket. And -- and I just don't think that sort of thing should be allowed.

MR. MAZZEO: Judge, I don't think -- there's no evidence -- for the one thing, the jury knows there's costs associated with his -- with the procedure that he performs and the services he provides obviously. Anyone that's in business has overhead costs. So there's certainly no need to break it down for the jury to say, Well, ladies and gentlemen, of the 70,000 per surgery, he's only making $5,355. That's -- that would be unrealistic. And unless I can see his -- if he wants to disclose his billing records, then I would ask the Court to preclude any such contrived reporting from the doctor from -- from the witness stand because I would want to verify that. I wouldn't want him just to underestimate what he's actually bringing home and putting in his pocket.

So we haven't been provided any billing records or ledgers from Dr. Gross's own business. So I would strongly object to them trying to -- you know, we allow for -- or to elicit from him a breakdown of what he actually brings home. It's not necessary, and -- and it's presumed anyway, that -- that's his total charges. It's not what he's going to actually take home. It's not his net, supposedly.

MR. TINDALL: What I would like to add to that, Your Honor, is with Mr. Roberts' admission now

that Dr. Gross does give discounts, I renew my objection from, I believe, yesterday, when we should be allowed to ask Dr. Gross about that. And even further, that testimony today when he testified that he was owed that money regardless of whether she recovered or not. But he didn't say how much he was owed of that. He left the door open for an implication that there are discounts, and now we know from Mr. Roberts there are.

So we request again, we renew our request, that we be allowed to ask Dr. Gross about issues regarding his liens where they are discounted in conjunction with Mr. Roberts' comments the other day during opening.

MR. ROBERTS: And, Your Honor, I want to correct the record right now. I never said he ever gave a lien discount. I have no personal knowledge as to whether he's ever discounted a lien in his life. But I do know, if he's performing 20, 25 surgeries and any of those are for insurance, I've never met an insurance company that paid full value. You always have to give the insurance company a discount. And -- and that's what I'm talking about. Because they're not talking about this case or even lien cases. They were asking him how many surgeries he did per year, every one of them, and asking him to multiply that out by the

amount he charged in this case.

MR. MAZZEO: Your Honor, also, I never met a doctor who charged for -- a lien amount that's equivalent to the contract rate that he would otherwise get for an insurance -- health insurance patient or a private pay patient. So if they want to open the door, let's have at it.

MR. ROBERTS: Well, we all know how that works, Your Honor. You bill your charge that you always bill, and then you show the discount, and then that's the amount that you, the insurance companies, pay. The contract rate is not going to be the amount shown on the invoice to the insurance company. It's going to be the full amount, less the discount, equals the amount paid. The discount is the collateral source. Over and over the supreme court has held that the discount is the collateral source.

And all I'm asking is they not be allowed to do this again, that Roger can't get up and do it again. It shouldn't have come in. It's in. I don't want to draw any more attention to it than I have to. But I just -- I would like an assurance that it's not going to happen again.

MR. MAZZEO: And, Judge, I'm sorry.

THE COURT: That's enough, guys. I'm not

going to let you keep going back and forth all night. Sorry.

If you want to address it in redirect and talk about what the net is as opposed to the gross, I don't care if you do that. If you open the door for additional questions about reductions, you may open the door. Even if you do, I don't know that it's open as it relates to this patient because the question that was asked didn't relate to this patient. It talked about gross billings. So there you go.

MR. ROBERTS: That's why I objected to relevancy, I believe, at the time.

THE COURT: I got it.

MR. ROBERTS: So, Your Honor, a couple other issues. One is the mention of Kabins, and I will say, that --

THE COURT: Kabins in this case?

MR. ROBERTS: He is not.

THE COURT: Okay.

MR. ROBERTS: And -- and this is hearsay.

MR. MAZZEO: I didn't mention him.

MR. ROBERTS: But someone else told me that -- that -- that Mr. Mazzeo in a prior cross-examination of Dr. Oliveri asked him if he ever got referrals from other physicians. Yes. Did you

ever -- did you ever get referrals from spine surgeons? Yes. You ever get referrals from Dr. Kabins? And in that case, Dr. Kabins had provided no treatment, was not an issue and, of course, it was only mentioned to try to tie Dr. Kabins and his indictment to Dr. Oliveri with no basis.

So I just would like an assurance that he's not going to pull anything like that. Whether he's done it in the past or not, I would like an assurance it's not going to happen here.

THE COURT: It's probably not appropriate.

MR. MAZZEO: It's not appropriate, Judge. I would not do that.

MR. ROBERTS: And the last thing is I would like an offer of proof from Mr. Mazzeo. There's a motion in limine which precluded counsel from raising hypothetical questions that didn't have a reasonable basis in the evidence. And I didn't object at the time, because I didn't know the file well enough, and -- and I wanted to verify it. But Mr. Mazzeo asked Dr. Oliveri if a lumbar adjustment --

THE COURT: Dr. Gross.

MR. ROBERTS: Dr. Gross.

-- if a lumbar adjustment by a chiropractor could cause a destabilization or movement of a

spondylolisthesis. And in reviewing the chiropractor's records in this case, there's absolutely no evidence in the records that a lumbar adjustment was ever done by the chiropractor. So I -- I think that violates the motion in limine. And unless he can make an offer of proof as to a reasonable basis for believing such an adjustment was done, I'd ask that that be stricken from the record tomorrow.

MR. MAZZEO: Judge, I have to look at the records of Dr. Gulitz. So I can't respond to that right now.

THE COURT: Okay. Talk about it in the morning.

MR. ROBERTS: That's all I have.

MR. MAZZEO: Thank you, Judge.

THE COURT: Okay. Off the record. See you in the morning, guys.

(Thereupon, the proceedings concluded at 4:47 p.m.)

CERTIFICATE OF REPORTER

STATE OF NEVADA)
) ss:
COUNTY OF CLARK)

I, Kristy L. Clark, a duly commissioned Notary Public, Clark County, State of Nevada, do hereby certify: That I reported the proceedings commencing on Wednesday, February 17, 2016, at 9:12 o'clock a.m.

That I thereafter transcribed my said shorthand notes into typewriting and that the typewritten transcript is a complete, true, and accurate transcription of my said shorthand notes.

I further certify that I am not a relative or employee of counsel of any of the parties, nor a relative or employee of the parties involved in said action, nor a person financially interested in the action.

IN WITNESS WHEREOF, I have set my hand in my office in the County of Clark, State of Nevada, this 17th day of February, 2016.

Kristy Clark

KRISTY L. CLARK, CCR #708

CASE NO. A-11-637772-C

DEPT. NO. 30

DOCKET U

DISTRICT COURT

CLARK COUNTY, NEVADA

* * * * *

EMILIA GARCIA, individually,

Plaintiff,

vs.

JARED AWERBACH, individually; ANDREA AWERBACH, individually; DOES I-X, and ROE CORPORATIONS I-X, inclusive,

Defendants.

REPORTER'S TRANSCRIPT

OF

JURY TRIAL

BEFORE THE HONORABLE JERRY A. WIESE, II

DEPARTMENT XXX

DATED THURSDAY, FEBRUARY 18, 2016

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

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I N D E X

LAS VEGAS, NEVADA, THURSDAY, FEBRUARY 18, 2016;
10:01 A.M.

P R O C E E D I N G S

* * * * * * *

THE COURT: On the record. We're outside the presence.

What do you got, Mr. Mazzeo?

MR. MAZZEO: Okay. A couple of matters. One is -- so I've looked -- there was a request or an objection, I guess, by Mr. Roberts yesterday with regard to my questioning of Dr. Gross about spinal adjustments that were performed by Dr. Gulitz, and so I have my offer of proof.

And so looking at Dr. Gulitz's initial report, which is dated 1/12 of 2011, he provides on the -- this is Plaintiff's 15, page 12, and -- actually, page 11 starts at. He provides a description of the treatment that he provides at his clinic. The following is a description of the types of treatment benefits used in this office: Chiropractic manipulation. It gives a -- the various services that he provides. Muscle stimulation, exercises, massage, and ice.

And so from that, then I went to Dr. Gulitz's or The Neck and Back Clinic billing records, and so what they provide -- provided to Ms. Garcia on various dates. First one was on January 19th, is manual therapy technique, myofascial release, and they -- and that's done a number of times at the -- by Dr. Gulitz or by someone at that facility. And I would equate the manual therapy technique with being equated to a -- a spinal manipulation or adjustment of some sort. So I think I had a good-faith basis to ask that of Dr. Gross, so there's my offer of proof.

THE COURT: Okay.

MR. SMITH: If I may, Your Honor. I know Mr. Mazzeo would equate it to that, but that's not what occurred. And Dr. Gulitz has been deposed in this case, as has been Ms. Garcia as to what happened at the chiropractor. And taking a look at the page -- the page Mr. Mazzeo's looking at in the record is a page where it says, These are the types of treatment our facility performs and what we may perform on a patient, on our first visit before she ever received any treatment. Then each of the treatment records from every specific date list exactly what was done on that particular day.

So, for example, on -- on her first date, she

received therapeutic exercise, which is what he's talking about, with -- with the manipulation, electrical muscle stimulation, heat therapy. And what Dr. Gulitz and Ms. Garcia testified to is that she came in on the first day, and the first thing that he did was take an X-ray. And Dr. Gulitz looked at the X-ray himself and said, I see a bilateral pars defect. And right then at that point, he decided he was not going to do anything on her low back.

So what Mr. Mazzeo is doing is mixing up the terms and saying things that didn't happen and then misstating the part of the body. So, for example, when Ms. Garcia was asked about it, and this is page 50 and 51 of her first deposition, when she was asked about it she said:

> "I came in and I received heat packs and electrical stimulation. That's all I received on my low back. And on my upper back, I received some massages."

And she got some trigger point release which is essentially a type of massage where they push on specific muscles. Only above her mid back. He never once adjusted her low back, or any part of her body for that matter. But he also never touched her low back, and there's absolutely no evidence of him ever touching

her back, and that's in sworn testimony by two witnesses that have been known about for years now.

And to ask the question of Dr. Gross and put it in the jury's minds that there was a -- an adjustment of her low back that never happened is totally improper and misstates the actual records because in every chiropractic record, he states what he did. And it never once says an adjustment of any part of her body.

MR. MAZZEO: And actually, Mr. Smith is wrong. I don't equate therapeutic exercise with manual therapy techniques because that's actually a separate entry and he billed separately for that on the billing entry, and I can show that to the Court.

So looking at this, to me it indicates -- doesn't say massage. It says various forms of therapy. You have therapeutic exercises. That's one. You have thermo chirotherapy. You have interferential current electrical muscle stimulation. And you also have manual therapy technique/myofascial release, I guess. And so that's what's indicated on this.

That's an offer of proof. And that's -- that would -- that would be equated to some sort of -- he's a chiropractor. So that would be equated to some sort of adjustment which I referenced in my question to

Dr. Gross. So --

THE COURT: I think there was a good-faith basis for the question.

MR. MAZZEO: Thank you, Judge.

THE COURT: Let's move on.

MR. MAZZEO: Thank you.

Oh, secondly, Judge, now, we have -- the defendant had filed a trial memorandum regarding compliance with the FCH case, Fiesta Palms case. And I know that plaintiff is calling a number of witnesses, medical -- treating physicians actually. And I just want to make sure that they are not going to render any opinion that's beyond the scope of any findings or opinions they identified or stated in their treatment record. If they do, that would be improper, unless they had supplemented with -- pursuant to 16.12 with an expert report. So I know, Dr. --

THE COURT: You guys know the expert reports and the medical records much better than I do, so if there's a need for an objection when something comes up, object.

MR. MAZZEO: I'll bring it up to the Court's attention.

And also, Judge, you had -- did you have an opportunity to review the trial memorandum regarding

Stan Smith and his --

THE COURT: I did.

MR. MAZZEO: Is that something that we can discuss? Maybe not -- Stan Smith isn't going to be called today, so I don't think we need to discuss it today. But the defense would certainly like to go on the record with our request that the Court exclude him from testifying with regard to hedonic damages and loss of enjoyment -- I'm sorry, and household services.

THE COURT: I'll give you time. Let's not do it right now.

MR. MAZZEO: No. Thank you, Judge.

MR. ROBERTS: He was originally scheduled this afternoon according to our plan when he was going to be one of our final witnesses. He has been rescheduled, I believe, to next Tuesday or so. We have time before Tuesday morning.

MR. MAZZEO: And then the last thing is I'm not going to stipulate or I will object to each time they -- the plaintiff asks a treating physician to be qualified and deemed an expert by the Court. They're treating physicians. Typically, unless they're -- and that rule, I mean, I think went by the wayside three or four years ago where the Court has to recognize an expert as an expert. They can lay the foundation for

it, but they don't actually have to have the Court rule on that anymore.

But with regard to a treating physician, I will object if they try to move each and every treating doctor in as an expert because, frankly, Dr. Cash was not designated as an expert. He's -- he's only a treating physician. Frankly, Dr. Gross wasn't designated as an expert. Even though they -- they did provide expert reports, he was -- we never received a CV, and he was never other -- otherwise formally designated in any of plaintiff's designations as an expert.

So with Dr. Lemper coming today, he is not an expert. He's a treating physician, so I would ask the Court for an advance ruling on the plaintiff requesting that and whether you will grant my objection to him being brought in here as an expert when he's only a treating physician.

THE COURT: Here's the -- the problem with that is I don't think that they necessarily have to be recognized by the Court as an expert to offer opinion testimony as an expert. But if they're not an expert, they don't get to offer opinion testimony. So with regard to treating doctors, they are experts to the extent that they're qualified as -- to testify as an

expert, and that's the only way they can offer opinions as to reasonableness and necessity, causation, things like that that they do as treating doctors.

So I mean, if they qualify as an expert and the plaintiffs ask me to recognize them as an expert, I I'm going to recognize them as an expert with the understanding that they're only an expert as -- as a treating doctor.

MR. MAZZEO: That's fair enough. Thank you.

THE COURT: And I think you -- you made some comment or an objection or some statement yesterday with regard to -- maybe it was Dr. Gross.

MR. MAZZEO: I think so.

THE COURT: And I think I said essentially the same thing --

MR. MAZZEO: Correct.

THE COURT: -- so ...

MR. MAZZEO: Fair enough. Thank you.

THE COURT: Good to go?

MR. MAZZEO: Ready.

THE COURT: All right. Let's bring our jury in.

MR. MAZZEO: Judge, when we break for lunch, or at that time, we have to -- we have to coordinate our expert witness schedule, plaintiff's case in chief,

when it will end, when we can start, and then have sufficient time at the end for closing arguments, and I guess plaintiff's punitive damages case because it may lead into a fifth week. And I would hate to have that happen, but I don't want to be cut short on the defendant's end on presenting evidence.

THE COURT: Sounds like a great conversation to have.

THE MARSHAL: Jury entering.

(The following proceedings were held in the presence of the jury.)

THE MARSHAL: Jury is present, Judge.

THE COURT: Thank you. You can be seated. Good morning, ladies and gentlemen. We're back on the record, Case No. A637772.

Do the parties stipulate to the presence of the jury?

MR. ROBERTS: Yes, Your Honor.

MR. MAZZEO: Yes, Your Honor.

THE COURT: All right. We had Dr. Gross on yesterday. We've heard some of Dr. Cash and some of Dr. Gross. I don't think either one of them is finished yet. And now we're going to take another doctor out of order.

So who's the plaintiff's next witness?

MR. ROBERTS: Your Honor, we would call Dr. Brian Lemper.

THE COURT: We will finish with the doctors that have been testifying already, just we have to work around everybody's schedules.

Good morning, Doctor. If you would come all the way up on the witness stand. Once you get there, I'm going to ask you to please remain standing, raise your right hand, and be sworn.

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

THE WITNESS: I do.

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

THE WITNESS: Brian Lemper. Brian with an "i," B-r-i-a-n. Lemper like temper, L-e-m-p-e-r.

THE CLERK: Thank you.

THE WITNESS: Thank you.

THE COURT: Go ahead and be seated. Try to talk into the microphone as much as you can.

THE WITNESS: Thank you.

/////

DIRECT EXAMINATION

BY MR. ROBERTS:

Q. Good morning, Doctor.

A. Good morning.

MR. ROBERTS: And Dr. Lemper has an issue with his back and occasionally needs to stand. He can't sit for long.

Is that okay if he stands --

THE COURT: Yep.

MR. ROBERTS: -- occasionally?

THE WITNESS: Thank you.

MR. ROBERTS: Feel free if you get uncomfortable, Doctor.

BY MR. ROBERTS:

Q. Dr. Lemper, could you give the jury your educational background starting with college?

A. I went to U of I, Chicago. That was University of Illinois. I graduated in three years with a -- I had an -- a degree with honors. I graduated from the honors college. I sat on the honors college advisory board. I was invited -- I graduated from college in 1995 and it was in the wintertime. So I applied for medical school come spring. That was at the Chicago College of Osteopathic Medicine. And I apologize, I graduated from medical school -- from

college in 1991, graduated from medical school in 1995. It's been a lot longer than it seems.

After medical school, I went to -- or I was at the Chicago College of Osteopathic Medicine where I did a four-year medical school program, graduated, took my boards, passed the osteopathic boards, went into an internship in 1996, completed the internship which was a combined trauma surgery and internal medicine. I was originally planning on becoming a neurosurgeon, and in the middle of my internship, I decided to change gear and go into pain management/anesthesiology and applied to Rush Presbyterian St. Luke's and got into the M.D. program at that point in time where I graduated from the residency by 1999 and was invited into the Rush St. Luke's fellowship program for a combined surgical training in spine as well as pain management in spine. Graduated that in the year 2000, which is when I moved to Las Vegas.

I was doubly board-certified in 2000. By the time 2005, I was capable of sitting for the pain subspecialty boards.

Q. Could you tell us what your first board certification is in, Doctor?

A. Osteopathic medicine.

Q. Okay. Thank you.

A. Second one was an internship board. Next was a -- the actual board certification for an anesthesiologist. That was an M.D. board.

So I am an osteopath which is a D.O. The real difference in training is I can crack backs like a chiropractor can. The rest of medical training is very similar. There was just a little additional training that we did that I thought was far superior from a musculoskeletal standpoint. I feel that following that training, I was very capable to apply to any school, and have actually proven that by passing all M.D. boards since that point in time.

Q. You mentioned a subspecialty board.

What was that subspecialty board, Doctor?

A. Correct. So a specialty is anesthesiology. So once I passed the anesthesiology board, which is a -- quite a fun board because it's a combination of a written exam and then after you pass the written exam, you get to sit in front of a board of anesthesiologists that fire questions at you like you're in the operating room.

After I passed the anesthesiology boards, then I sat for my pain management boards, which was after I did a residency, I then had to apply for a subspecialty. So you're in a specialty of

anesthesiology. A subspecialty was pain management. Part of that, you do surgical training, you do injection training, and you do medication training. And you pretty much live in the hospital for that year. And when you're done, after a period of practicing, you can sit for the pain management boards, which is what I did in 2005. And thank God, again, in -- just in October of -- of last year, sat and passed the boards again. The first test I had taken in ten-year period of time. It was not fun studying for that, but I still got it.

Q. Thank you. Thank you, Doctor.

So you mentioned you came to Vegas in about 2000?

A. Exactly 2000.

Q. And what was your first job when you came to Vegas?

A. When I first came to Vegas, I was an anesthesiologist that was interested in starting a pain practice, but I essentially had -- excuse me. I was doing anesthesia for a spine surgeon by the name of Patrick McNulty. I did pretty much 80 percent of all of his surgeries, and on my downtime -- he operated three days a week. So I would do anesthesia for whatever surgeon didn't have an anesthesiologist at the

hospital. I would hang around the doctors' lounges and kind of look for work. When you're brand new in town and you're not joining a big group, you kind of have to solicit yourself.

Q. Did you work at Spring Valley Hospital?

A. I did. I -- actually, Spring Valley Hospital, I sat -- I had a position as director of pain management for the hospital for some time.

Q. And what is your current work?

A. Presently -- in 2009, I opened up a surgery center, surgery center with an urgent care and a diagnostic center as well, all in the same facility. What I do now is patients come to see me when they have pain. They've either been treated by other doctors or they're fresh off the street, and they have an issue and they need me to identify the problem, see if I can manage the problem. And if I can't manage the problem, do I prescribe surgery in the appropriate fashion?

Q. The jury is going to hear a couple of names associated with your treatment. One is The Center for Surgical Intervention.

Could you explain to the jury what that is and what your role is in that?

A. Yes. That is my surgery center. My role in it is I'm a doctor that goes there and does surgeries

and -- and injections there. As well I own facility.

Q. And how does that differ from Brian A. Lemper, D.O., Limited?

A. Brian A. Lemper, D.O., Limited is my private practice as a doctor. You come see me. I ask you to bend over, push on your back. I might give you a shot. I might prescribe medicine or an exercise regimen. What you -- when you come into my practice, I am Brian A. Lemper, D.O., Ltd. So myself was actually incorporated for my medical practice.

Q. Could you describe a little bit more to the jury about your pain management practice over the last five years as it relates to people with spine pain or back pain.

A. In the last five years, I would say my pain management evolved going all the way back into the late '80s. I was in college and I was a mover, and I was going to be a stockbroker in college. And I had a great weekend job making excellent money being a mover. And I herniated a disk. And I went to doctor after doctor being told I had all kinds of issues going on because I had leg pain and no back pain. And I was about to get operated on for a knee problem and a physical therapist told me he thinks I had a back problem. I went and got an MRI for the back problem,

went to a doctor and the doctor actually said, You need back surgery, and quickly went ahead and operated on the wrong level.

So I had kind of a -- a situation where when I was 19 years old; I said, If these bozos are doctors, it must not be that tough to become one. And I actually was right. And I applied to medical school, got in. And once I got into medical school, I realized that I had figured out a way to make back pain better than just giving pills and shots. I make people stronger.

And the last five years of my practice, that has actually unleashed into -- I have a huge following of professional athletes, MMA fighters, people who are in top shape who come to see me because I don't like to prescribe medicine. I don't like to send them for surgery. I try to do everything I can to help manage their problem and make them as strong as possible so that they need me as little as possible, because that's how you survive with a back problem.

Q. Do you consider it one of your primary goals of your back-related practice to help people avoid surgery?

A. That is true. And I avoided surgery for 20 years between my last two surgeries. I actually had

to have one about a year and a half ago, and I was able to do it without taking narcotics. And I had -- I -- I -- I show my patients, I say, Don't do what I tell you. Do what I do. I have a very similar problem to you. I have difficulty sitting. I don't travel very well. I haven't flown to Europe. Not that I can't. I just have no desire to sit on an airplane for 12 hours to get somewhere. I can't possibly get there and function once I get there.

I get how my patients are. I also get how my patients substitute things to take care of their families too. There's -- there's a lot of personal interest with what I do. And my main goal is to fix people. My main goal is when somebody comes in my office, I've got to figure out how they will not need me.

Q. Doctor, do you regularly perform facet injections as part of your practice?

A. I do.

Q. And how many of those procedures could you estimate for the jury that you've done over the years?

A. I do a little less than 2,000 injections in a year. Okay? I've been doing that for 20 years, 15 of which -- or 16 of which have been in my own private practice. And in the last 4 or 5 years, I've been

working to set my schedule right so that -- you know, I don't like to overwork. I like to see patients, I like to spend time with them, and I like to get involved in their lives. I can also ramble on, too, when you ask me a question, so keep me on track.

Q. When -- when you told the jury you did about 2,000 injections a yeah --

A. Correct.

Q. -- does that include nerve root blocks?

A. It includes nerve root blocks, and out of those, I would say probably 25 percent of all the injections I do are facet-related injections. Could be as high as 50 percent of the injections that I do have facet symptomatology as part of the problem. Statistically speaking, a very nice study was done on the cervical spine that showed after a car accident, you're more likely to have facet problems than any other problems at a 66.6 percent. That's just a study that kind of came about. I'm not familiar with a study for the low back saying that facet disease is a certain prevalence in the trauma, but I do know that it has been studied in the cervical spine.

Q. Thank you, Doctor.

MR. ROBERTS: Your Honor, at this time, we would ask the Court to recognize Dr. Lemper as an

expert in pain management and, in particular, pain management of the spine.

THE COURT: Objection?

MR. MAZZEO: Only insofar as he is here today as a treating physician.

MR. STRASSBURG: We welcome Dr. Lemper.

THE COURT: He'll be so recognized.

MR. ROBERTS: Thank you.

THE WITNESS: Thank you.

MR. ROBERTS: Audra, do you have our timeline?

BY MR. ROBERTS:

Q. This is the timeline that we showed the jury during opening statement.

And, Doctor, do you see that on your screen?

A. I do.

Q. Okay. Just because we're -- we're going a little bit back in time chronologically, when did your treatment first start with Emilia Garcia?

A. I want to say it was in June of '11.

Q. June of '11. Okay.

So in June of '11, did you become aware that she had received prior treatment for her back?

A. Prior treatment or prior evaluations?

Q. Let's -- let's just go with prior

evaluations.

A. Yes, I was.

Q. And what -- what medical records did you become aware of on your first visit?

A. You know, I do know I had Dr. Gulitz's notes. I do know that I had either had Cash's notes, or I had spoken to him at some point in time. Dr. Cash, sorry. And I don't know if I had actually reviewed his records, but I do know that she was familiar from his office. So I had very likely either spoken to him, or his office staff member called my staff member and somebody gave me a -- a once through about him.

As well, Dr. Gross was involved early on, and Dr. Gross and I actually exchanged, I would say, medical records fairly frequently.

Q. At the time she first came to see you in June of '11, were you aware that Dr. Cash had recommended a fusion surgery?

A. I was.

Q. Were you aware that Dr. Gross had recommended a fusion surgery?

A. I was. That's pretty much the reason why she would be in my office. People don't just -- you know, if you're in need of surgery, they will very likely send you to me to either identify the problem exactly

or to try to get them to avoid it. I look at them like I want to get them to avoid it.

Q. Do you recall how Ms. Garcia came to see you?

A. Like her -- somebody drove her or -- kind of thing or --

Q. Do you know who referred her to you?

A. I do know that Dr. Gulitz referred her.

Q. Okay. And did you either speak to Dr. Gulitz or review his records?

A. I very likely reviewed his records, but it is not the standard that I would get on the phone with a chiropractor and pick his brains for a new referral, so ...

Q. Do you recall the complaints that Ms. Garcia related to you at the first visit?

A. It was mainly low back. I remember that she had some neck problems but said that the manipulation, the chiropractor that helped that the most. At one point in time, some of the treatments was helping her low back. But overall, she felt she got to a level that helped everything except that low back problem, and she was starting to get a little frustrated because she started to believe it was getting worse.

THE WITNESS: Is it okay if I drink water?

THE COURT: That's fine.

BY MR. ROBERTS:

Q. At the initial visit, did you have a consultation with Ms. Garcia?

A. I did.

Q. Do you recall about how long that took?

A. My consultations are scheduled for about an hour and a half. It takes -- face-to-face time with me is about 45 minutes of face-to-face time out of that whole thing. You have one of my physician assistants is in the room as well as two medical assistants and a nurse. We go through an initial physician examination once they identify problems. Then I come in and confirm the problems. Once I confirm the problems, I'll set up a diagnostic plan and very likely go through the MRI studies or order more diagnostics that I need in order to formulate up a plan.

Q. Did you perform a physical examination on Ms. Garcia?

A. Yes.

MR. ROBERTS: And, Audra, if you could pull up Exhibit 12, page 4, which is already in evidence, and just put the top half of that up on the screen for the jury.

BY MR. ROBERTS:

Q. And, Doctor, this is from the medical records

or do -- does this page reflect the findings from her physical examination with regard to her spine?

A. It does. I think that there was a -- one line missing, a general line. It goes HEENT, which is the head, eyes, ears, nose, and throat. Before that, there's a general comment and I -- I believe that I said she was walking funny or --

MR. ROBERTS: Can you go back one page, Audra, to page --

THE WITNESS: Or just one more.

MR. ROBERTS: -- page 3?

BY MR. ROBERTS:

Q. It's at the bottom of page 3, I believe, that you're referring to, Doctor.

A. Yeah. That would be the only thing that I would say would possibly have something to do with it that's not visual in here.

Okay. So well developed, well nourished. She appears uncomfortable and emotionally labile. She sits supporting her weight on her chair with her hands. Ambulates with a bilaterally antalgic gait, but she did not need an assistive device like a cane. So basically, in a nutshell, she looked like she was in pain. She was having trouble sitting there.

Q. And what about the antalgic gait?

A. Antalgic gait means it looked like it hurt when she was walking. So she was walking in a way where she was an abnormal gait because of pain. So it was usually short based -- sorry, wide based and short stride is the standard. I didn't describe it that much or any more than just it looked like she was hurting when she was walking.

Q. Thank you, Doctor.

MR. ROBERTS: Let's go to the next page again, Audra, page 4, the top half.

BY MR. ROBERTS:

Q. And what did you observe at this time with regard to her cervical spine?

A. Cervical spine, she had some tenderness to palpation. There was some palpable spasm as well as midline tenderness. However, range of motion was full. Her lordosis was maintained, which she had pretty good posture in her neck regardless. So it was -- her neck was sore. Some of the muscles were sore.

Q. Now -- now, the jury's heard some of -- testimony about spasms in the back.

What is a palpable spasm?

A. Basically, we've all been fatigued and tired and you look in the mirror and your eyelid goes like that (witness indicating). That usually happens when

you're fatigued. If you haven't slept a couple of nights in row or something is going on, you didn't a good REM sleep.

Your muscles do the same thing. When there's an issue, especially in a spine, your spine sends a message to your brain that it's broken. That's it. It's either broken or not broken. And your brain doesn't know if it's a pinched nerve, a broken bone, a blood clot, a tumor. It doesn't know. So what it does, it says, You're going to heal better if you don't move. So it spasms the area that hurts. So when your brain sends -- or your spine sends a message to your brain that I'm hurt, it reflexively spasms. In general, that lasts for about two to three months unless you have an ongoing underlying problem that keeps triggering the spasm.

So here she is six months or what, five months later, she shouldn't have had an ongoing spasm if she had a muscular injury. She had something underlying going on which is why I even test for a spasm. At six months out, if she's still got something acutely active there, there's an ongoing injury.

So the spasm itself is you put your hand on the skin, you can feel that twitching. When you can feel the twitching, it either hurts or doesn't hurt,

but they're guarding around that area, reflexively speaking. It's up to me to figure out can I break that spasm and in breaking that spasm, did I identify the problem and did this person get enough time to actually heal on their own while I gave them relief from the pain.

Q. Is this something that you are able to objectively verify yourself, or did you rely on her reporting of the spasm?

A. I only rely on her to say, Ouch, it hurts. But most of the time, I don't even ask them. You can tell. I mean, you bend somebody over and you push on them, you can tell who's hurting and who's not hurting. But as far as feeling a spasm, a spasm is I feel it.

Q. The -- the next level that you discuss is the thoracic spine.

A. Yes.

Q. And what -- where is that from -- in relation to --

A. The thoracic spine is every part of your spine that has a rib on it. So there's 12 levels from the base of your neck to right around the base of your diaphragm down there. And you have ribs that attach to each of the thoracic spine, the most stable areas. But they do get a lot of pain referred from the neck.

On her physical exam, I wasn't very impressed with her thoracic physical either.

Q. And the next level identified is the lumbar spine. Please explain to the jury what your findings were on physical examination. And, again, this is on June 29th, 2011.

A. Gotcha. First thing I do is I have them stand up and I have them lean over the table and I make a joke with them like I'm going to frisk them for weapons. And I get on their back and I kind of push on it, and I feel their iliac crest. From that point in time coming straight in, that's about the L4-5 level on 99 percent of -- of adult people.

I can push on the area and feel actual spasming, but when I push on it, she winces, her knees would buckle. She was not having -- actually, I think I made her cry during the examination. I mean, it's not like I'm trying to hurt these people, but it hurts trying to figure out what's going on. And then they're on the fourth doctor, and every time they come in, they're like, It hurts when I bend over. And bending -- I know before I had my back surgery, putting on my shoes was horrible. So I understand what people -- and they go through the stress, like, I'm going to have to reproduce my problem again.

So on her, she had some back tenderness. There was some spasm in her paraspinal musculature. At midline, when I pushed midline on the bony processes, that hurts. That's the most significant factor to me, which is an indication that -- you push on those bones on your back, nothing should move it. That shouldn't hurt. When it radiates out or it hurts out, that tells me something's going. Something that's moving that shouldn't be moving or there's swelling over that area.

Q. Thank you, Doctor.

MR. ROBERTS: Audra, could we go down to the bottom half starting with Impression?

BY MR. ROBERTS:

Q. So the section of your report, Impression, explain to the jury what -- what an impression is.

A. Impression is what do I think's going on.

Q. Thank you. And -- and I see you've got the findings here.

Could you explain your impressions from your initial physical examination and discussion with Ms. Garcia?

A. Correct. Number 1, posttraumatic lumbar radiculopathy. In order to have back pain, you have to have pain coming from a nerve root in your spine. Even if your disk hurts, no matter what, the only

transmission of that pain is from the nerve root. A nerve root is called a radical. A radiculopathy -- opathy is Latin or Greek for pathological process or something's wrong with it. So a nerve radiculopathy, a lumbar radiculopathy means there's something going on with her lumbar nerve.

When she had the back pain, she had lower extremity radiation of symptoms. She did not have damage every inch going down her legs, but she had pain. So that was an indication of an abnormal nerve firing which is a nerve pathology, the pathology of which we found out later once we took the MRIs and identified issues.

Q. The first part of that impression is posttraumatic.

Could you explain to the jury the significance of that finding and how you came to believe more likely than not the injury you observed was posttraumatic?

A. She never had any indication in her medical records or in her history or in any discussion that I had with her that she had any referred nerve root pain down her legs before this trauma.

I know that it took a few days to manifest the lower extremity symptoms, but you cannot discount

the fact that she was nailed by a 3,000-plus-pound automobile. And something just wasn't right after that, and she started to have progressive lower extremity issue. By the time she got to see me, she had seen some fairly competent doctors and chiropractors, and I was her only hope to avoid surgery.

Q. Can you continue with your remaining impressions for the jury?

A. Posttraumatic low back pain with displaced intervertebral disks, facet arthropathy, and anterior subluxation of L5 on S1, 4 millimeters, with bilateral pars interarticularis defect, and history of previous asymptomatic spina bifida occulta. That's a lot. Basically, means she slipped.

Q. So the anterior subluxation of L5 on S1 4 millimeters with bilateral pars interarticularis defect, is that the same thing as a spondylolisthesis?

A. That's exactly it. I'm just describing the mechanical terms of what happened without labeling it as -- as a name.

Q. Was this impression based just on your physical examination and discussion with Ms. Garcia, or was it also based on a review of MRIs, X-rays, or both?

A. As well. Everything. MRIs, X-rays, and her

physical exam findings.

Q. The 4 millimeters, what does that refer to?

A. The amount of slippage. Anterolisthesis, your bones in your spine are stacked up. It's like you've got two bones between a rubber tire. So you've got bone, rubber tire, bone, rubber tire going all the way up. When you have anterolisthesis of 5 on 1, the bottom two levels in your spine are -- L5 is the last lumbar bone, and S1 is the first sacral bone. So when you have anterolisthesis, anteriorly means forward slipping of the L5 bone. The only way to have forward slipping of the L5 bone and still have your lower extremities working is to have a spondylolisthesis.

You have spinal bones that are in a circle. So if you slip too far, a guillotine goes (noise) and cuts the spinal cord. Your body -- we were made a very wonderful way to degenerate and fracture in order to actually keep going. And that usually occurs from over time having a belly. You have a belly, you'll get spondylolisthesis. And if it fractures, that's you're still walking.

Q. Do you recall, Doctor, if the 4 millimeters noted in your impression was measured by you or did you rely on the radiologist's report?

A. You know, very likely a radiologist's report.

I do do evaluations on the MRIs, but it's rare that I would actually throw up a calibrated number like that. I would say large, small, Grade I, II, III, or IV.

Q. The -- the last part of Impression No. 2, reads, "History of previously asymptomatic spina bifida occulta."

Could you explain to the jury that finding? What is spina bifida occulta?

A. Twenty percent of all human beings made have something abnormal in their spine. They either have one less rib, one more rib, one less lumbar bone, one extra lumbar bone. Basically we all have the same number of nerves, but when we're developing, your bones and your disk all come from what's called a neural tube. And at some point in the last couple of months of development, you either make an extra bone and a disk in the lumbar spine above your sacrum or you incorporate that and have an extra level. They have proven that 20 percent of the population has this, and they're at no higher incidence than anybody else for having problems.

I noticed this on her. She had no problems preexisting. She had no complaints preexisting. It was a preexisting asymptomatic defect. It was just how it is.

Q. When you say "previously asymptomatic," did you believe that that condition --

A. I don't believe that the spina bifida occulta became symptomatic afterwards either. It was just -- it's there. I just believe that the -- that's not even proven that it would cause pain. They do have further severity of spina bifida where you get tethering of the cord. But the children are normally born with that and are usually paralyzed or paralyzed and then released and -- and -- through surgery. And they can release those nerve roots out. But this is nothing like that kind of a spina bifida.

Q. So there's a wide range of --

A. There's a very wide range. What she had is an incomplete fusion of the posterior wall of the, I want to say, S1 spinous processes, which is of no structural difference or change. It's not even a weight-bearing part of the bone.

Q. So that's a very mild form?

A. Yes.

Q. Go to Impression No. 3. Could you explain that finding to the jury.

A. Posttraumatic cervical radiculopathy. She had nerve root irritation in her neck after the trauma.

Q. And does the posttraumatic indicate that you

also attributed that finding more likely than not to the motor vehicle collision of January 2nd, 2011?

A. I did. There was no other intervening incident nor -- I mean, she had some spasm, got some treatment, it got better. It was fairly straightforward.

Q. Finding No. 4, if could you review that with the jury.

A. Posttraumatic neck pain with symptoms consistent with displaced intervertebral disk and facet arthropathy. So she had neck pain, and I don't know if it was from the disks or from the facets.

Q. And, again, your finding is that this was posttraumatic pain?

A. Correct.

Q. And could you review Impression No. 5 now?

A. Number 5 is posttraumatic bilateral hip pain consistent with arthropathy or enthesopathy, which is just pain on the ligament insertion of the bone.

Q. Okay. Finding No. 6?

A. Posttraumatic myofascial pain with spasm. No muscle spasms and muscle pain.

Q. And, Doctor, I think you've skipped No. 6 and gone to No. 7.

A. Oh, six. I'm sorry.

Q. Yes.

A. Posttraumatic bilateral sacroiliac joint arthropathy. That's what SI stands for sacroiliac.

Q. And can you explain what arthropathy is and how you related that to the collision?

A. Anywhere you see opathy is pathologic finding. Just means there's something wrong with it. Arthro is the joint articular surface. When you get into a trauma and you have pain in that joint, that's a posttraumatic arthropathy. It can turn into arthritis later on, but the arthropathy is the painful joint.

Q. Okay. And we saw up above in your physical examination, you noted tenderness to palpation, left and right sacroiliac.

Explain to the jury that finding and -- and -- and whether that's common in a person without a problem at their SI joint.

A. That's very common when somebody has a back problem and they walk around hunched over like this (witness indicating). Your sacroiliac joint is weakest with forward bending. It's the joint right where your hips attach onto your sacrum. So your sacrum is your tailbone which is -- do we have a spine? I can show you guys.

Q. Sure. Actually we -- Bruce is right here.

Here you go, Doctor.

A. Okay. Thanks. If it's okay, I'll stand while I do this discussion.

So the spine -- you have three main curves in your spine. This is -- can you hear me without this? Are you okay? I just feel like I should say tip the wait staff and -- okay. Two shows on Sunday.

So you have a -- you have three curves. One -- this is the back of the head. So the lordosis in the neck, lordosis in the low back. They both curve the same. Your thoracic spine is curved over like this (witness indicating). Your sacrum -- your sacroiliac joint -- this is your ilium. This is your hip bones. This is your sacrum. Sacroiliac joint is this joint space right in here. You spend all day hunched over like this, all of your stress is going right on there.

Right between the ilium, the L5, and the sacrum, the L5 nerve root goes right through a meshwork of ligaments. It's just a hotspot in the low back to have problems. And you either have -- you can inject into the joint and help some of the L5 irritation. Some of the L5 irritation can cause spasm over the back of the SI joint. But the bottom line is, she had tenderness not only when I pushed over her lumbar spine, but when I pushed on her posterior superior

iliac spines, it was painful. When she bent over forward, it was painful. So I called her painful sacroiliac joint arthropathy posttraumatic.

Q. Thank you, Doctor.

Impression No. 8.

A. Long-term medication used -- use for chronic posttraumatic pain. Anything longer than a month to me is long-term medication use. Your body was not built -- your kidneys were not built to have long-term medication use. Your whole body goes through a change.

Q. Thank you, Doctor.

In discussing Ms. Garcia and her symptoms with her performing your physical examination, did you find her reporting of symptoms to be consistent or inconsistent with your physical examination and review of her films?

A. No, she was very consistent. And when she had possibilities, you -- I mean, she -- she had the ability -- she was in my office. She could have been treated for anything. She specifically stated where she got better in her neck. She specifically told me when I pushed on her, where it didn't hurt. She was a normal person that was just trying to get out of pain. And it was kind of breaking her down. It was taking -- it was taking a toll.

MR. ROBERTS: Audra, could we see page 5, mid point beginning with Plan?

BY MR. ROBERTS:

Q. So at the initial visit, June 29th, 2011, did you formulate an initial plan for Ms. Garcia to try to help her get better and avoid surgery?

A. I did. I did. Number 1, as you can see, from No. 1 on there, I shake my finger at them and I say, Don't lie to me about drugs. Don't take somebody else's drugs. If you have any problem with drugs, you tell me. Otherwise, I turn my back on you. That's No. 1.

Q. Let's stop there for a second.

You were prescribing Lortabs at that time?

A. I was. And I want to say Soma, like, a muscle relaxer too.

Q. And are Lortabs a scheduled narcotic?

A. They are. And now they're Schedule 2, which is of the highest level.

Q. Do you, as part of your practice, take any precautions with regard to -- to drug-seeking patients that may come to see you?

A. I do, hugely.

Q. Okay. Could you -- could you tell the jury what that concern is and what precaution you take?

A. If I could even start by telling you a story that back when I was in medical school, we used to do what's called triplicate forms for narcotics. Back in 1996, one of our fantastic politicians did a federal law that lifted the ability and anybody could write narcotics to everybody.

Now, at that point in time, I was a resident as an anesthesiologist. And then -- and in an emergency room, anytime anybody goes to the ER and they stop breathing, they call anesthesia because we put the airway and we get them breathing again. That's what we do. We're on call at the hospital for that.

I watched in the '90s a prevalence of people in their 50s and 60s with alcohol problems and pill problems coming in conscious levels, and in the -- before the '90, late '90s. After the '90s, I started seeing high school kids coming in on narcotics, coming in having strokes because they're taking their grandma's Oxycontin and they're snorting it and stuff like that.

If I could tell you, I got into pain management to stop that from happening. I -- I -- I just -- I couldn't believe that we had just, because a law had changed, unleashed narcotics into this society and just destroyed our high school kids.

Q. So -- so what do you do --
A. So to me, I do drug testing before they come in, while they're in their treatment. All kinds of people have all kind of issues, and what I do is I guide them and help them. All kinds of people use their pains -- their pain medicines at different times of the day, and I've got to make sure that it's safe, that they're not using their grandma's medicine or their brother's medicine or their cousins's medicine, and --
Q. So you do --
A. -- so I do drug testing before, during, and throughout their treatment.
Q. And that's to determine if they're taking any medications that are not being prescribed and that you're not aware of?
A. And just to make sure everything is safe, yes. And -- and I educate people frequently because, you know, sometimes you're at your aunt's house or something like that and you're having coffee, and you can't drive home to get your pill bottle. So goes, Oh, I just had a knee surgery last week. Take my Tylenol No. 3. I get that. That happens, but I get down on my patients about it because it's the law.
Q. Do you have the ability to check to see if

people have had previous prescriptions for scheduled narcotics?

A. I do. Before somebody even comes into my office, I do something what's called a DEA screen which is provided by the Nevada Board of Pharmacy. What I can do is, just like the pharmacies can do, if a patient's skipping around doctor to doctor, pharmacy to pharmacy, you got to have a real reason to be on these meds. And you can't get them without me knowing it.

So that's also part of the initial visit. When people come in, I know a lot about them already. So they don't stay my patient if I start asking them a line of questions and they start giving me an answer that's different than the answer I know.

Q. Did you do a DEA screen on Ms. Garcia prior to her initial visit?

A. I did. I think she had, like, one pain prescription couple years prior for -- it was associated with, like, a dental procedure or something like that. So she had no previous narcotic use that I would consider indicative of anything other than a short outpatient procedure.

Q. Part 2 of your plan, could you explain that to the jury?

A. Procedures done in the office. I explained

risk, benefit, realistic expectations, outcomes. In general, if I screw up, you could die. If I give you an infection, you could be paralyzed or have all kind of problems. So there's -- there's a great deal of faith they have to put into me. Plus I'm sticking a needle in their spine. I knock people out because of the comfort level. I knock people out because I don't want them having nightmares of me coming at them with a needle. And I knock them out because it's a much more -- we have technology. It is safe if you do it the right way with an anesthesiologist, and their treatment is pleasant. You don't -- we've got technology. I'm sorry.

Is it really worth it to save 150 bucks or 300 bucks to have an anesthesiologist keep you wide awake while you have to torture yourself through a procedure if I can just get you knocked out? So I usually knock out people, and I offer that to most of my injections. But there are risks associated with everything that I do.

Q. And you explain that to Ms. Garcia?

A. I did, yes. I even talk about death. People can die getting shots like this.

Q. Number -- Item No. 4 is a lumbar support orthotic.

Could you explain what that was to the jury and the purpose?

A. It's a tight-fitted back brace. The one that I like is -- I actually use one myself. It's a sport orthotic from Aspen. I use it skiing, and it just gives me a little bit of extra kind of stability. My patients, I tell them, here's a back support. It's got a lace up on the side of it. So what you do is you Velcro it on yourself, but then you have this lace system that just locks it in like a steel belt around you. And I say, Put it in the trunk of your car. When you go to Costco, put it on. When you unload your car, put it on. Can you use it all day long? You can, but it becomes uncomfortable right above and below. And I don't want you being dependent on something, but I want you to use it when you've got to, like, move some furniture around, you got to make the beds in the morning. Half my patients put it on for a couple of hours in the morning, brush their teeth, get ready for work, take it off.

Q. Item No. 5, MRI bilateral hips, cervical thoracic, and lumbar spines.

What -- what -- why did you want additional MRI as part of your plan?

A. She was getting worse. That was the bottom

line. And if I've got an MRI from six months ago and they're telling me something that just sounds like it's getting worse, I want to make sure it's getting worse. And it was. We had some significant changes.

Q. Could you explain Item 6 of your plan, the selective nerve root blocks?

A. She had a tear at the L4-5 disk, which is here, the second-to-the-bottom one. She had all the problems with the slippage and the fractured bone at L5-S1 which is the bottom one. So you name the disk for the bone it's between. So your lumbar bones are L5, L4, L3, L2, L1 -- I'm sorry, I had an energy drink right before I came in here, so ...

But this disk is L4-5. This disk is L5-S1. This one has the anterolisthesis. And if you look, look at the canal that the nerve's coming out. It's a notch in the bone below, and a notch in the bone below -- above, and it fits just right together. Now, you lose disk space by having a herniation, you lose height. You have a slippage, you're likely to pinch it because it's going to slip. One of them is going to slip forward and then you don't have a canal anymore. You have two archways that have a nerve either wedged up in the corner there or wedged in the corner there or, God forbid, stuck right there between the two facet

articular surfaces.

Q. And the jury has heard a couple places already.

With your fingers, were you making the foramen, or were you making the central canal?

A. I was making the foramen. Okay? So the foramen at the slipped area has two, like, halfs of the tunnel that -- it's all one bone. It's slipped. 4 millimeters of a slip, that's, like, what, 8 millimeters? Seven -- that's half -- it slipped half of the -- so no matter what, if you get an MRI with somebody laying down, you may not see it pinching, but you can't tell me this lady didn't walk around every time she leaned over or leaned to go get something --

MR. MAZZEO: Objection, Your Honor.

THE WITNESS: -- it wasn't nailing that nerve.

THE COURT: You can't keep talking when there's an objection.

THE WITNESS: Oh, sorry.

THE COURT: What's the objection?

MR. MAZZEO: His ancillary comments, speculation about what Ms. Garcia was feeling.

THE COURT: Overruled. It's overruled.

Go ahead.

BY MR. ROBERTS:

Q. So, Doctor, let's go back to the nerve root blocks.

A. Okay.

Q. And explain where those go, how they're done, and what would make you do that as opposed to initially trying a facet injection.

A. Got you. If -- if -- you don't mind if I stand up again just to take the --

Your whole body is mapped out. And your skin -- there's a guy by the name of Frank Netter in the '50s did a whole bunch of beautiful drawings. He was a general surgeon, but he loved art. So he did all of the textbooks. He did all kinds of human dissections. Did some wonderful things for the anatomy. Dermatomal distribution, d-e-r-m-a-t-o-m-a-l. Dermatomal distribution means if you're telling me it hurts -- when I have a patient come in, I say, Where does it hurt? Draw on your body. When they draw -- you draw from here down to your thumb, that's C6. You draw here down to the palm of your hand or the back of the hand or your middle finger, that's C7. You draw a line through your knee, L4 is on the bottom, L3 is on the top. You have pain going in your calf, either L4 or L5. L4 can go to the inside toe. L5 and S1 go to

the big toe. S1 can also go to the -- to the little toe.

So when you're describing spots on your body, I'm thinking, all right, what's pinching, what's irritated, what's the problem? Then I look at the MRI and I go, ah, this matches her complaint. This matches her complaint. I've got an area to do an injection.

So when I first saw her, she drew a picture or she described a picture, and my staff drew it out on the computer; pretty much from her bellybutton down, she had problems and complaints. And the only thing that would pretty much take care of 80 percent of that, sciatic nerve. Sciatic nerve, 4 through S1. 4-5 and S1 were her biggest problems. It's actually 4 through S2. That was where she was having her problems.

So what I did is I said, All right. I'm going to stop her problem right now, and if I inject all these levels -- plus I believe her groin symptoms were coming from her hips, I just want to turn it off and see what happens. And most of the time I turn it off, when something comes back, it's the primary problem. And then I attack the primary problem, and I can focus in.

So with her the only thing I knew on the first injection was that these two disks were causing

havoc. And there are two nerves on each side, and the S1 nerve goes right past the L5-S1. So I took that one as well because she was having symptoms down her leg at that area. So all I tried to do was to turn off the segments she was having pain and to get a diagnosis when she woke up.

Then I have her call -- call a day later and a week later, and I see, did I give you not only a diagnostic injection, but now did I provide you therapy for it? Was there a therapeutic benefit after I do the injection?

So if she has relief a couple weeks later, I'm actually doing diagnostic and therapeutic on her. I've got a way to fight this thing.

Q. Okay. Give me just a second, Doctor. We'll skip a couple of visits. And let's -- let's go to the procedure.

You saw her a couple more times in between the initial visit and doing the procedure that you just described to the jury; correct?

A. That is correct, yes.

Q. And anything significant change in those visits?

A. No. She was fairly consistent. You know, the only thing that changed is she agreed to an

injection. First time I saw her I -- you know, you just told me you're going to kill me. No, I didn't tell you I'm going to kill you. I said there are risks involved -- there's a lot that goes on when I first try to explain what I'm going to do to you.

Q. So you described your plan at the first visit, but it was not a plan that was immediately accepted by Ms. Garcia.

A. No. A lot of things I did in the first visit made her cry.

MR. ROBERTS: Audra, could you go to page 18?

And we're going to show you now your procedure notes for a procedure dated August 30th of 2011.

So let's go down to the bottom of the page, Audra, Postoperative Diagnosis and Preoperative Diagnosis -- which follows Preoperative Diagnosis.

BY MR. ROBERTS:

Q. So did you go forward with the procedure that you had in your initial plan?

A. I did.

Q. Okay. And you've already described to the jury, you know, what -- what that was.

A. Correct, the nerve blocks.

Q. So what was your postoperative diagnosis?

A. If we go down, postoperative diagnosis was the same. All of her diagnoses, it confirmed the fact that she had lumbar pathology but couldn't get as far as telling you -- when you do a -- a selective nerve root block, you're placing about a fourth of a table -- a fourth of a teaspoon worth of medicine, about 2 cc's of medicine that -- the teaspoon is 5 cc's. So you're putting about a cc and a half to 2 cc's right on this nerve root.

When you do that, there's the facet right there. There's the disk right there. You actually can -- because this nerve root sends the -- the hair-thin nerves around -- swings around and goes into this facet joint. So when I do a nerve root block, I'm turning off any kind of pain that that level can have. So I'm turning off facet pain. I'm turning off disk pain if I do it bilaterally.

However, in the lumbar spine, you can't completely turn off the disk. So sometimes you get partial relief even when you inject the right disk correctly because sometimes nerves from the level above go down and share into that disk. That's what referred pain does. It really kind of -- it's interesting because your body has reserve pathways. Like, in your heart when you get a blockage, there's other arteries

there that open up when there's a blockage. Same thing with your nerves. When certain nerves stop working right or get cut, you can actually modify where your nerve structures go or actually how your nerve functions in both your spinal cord and your brain.

So the lumbar spine when I did the injections, she still had about 60 percent improvement when I was done with that, and maybe I knocked the edge off of her hip pain. So at that point in time, it told me that I was on the right track, but I didn't turn it off.

Q. And -- and the jury heard a little bit before about the horse tail, how the spinal cord actually ends above the lumbar region and then it --

A. Correct. Right at L1-L2 is when the spinal cord ends. Actually, they did a European study. Europeans end at L1. Americans end around L2.

Q. And in addition to not being able to completely turn off the pain at the level you're at because of the complexity of the nerve structure --

A. The shared, yes.

Q. -- does the anesthesia sometimes travel up the nerves into other levels?

A. Like I said, you're injecting into the body. You're not injecting into a closed compartment. You do

the best that you can. I use a dye that's got an iodine impregnated in it, and when I shoot an X-ray picture, it's like a black blob that I see. If you have any of my injections, I can show you what the dye is.

So I squirt about a quarter cc of dye first, and then I inject my medicine. I watch where the dye spreads. So I at least control it pretty darn good. But there's no way. You -- even half-hour after you do the injection, that stuff's still moving around a little bit.

Q. And -- and if you could look at Item 3 on your operative procedure.

MR. ROBERTS: Just down a little bit further, Audra, on the page.

BY MR. ROBERTS:

Q. What -- what is that? Is that the procedure you were describing to the jury?

A. That is the operative procedure, selected nerve root blocks, at -- and I go from the back, so I do L4, L5, and Sacral 1 on both sides. And then I went into her hip joints on each side. So bilateral interarticular hip injections. And then that thing fluoroscopy, that's just a fancy X-ray machine that I have. That's also called the C-arm. It's an X-ray

machine that's on an arc. And I can slide it around. I can flip it over. And I have a technician in the operating room. It's the best way to do live X rays on a human body when you're on an operating room table without having to move the body. I move the X-ray machine around the human.

Q. And is that what allows you to observe the dye?

A. And that's what allows me to observe the dye to place a needle 6 inches into a body where -- you know, you've got a beveled needle, and you stick a needle 6 inches into a body, that needle's going all kinds of places. What I do, it's a very controlled passageway. We bend the tip of the needle. I use a tool. I drive it in. It's -- pretty much anytime my needle is moving, I'm using X-ray.

Q. What do you mean by "drive it in"?

A. I use the term "driving it in" because it's called a needle driver, is what I hold. When you're sewing in surgery, you don't really hold needles and push them through and grab it. You're going to poke yourself. So you use instruments. And when I'm passing a needle, I'm also in an X-ray beam. And guys that stick their hands in the X-ray beam end up melting their fingers off over 20 years. I've got all my

fingers and nails in place because I wear leaded gloves and I use a needle driver.

So I use the phrase that I drive the needle into the canal because I'm actually steering it. It's -- I put a little bend in the needle tip, and you can push a needle through tissue, and I steer with my back hand, and I use my needle driver, and I push it right into the nerve root.

Q. Do you always have to use the X-ray machine in order to perform a nerve root block?

A. A selective nerve root block, to do it properly, you have to. Anybody that says they don't need to is either passing a needle 2,000 times until they hit a nerve root, which is barbaric, or they're fooling themselves.

Q. So you mentioned that -- that you -- you didn't want -- you wear lead-lined gloves.

A. I do.

Q. Does the X-ray that you use in this procedure have the same risks of repeated exposure that -- that other X-rays have?

A. Oh, yeah, especially on the patient. Almost as bad as going to the airport.

MR. ROBERTS: So let's look at page 19, Audra, bottom half of the page.

BY MR. ROBERTS:

Q. Your evaluation. And I think you've already told the jury about the resolution of her pain symptoms.

What was your plan following this?

A. Let's see where I'm reading. Lumbar spine. Basically, same thing I told you before. I call them the day after -- my nurses will call them the day after -- really the day after a phone call, I have Novocain that only lasts for, like, six hours. It's actually Marcaine, but I just say Novocain because everybody knows that. I have a steroid that doesn't start to work for six hours after the procedure.

So sometimes when I make somebody go home all happy, they go clean their garage or they go do something, and they have a huge flare-up right afterwards. So I call them the day after. I find out, you okay? If you're having a flare-up, that's normal. It's because I turned everything off, but I also stuck a needle on a nerve that was kind of PO'd to begin with. So sometimes before that nerve feels better, it hurts a little bit.

So the day after, a phone call I do just to make sure nothing's going wrong. And then a week later, I have her come back into the office to do a

full evaluation.

Q. So the numbing agent wears off how long after the surgery?

A. About six hours. That's the diagnostic aspect of the injection. And then the steroid is the therapy. If -- see, I know -- if they leave -- if I -- if this patient leaves my office feeling good, I sleep better because I know my steroid is in the spot most likely is having the problem.

Q. If the patient has immediate relief from the numbing agent --

A. Correct.

Q. -- but then that relief returns to baseline because the steroid doesn't take effect, does that mean you haven't found the pain generator?

A. No. That's the opposite. That means I found a pain generator that's a bugger. That's like water puts out a fire. Okay? Steroids calm down irritated nerve roots. But if somebody's house is on fire and I throw a cup of water at it, I'm not turning that fire off. Some spine problems, I throw steroid at it, I can't put out the fire. It just keeps getting worse. That's all that that means is that I couldn't put out the fire with one shot.

Q. Okay.

MR. ROBERTS: Audra, if we go page 21.
BY MR. ROBERTS:
Q. This is September 6th of 2011. So we're talking about a week after the nerve root blocks that you just described to the jury.
Could you tell the jury about that visit and whether the patient was continuing to get relief from your procedure?
A. Actually, at this point in time, the most significant aspect is that she told me she was able to take less medication. She may have still been miserable. She may have still had pain, but the fact that she was able to take less medication, that tells me I was doing something in the right direction. And if I can get them to tolerate life without medications, get them on a regular program, I did my thing.
Q. Very good.
MR. ROBERTS: Audra, could we go to page 26, now? And if you could just blow up the top level to show the date of service of September 14th.
BY MR. ROBERTS:
Q. So now we're -- we're eight days from the previous visit, and I see at the top for the first time "emergent office visit."
What does that mean?

A. Basically, I'm your doctor. I don't want you going to emergency room if I'm there. This woman was washing her ankles or something like that and just -- her back went in a flare-up of all flare-ups. She came into my office, she couldn't stand up straight. Spondylolisthesis, the slipping, if you're bending over, that will hurt. You're slipping.

So remember when I told you you could try to do this and go wham and nail something acutely, I believe she had a severe slippage or had just -- you know, I mean, like I was saying before, putting my socks on before I had my back surgery was horrible. She bent over trying to wash herself and didn't get back up right.

She came into my office, and when you look at the mechanics of a spine, if you have pain bending forward -- you look at a disk with a crack in it -- imagine a jelly doughnut with a hole in the back between two bones. So I got a jelly doughnut with a hole in the back and I bend forward, what's going to happen? I'm going to squirt that jelly out of the doughnut. A disk problem will get worse you bending over. When you bend over and you can't get back up, look at the knuckle joint. You bend forward, you can't get back up, these joints were swollen and inflamed.

And they were swollen and inflamed because she had an unstable segment at the bottom of her spine and just doing normal daily activity, she flared things up. So she came into my office, and yeah, I probably could have made her pain go away with a nerve root block,but I was trying to be more specific and to do something that would give her permanent relief. Because if I can give her temporary relief about a knuckle joint injection, I can actually burn that nerve and make it dead for about a year and a half, and you don't care that your facets hurt.

So my goal was -- she's not doing real well. Can I do anything to at least knock out this problem, and give her some kind of relief so I could avoid surgery.

Q. If --

MR. ROBERTS: Audra, could we go to page 27, Impression?

BY MR. ROBERTS:

Q. So is it fair to say that your clinical impression at this time remained fairly constant from your first visit?

A. This was -- yes. This was -- what do you say? -- par for the course. She had an unstable L5-S1 segment. I could give her all the shots I could and

she'll have flare-ups like this.

Q. When you refer to posttraumatic in your impression, are you still referring to the automobile collision --

A. Yes.

Q. -- on January of 2011?

A. She had no other trauma.

Q. Well, was -- was the shower incident a new and independent cause, in your medical opinion?

A. I don't consider bending over in the shower a trauma.

Q. Okay.

A. No. It's like -- I don't really have a similar analogy for that. That's -- I'm sorry. You've got to wash your feet. You can't wash your feet, something's wrong.

MR. ROBERTS: Audra, could you go to page 28? And look at line 9 of the plan, which is the -- the last item on the plan.

BY MR. ROBERTS:

Q. An extended visit is done with Dr. Lemper. The patient will be brought back to the OR now for interarticular facet blocks.

Are these the same thing as the knuckle joint --

A. That's exactly it. I'm a regular guy. I break everything down to regular phrases.

Q. Perfect. So explain again the -- the difference between this and the -- why are you moving to this from the nerve root blocks, and what are you expecting to accomplish?

A. Okay. And if I can show you, in the spine, there's three reasons that you'll hurt. Number 1, and the worst one, the disk itself hurts. Usually when that occurs, you have good days, bad days, but no matter what, long term, it's almost impossible to get that thing calmed down because you have an unstable -- this rubber tire is unstable, so it's wiggling around. That's discogenic.

Number 2, you can pinch a nerve. You could pinch a nerve from herniation. You could pinch a nerve from -- because you've herniated -- the disk is a rubber tire that's filled with air. When you herniate, you're losing air. When you lose air, the canal collapses. When you have a slippage in the -- in the -- like we described earlier, the canal can pinch it. So impingement is another reason.

Last one, bony problems. Knuckle joints, tumors, fractures. So when I'm doing an injection -- when I said the selective nerve root block that I do or

an epidural that you do, that encompasses pretty much most of all three of the problems. The best way to get the disk is to actually stick a needle in the disk and inject it because sometimes the inflammation around the disk itself will impede you from turning off the disk as well. The shared nerve that might come from the level above, if you stick a needle into the disk, you're turning off the nerves that are coming from above and below. That's what's called a diskogram.

So when I first treated her, I did the nerve root blocks. But when she bent over, the nerves -- this was a month after the injections. She was still having some improvement. So I was looking at her like, Well, what's the next thing going on? This was a continuation of the same trauma to the same area of the lumbar spine. It was just one of the three areas different was causing the pain.

Not saying when she first came to see me she didn't have facet disease. That just wasn't isolated. She had the benefit of having a selective nerve root block a month before and had consistent improvement in her symptoms and then had this flare-up, which was not a new pain, a different pain. It was just pointing out a different region of what I normally associate with facet pain.

Q. All right.

MR. ROBERTS: Audra, could we go to page 29, Exhibit 21? And this will indicate the procedure notes for procedure dated September 14th of 2011 at the Center for Surgical Intervention. Audra, if you could highlight Operative Procedure.

BY MR. ROBERTS:

Q. Is this the procedure you just described to the jury?

A. That is. That's the knuckle joint shots.

Q. Okay.

A. Basically, for six levels.

Q. Very good.

MR. ROBERTS: And, Audra, next page, the Post Procedural Evaluation. If you could highlight that for the jury and the doctor.

BY MR. ROBERTS:

Q. How successful was this procedure, Doctor?

A. What flared up, I turned off.

Q. Diagnostically speaking, what did that tell you about the pain generator?

A. That the nerves going to her facets were a significant portion of the pain at that day.

Q. Okay.

MR. ROBERTS: If we could go to page 34 of

Exhibit 21 now.
BY MR. ROBERTS:
Q. And this is an office visit of November 9th. So we're talking about six weeks out.
If you could explain to the jury what the changes were since the last visit in which she had the facet injections.
A. Only gave her relief for a couple of days. So it was diagnostic at best.
Q. So the -- the numbing agent helped her pain, but the corticosteroid you injected did not have any long-term lasting effect?
A. She had instability. So I could possibly turn off the facet pain. I could possibly turn it off or get rid of a chunk of her problem for a while and -- but I can't change the fact that she had an unstable segment.
Q. The notes of the office visit indicate that she told you she had followed up with Dr. Gross, and he is planning on doing a fusion.
Did she tell she was going to do the fusion?
A. Yeah, she wanted to. She really -- I mean, she was -- when you're not sleeping and you still got to get up and go to work, you're willing to do whatever you have to to turn off the pain problem.

Me, I'm willing to do whatever I can to help her avoid surgery. Problem with surgery is you do a fusion, you're pretty much guaranteed another fusion. When you lock in a level, there's what's called a Kaplan-Meier survival curve. So you fuse a level, most people don't notice a lack of movement. They actually move more level above and level below. That beats up those disks at an accelerated level. And actually, this morning I saw her 2014 MRI, and the L3-4 disk is already turning dark. So -- but -- it's already starting to degenerate a couple of months after her surgery.

MR. ROBERTS: Audra, could we have Exhibit 21 at page 36, the plan indicated in Dr. Lemper's office notes?

BY MR. ROBERTS:

Q. So she told you she's going to get surgery.

Are you ready to -- to give up and -- and recommend surgery to her at this time?

A. Man, I really, really didn't want to. And I also knew that if she had surgery, the type she would have, this put a big dent in her lifestyle where she couldn't work. I don't know how she'd pay her bills, but I did not want her to have surgery at that point in time, but she continued to get worse.

Q. Okay.
A. Yeah.
Q. And this came up yesterday.
MR. ROBERTS: Could you highlight the signatures, Audra, both of them?
THE WITNESS: I've said before, sometimes I feel like if I send them for surgery, I failed, because my goal is to try to get them to avoid it.
BY MR. ROBERTS:
Q. Okay. I was -- can you see those if they're not blown up, Doctor?
A. What do you need me to see?
Q. Okay. So is that your signature?
A. Signature, and my PA, Todd Radivan, R-a-d-i-v-a-n.
Q. And I see you've signed it, but it indicates it was dictated by Mr. Radivan.
Could you explain how that works in your office?
A. Normally, follow-up clinic is done while I'm doing injections. And if somebody has an issue, I'll run out and kind of go over things with them very quickly if they have other questions or they just want to hear me tell them what's going on next.
I am, however, responsible for everything

that he does. So I -- I cosign every note. I look it over, and I actually give him the plan. Can't necessarily control every single thing that he does and says to the patients, but I trusted him at that point in time to -- to evaluate these people. And so he would see them, but what do they call that trust with verification? So I trust him, but I still review the notes before I stamp them.

Q. Okay. Thank you, Doctor.

MR. ROBERTS: Let's go to page 37, Audra. Another office visit on December 21st of '11.

BY MR. ROBERTS:

Q. Is the patient continuing to have recuring pain?

A. Yes.

MR. ROBERTS: And if we could go --

THE WITNESS: So in general, what I do, and this first line talks about not going to therapy. However, she's walking the steps at work. The most significant thing a pain patient can do is to stay active. Kids at home, full-time job, go to physical therapy rather than go home, go to physical therapy rather than sleep an extra hour. I tell her do some activity. So I'm okay with that. So I -- she was walking the steps at work, and -- and that was -- and

if she can't do go that, she couldn't tolerate that, she couldn't tolerate physical therapy either.

Q. And -- and do you refer to that as self-based physical therapy?

A. That's exactly what that is.

Q. And you told Ms. Garcia you were fine with that.

A. Always, yes.

Q. Did the injuries as you had evaluated them make it difficult for Ms. Garcia to exercise and condition?

A. You know, I want to say that just a simple bending forward could cause a -- just with this instability like happened in the shower kind of a thing. She -- she has an unstable segment. So when you go to physical therapy, they're going to twist you and push you. And when I send people to physical therapy, Matt Smith Physical Therapy is a big name, but they label the -- my order sheet called the Lemper sweat program. And the reason they -- and they have that on the title of their physical therapy sheet is I put them in for foo-foo therapy which means they can't move, they can't -- they need ultrasound. They need some massage, hot packs. And then I put them in for sweat therapy, and I push them hard. I want them to

work out. If you -- if you get stronger, you can leave me. If you can't get stronger, you're stuck.

Q. Did she still have palpable spasms at this time?

A. Yeah. This was an ongoing issue.

MR. ROBERTS: Page 39, Audra, the Plan.

BY MR. ROBERTS:

Q. So the previous procedures had started with the selective nerve root blocks. You'd gone to the facet injections.

And what additional procedure are you contemplating now?

A. I'll say one other thing that kind of -- not too much to do with the case but a lot to do with her personality. She needed gallbladder surgery. She wouldn't even make time for that. There's kind of something going on which is her. For this woman --

MR. MAZZEO: Objection, Judge. Speculation. Not relevant.

THE COURT: I'm going to sustain that one.

Ask another question.

MR. ROBERTS: Thank you.

BY MR. ROBERTS:

Q. And -- and I'm looking specifically at Item No. 2 of your plan.