No. 71348

IN THE SUPREME COURT OF THE STATE OF NEVADA

EMILIA GARCIA,
Appellant,

v.

ANDREA AWERBACH,
Respondent.

APPELLANT'S APPENDIX
VOLUME XV, BATES NUMBERS 3500 TO 3750

D. Lee Roberts, Jr., Esq.
Nevada Bar No. 8877
Jeremy R. Alberts, Esq.
Nevada Bar No. 10497
Marisa Rodriguez, Esq.
Nevada Bar No. 13234
WEINBERG, WHEELER, HUDGINS,
GUNN & DIAL, LLC.
6385 S. Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
Telephone: (702) 938-3838
lroberts@wwhgd.com
jalberts@wwhgd.com
mrodriguez@wwhgd.com

Corey M. Eschweiler, Esq.
Nevada Bar No. 6635
Craig A. Henderson, Esq.
Nevada Bar No. 10077
GLEN J. LERNER & ASSOCIATES
4795 South Durango Drive
Las Vegas, Nevada 89147
Telephone: (702) 877-1500
ceschweiler@glenlerner.com
chenderson@glenlerner.com

ALPHABETICAL INDEX

Vol	Page Numbers	Description	Date Filed
I	22 – 28	Amended Complaint	01/14/2013
V	1031 – 1282	Appendix of Exhibits to Plaintiff's Motion for New Trial or, in the Alternative, for Additur	05/26/2016
V, VI	1304 – 1486	Appendix of Exhibits to Plaintiff's Renewed Motion for Judgment as a Matter of Law	05/26/2016
I	1 – 6	Complaint	03/25/2011
III	642 – 646	Decision and Order Denying Defendant Andrea Awerbach's Motion for Relief from Final Court Order	04/27/2015
III	623 – 629	Decision and Order Denying Plaintiff's Motion to Strike Andrea Awerbach's Answer; Granting Plaintiff's Motion for Order to Show Cause; and Granting in Part and Denying in Part Plaintiff's Motion to Strike Supplemental Reports	02/25/2015
I	164 – 165	Defendant Andrea Awerbach's Correction to Her Responses to Plaintiff's First Set of Requests for Admission	10/20/2014
III	630 – 641	Defendant Andrea Awerbach's Motion for Relief from Final Court Order	03/13/2015
I	96 – 163	Defendant Andrea Awerbach's Motion for Summary Judgment	11/08/2013
I	13 – 21	Defendant Andrea Awerbach's Responses to Request for Admissions	06/05/2012
I	29 – 35	Defendants' Answer to Amended Complaint	02/07/2013
I	7 – 12	Defendants' Answer to Complaint	01/23/2012
I	36 – 60	Defendants' Second Supplement to List of Witnesses and Documents and Tangible Items Produced at Early Case Conference	07/22/2013
I	61 – 95	Deposition of Andrea Awerbach [Vol. 1]	09/12/2013
I, II	166 – 391	Deposition of Andrea Awerbach [Vol. 2]	10/24/2014

ALPHABETICAL INDEX

Vol	Page Numbers	Description	Date Filed
XXVI, XXVII	6441 – 6942	Deposition of Jared Awerbach	
III	581 – 616	Deposition of Teresa Meraz	01/08/2015
IV	948 – 997	Jury Instructions	03/08/2016
IV	998 – 1000	Jury Verdict	03/10/2016
VI, VII	1499 – 1502	Minute Order	08/22/2016
VII	1513 – 1554	Notice of Appeal	09/19/2017
III	647 – 649	Notice of Department Reassignment	08/27/2015
VII	1508 – 1512	Notice of Entry of Judgment Upon the Verdict	08/21/2017
III	617 – 622	Order Granting, in Part, and Denying, In Part, Plaintiff's Motion for Partial Summary Judgment that Defendant Jared Awerbach was Per Se Impaired Pursuant to NRS 484C.110(3); and Denying Defendant Jared Awerbach's Motion for Partial Summary Judgment on Punitive Damage Claims	01/28/2015
IV	946-947	Order Modifying Prior Order of Judge Allf	02/12/2016
VI	1487 – 1498	Order Re: Post –Trial Motions	08/12/2016
VII	1503 - 1507	Order Vacating Judgment as to Jared Awerbach only	08/21/2017
V	1001 – 1030	Plaintiff's Motion for New Trial or, in the Alternative, for Additur	05/26/2016
III, IV	650 – 900	Plaintiff's Motion to Disqualify Defendant Jared Awerbach's Counsel Randall Tindall and Motion For Reassignment to Department 27 on Order Shortening Time and Request for Leave to File Extended Memorandum of Points and Authorities	09/08/2015
II, III	392 – 580	Plaintiff's Motion to Strike Defendant Andrea Awerbach's Answer	12/02/2014
V	1283 – 1303	Plaintiff's Renewed Motion for Judgment as a Matter of Law	05/26/2016
IV	933 – 945	Plaintiff's Trial Brief Regarding	02/10/2016

ALPHABETICAL INDEX

Vol	Page Numbers	Description	Date Filed
		Permissive Use	
IV	901 – 932	Reporter's Transcript of Proceedings	09/15/2015
VII, VIII	1555 – 1765	Trial Transcript – 02/08/2016	11/10/2017
VIII	1766 – 1996	Trial Transcript – 02/09/2016	11/10/2017
VIII, IX, X	1997 – 2290	Trial Transcript – 02/10/2016	11/10/2017
X	2291 – 2463	Trial Transcript – 02/11/2016	11/10/2017
X, XI	2464 – 2698	Trial Transcript – 02/12/2016	11/10/2017
XI, XII	2699 – 2924	Trial Transcript – 02/16/2016	11/10/2017
XII, XIII	2925 – 3177	Trial Transcript – 02/17/2016	11/10/2017
XIII, XIV	3178 – 3439	Trial Transcript – 02/18/2016	11/10/2017
XIV, XV	3440 – 3573	Trial Transcript – 02/19/2016	11/10/2017
XV, XVI	3574 – 3801	Trial Transcript – 02/22/2016	11/10/2017
XVI, XVII	3802 – 4038	Trial Transcript – 02/23/2016	11/10/2017
XVII, XVIII	4039 – 4346	Trial Transcript – 02/24/2016	11/10/2017
XVIII, XIX	4347 – 4586	Trial Transcript – 02/25/2016	11/10/2017
XIX, XX	4578 – 4819	Trial Transcript – 02/26/2016	11/10/2017
XX, XXI	4820 – 5045	Trial Transcript – 03/01/2016	11/10/2017
XXI, XXII	5046 – 5361	Trial Transcript – 03/02/2016	11/10/2017
XXII, XXIII	5362 – 5559	Trial Transcript – 03/03/2016	11/10/2017
XXIII, XXIV	5560 – 5802	Trial Transcript – 03/04/2016	11/10/2017

ALPHABETICAL INDEX

Vol	Page Numbers	Description	Date Filed
XXIV	5803 – 5977	Trial Transcript – 03/07/2016	11/10/2017
XXIV, XXV	5978 – 6203	Trial Transcript – 03/08/2016	08/23/2018
XXV, XXVI	6204 – 6422	Trial Transcript – 03/09/2016	08/23/2018
XXVI	6423 – 6440	Trial Transcript – 03/10/2016	08/23/2018

ALPHABETICAL INDEX

Vol	Page Numbers	Description	Date Filed
I	22 – 28	Amended Complaint	01/14/2013
V	1031 – 1282	Appendix of Exhibits to Plaintiff's Motion for New Trial or, in the Alternative, for Additur	05/26/2016
V, VI	1304 – 1486	Appendix of Exhibits to Plaintiff's Renewed Motion for Judgment as a Matter of Law	05/26/2016
I	1 – 6	Complaint	03/25/2011
III	642 – 646	Decision and Order Denying Defendant Andrea Awerbach's Motion for Relief from Final Court Order	04/27/2015
III	623 – 629	Decision and Order Denying Plaintiff's Motion to Strike Andrea Awerbach's Answer; Granting Plaintiff's Motion for Order to Show Cause; and Granting in Part and Denying in Part Plaintiff's Motion to Strike Supplemental Reports	02/25/2015
I	164 – 165	Defendant Andrea Awerbach's Correction to Her Responses to Plaintiff's First Set of Requests for Admission	10/20/2014
III	630 – 641	Defendant Andrea Awerbach's Motion for Relief from Final Court Order	03/13/2015
I	96 – 163	Defendant Andrea Awerbach's Motion for Summary Judgment	11/08/2013
I	13 – 21	Defendant Andrea Awerbach's Responses to Request for Admissions	06/05/2012
I	29 – 35	Defendants' Answer to Amended Complaint	02/07/2013
I	7 – 12	Defendants' Answer to Complaint	01/23/2012
I	36 – 60	Defendants' Second Supplement to List of Witnesses and Documents and Tangible Items Produced at Early Case Conference	07/22/2013
I	61 – 95	Deposition of Andrea Awerbach [Vol. 1]	09/12/2013
I, II	166 – 391	Deposition of Andrea Awerbach [Vol. 2]	10/24/2014

ALPHABETICAL INDEX

Vol	Page Numbers	Description	Date Filed
XXVI, XXVII	6441 – 6942	Deposition of Jared Awerbach	
III	581 – 616	Deposition of Teresa Meraz	01/08/2015
IV	948 – 997	Jury Instructions	03/08/2016
IV	998 – 1000	Jury Verdict	03/10/2016
VI, VII	1499 – 1502	Minute Order	08/22/2016
VII	1513 – 1554	Notice of Appeal	09/19/2017
III	647 – 649	Notice of Department Reassignment	08/27/2015
VII	1508 – 1512	Notice of Entry of Judgment Upon the Verdict	08/21/2017
III	617 – 622	Order Granting, in Part, and Denying, In Part, Plaintiff's Motion for Partial Summary Judgment that Defendant Jared Awerbach was Per Se Impaired Pursuant to NRS 484C.110(3); and Denying Defendant Jared Awerbach's Motion for Partial Summary Judgment on Punitive Damage Claims	01/28/2015
IV	946-947	Order Modifying Prior Order of Judge Allf	02/12/2016
VI	1487 – 1498	Order Re: Post –Trial Motions	08/12/2016
VII	1503 - 1507	Order Vacating Judgment as to Jared Awerbach only	08/21/2017
V	1001 – 1030	Plaintiff's Motion for New Trial or, in the Alternative, for Additur	05/26/2016
III, IV	650 – 900	Plaintiff's Motion to Disqualify Defendant Jared Awerbach's Counsel Randall Tindall and Motion For Reassignment to Department 27 on Order Shortening Time and Request for Leave to File Extended Memorandum of Points and Authorities	09/08/2015
II, III	392 – 580	Plaintiff's Motion to Strike Defendant Andrea Awerbach's Answer	12/02/2014
V	1283 – 1303	Plaintiff's Renewed Motion for Judgment as a Matter of Law	05/26/2016
IV	933 – 945	Plaintiff's Trial Brief Regarding	02/10/2016

ALPHABETICAL INDEX

Vol	Page Numbers	Description	Date Filed
		Permissive Use	
IV	901 – 932	Reporter's Transcript of Proceedings	09/15/2015
VII, VIII	1555 – 1765	Trial Transcript – 02/08/2016	11/10/2017
VIII	1766 – 1996	Trial Transcript – 02/09/2016	11/10/2017
VIII, IX, X	1997 – 2290	Trial Transcript – 02/10/2016	11/10/2017
X	2291 – 2463	Trial Transcript – 02/11/2016	11/10/2017
X, XI	2464 – 2698	Trial Transcript – 02/12/2016	11/10/2017
XI, XII	2699 – 2924	Trial Transcript – 02/16/2016	11/10/2017
XII, XIII	2925 – 3177	Trial Transcript – 02/17/2016	11/10/2017
XIII, XIV	3178 – 3439	Trial Transcript – 02/18/2016	11/10/2017
XIV, XV	3440 – 3573	Trial Transcript – 02/19/2016	11/10/2017
XV, XVI	3574 – 3801	Trial Transcript – 02/22/2016	11/10/2017
XVI, XVII	3802 – 4038	Trial Transcript – 02/23/2016	11/10/2017
XVII, XVIII	4039 – 4346	Trial Transcript – 02/24/2016	11/10/2017
XVIII, XIX	4347 – 4586	Trial Transcript – 02/25/2016	11/10/2017
XIX, XX	4578 – 4819	Trial Transcript – 02/26/2016	11/10/2017
XX, XXI	4820 – 5045	Trial Transcript – 03/01/2016	11/10/2017
XXI, XXII	5046 – 5361	Trial Transcript – 03/02/2016	11/10/2017
XXII, XXIII	5362 – 5559	Trial Transcript – 03/03/2016	11/10/2017
XXIII, XXIV	5560 – 5802	Trial Transcript – 03/04/2016	11/10/2017

ALPHABETICAL INDEX

Vol	Page Numbers	Description	Date Filed
XXIV	5803 – 5977	Trial Transcript – 03/07/2016	11/10/2017
XXIV, XXV	5978 – 6203	Trial Transcript – 03/08/2016	08/23/2018
XXV, XXVI	6204 – 6422	Trial Transcript – 03/09/2016	08/23/2018
XXVI	6423 – 6440	Trial Transcript – 03/10/2016	08/23/2018

A. Only for a day or two. So her pathology in her low back is sufficient that -- or significant enough that the steroid really didn't help her low back, but I think it helped her neck.

Q. You told the jury before that you're fairly conservative in reporting pain; correct?

A. Correct.

Q. When you say, The patient is in a great deal of pain today, is that usual or unusual note for you to make?

A. It's unusual verbiage. You know, most of my patients will come in looking in mild to moderate discomfort. But when I say severe, extreme, that's very unusual verbiage. You know, I want to report accurately and don't gild the lily. Just call it like I see it.

Q. The jury has seen a number of medical records where Ms. Garcia was asked to self-report her pain and reported on a scale of 1 to 10 or reduction by percentage.

Over the course of your treatment with Ms. Garcia, did you form an opinion based on how conservative or nonconservative she was in self-reporting the pain?

A. Certainly. In the mid scheme of things,

taking the context of the thousands of pain patients I see, I think she was underreporting. I think she was worse than she indicated. She'd have a 7 or 8, couldn't sit down --

MR. MAZZEO: Objection. Speculation, Judge.

THE COURT: I am going to let him testify what his understanding is.

THE WITNESS: Well, yeah, it's a judgment on my part having experience with thousands of patients.

This is a patient who was in severe pain by anybody's definition. I don't know. I think I probably could have made it worse if I lit her on fire, but that's about how close it was when I first saw her.

BY MR. ROBERTS:

Q. Doctor, it looks like you did a urine drug screen on Ms. Garcia on this visit.

What's the purpose of doing a urine drug screen on your patients, including Ms. Garcia in this case?

A. Well, it's required to -- for us to monitor patients who we write prescriptions for. I need to know if they're taking what I'm giving them, not taking something I'm not giving them. And I worry about illicit drugs. I don't want to do a procedure on somebody and have them have a cardiac arrest because

they're taking methamphetamine or something. So we monitor patients we write prescriptions for.

And that's just in keeping with state law. It's not super aggressive. Our rules are at least twice a year, if possible, sometimes more. If I have a suspicion of something, I'll do it any time. But most of the time, it's just random. Medical assistants determine the schedule.

Q. And did Ms. Garcia pass the drug screen in this case?

A. Yes.

Q. Did she fail any of the drug screens that you gave her over the course of her treatment?

A. No.

Q. Okay.

MR. ROBERTS: If we can go to page 62, Audra.

BY MR. ROBERTS:

Q. You saw the patient next on December 5th.

Does that agree with your notes?

A. Yes, sir.

MR. ROBERTS: Okay. If you could pull up the top half of page 62.

BY MR. ROBERTS:

Q. So what was the chief purpose of the follow-up visit of December 5th of 2012, Doctor?

A. Reevaluation of the medication renewals. She was scheduled for surgery with Dr. Gross for December 26th, 2012, and indicated I will maintain her medications to get her through the perioperative period.

Q. So as of this visit, you knew she had scheduled surgery with Dr. Gross.

A. Correct.

Q. And you told the jury earlier one of your goals of treatment is to avoid the need for surgery.

Is that fair to say?

A. That's correct.

Q. And also to avoid need for lifetime medications.

A. Correct.

Q. Okay. In this case, as of December 5th when she's going to have surgery later that month, did you agree or disagree with the decision of Ms. Garcia to proceed with the lumbar fusion surgery?

A. No, I agreed. She has a Grade II spondylolisthesis, which is a big $50 word for one vertebral body slipping forward on the other one. And that can cause impingement of the nerves that come out at that level of your legs. And so if you're symptomatic and you've got a Grade II, that's generally

when you're going to get fused at some point anyway. She's miserable, didn't respond to injections. So I think that's her best option at this point.

MR. ROBERTS: Audra, if you could highlight Work Status for us.

BY MR. ROBERTS:

Q. Were you aware at this time that Ms. Garcia continued to work full time?

A. Yes.

Q. And were you aware of the general nature of her duties?

A. It's my understanding she was a cashier.

Q. When you put work status, is that something you commonly put in your medical records?

A. Usually, there's a notation about whether a patient is working or not. In this case, I made a point that she's working despite all this, and I really don't know how she was doing it. It's really a testament to her.

Q. Does the fact that she was able to work full time and stand all day as a cashier indicate to you as a doctor that her -- her pain was not that severe?

A. No. No. I mean, I've seen her in the office. You can't fake what I've seen. No, not at all. I mean, I -- she's one of those many patients I

have that need to work. And they have pain, and -- and they work. Some people have that kind of work ethic. Shit, I worked ten days with a kidney stone. They said I looked toxic, but, you know, I could be at home and be miserable, or I could be at work and be miserable. Miserable either way.

Q. So let's move now to the next appointment.

It appears that the first time you saw her was about a month post surgery; is that correct?

A. Yes, sir.

Q. January 30th of 2013?

A. Correct.

MR. ROBERTS: Okay. Audra, if you could put up page 27.

BY MR. ROBERTS:

Q. Okay. Are we looking now at the notes from the office visit with you on January 30th of 2013?

A. That's correct.

Q. How was she feeling after the surgery as she reported to you that day?

A. In regards to her low back, pain was about a 7 out of 10. For being, you know, a few weeks post-op, she was doing pretty well. I mean, you know, it's a big surgery.

Q. She's about four weeks post-op at this time?

A. Yes. A lumbar fusion, especially at two levels, that's a really big deal.

Q. The medication she was on post surgery, would they have completely taken away the pain of the surgery?

A. Probably not. I mean, when you're using narcotic pain medications, they never really take away all the pain. They can take the edge off the pain. Another way -- if you take enough of them to take away all the pain, generally you take away consciousness too.

Q. Her -- her neck at this time, was that improved?

A. Yes.

Q. And what pain level was she reporting in her neck on that day?

A. About 2 to 3 out of 10.

Q. Okay. Let's move now to your next appointment.

Was that April 10th of 2013?

A. Correct.

Q. About how many months post-op is that? Do you note that in your report?

MR. ROBERTS: Audra, top of page 31.

THE WITNESS: Approximately, four months.

BY MR. ROBERTS:

Q. And how was Ms. Garcia doing?

A. She was making progress. She just started physical therapy. Pain scores are about 5. We discussed starting to bring her medications down, which is appropriate at that point.

Q. And she's still on Norco at that point?

A. I believe so. Let me see. Yes. 7.5 milligrams. So that's the middle dose.

Q. Okay. And did you make any decisions with regard to her pain medication? You're going to start weaning her? Did you increase, decrease the dose that day?

A. Let me check. I think I decreased the dose. Pretty sure I did.

Q. Do you have experience in treating patients for pain post lumbar fusion?

A. Yes.

Q. And do you treat a significant number of patients in that condition?

A. Yes. Lots.

Q. Okay. Explain to the jury how long it takes for the benefit of a spinal fusion to take effect. At what point can the benefits be expected and how long can the patient expect continued improvement from the

surgery?

MR. MAZZEO: Objection. Foundation. Speculation. Can we approach, Judge?

THE COURT: Come on up.

MR. MAZZEO: Thanks.

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

THE COURT: Objection as to foundation sustained.

Ask him a question.

BY MR. ROBERTS:

Q. Okay. Let's go back to what when I was asking you about treating patients for pain post lumbar fusion.

Approximately, how many patients would you say you've treated over the course of your career for pain following a lumbar fusion?

A. Hundreds, perhaps thousands.

Q. And for hundreds and perhaps thousands of people post lumbar fusion, did you follow their treatment and manage their pain for over a year?

A. Yes.

Q. For a significant portion of those patients, did you treat them for their pain post lumbar fusion for at least two years?

A. Many, yes.
Q. In the course of treating your own patients for pain post lumbar fusion, were you able to observe patterns in the level of improvement that they achieved over time post lumbar fusion?
A. Yes. You look at whether somebody's on track or not on track. There's not a fixed level of improvement you want to see that each month because it varies from patient to patient.
Q. And --
A. However --
Q. If I could stop you before you -- you go and give any opinions. Just laying foundation at this point.
As part of your medical training, your internship, your fellowship, all the things you described to the jury that you did to become a pain management board-certified specialist, did any of that training, experience have to do with treating people post surgery?
A. Yes.
Q. And as part of your education, training, and experience, do you have an understanding based on your medical training and experience as to what level of improvement to expect in the pain of patients who are

post fusion?

A. Yes.

Q. So we go back and ask now.

A patient has just had lumbar fusion. Just talking about the general population. Over what period of time would you expect to start seeing improvements in their pain that they had presurgery?

MR. MAZZEO: Objection, Judge. Speculation.

THE COURT: Overruled. He can answer.

THE WITNESS: Recognizing this is not like a fractured arm where you could put a cast on and immobilize it to let it heal in 6 to 12 weeks, you have to use your back whether you just had surgery or not. Just to stand up, you have to load the spine. Roughly, it takes two years to get as good as you're going to get after a lumbar fusion it. Doesn't mean you're miserable for two years and then, boom, you're fine. It's a transition.

What we look for is progress. Are they getting better every day? Is the trend positive? If the trend is positive and they're on track and reducing medications, then at some point, the surgeons will allow them to have therapy. Some surgeons don't want them doing therapy too quick because they just fused the area. But you put the hardware in, but the bones

still have to fuse, and that takes time. So roughly two years to get as good as you're going to get.

We look for progress. Progress is measured by improvement in pain improvement in function. Reduction of medications. Returning to normal at some point, whatever normal is.

BY MR. ROBERTS:

Q. At this point, April 10th, 2013, about four months post surgery, were you seeing progress?

A. Certainly. Pain score's down to 5. She stopped taking Valium. I reduced the strength of her pain medication from 10 milligrams to 7.5 milligrams. That's progress.

Q. Thank you, Doctor.

Let's go to your next date of service, May 8th, of 2013. So we're about a month later, five months post fusion.

MR. ROBERTS: Page 35.

BY MR. ROBERTS:

Q. Is the patient still making progress at this time?

A. Yes. Yeah. She's improving, starting to wean her medications even more. She indicated she had some withdrawal symptoms from the medication, which is normal. That's normal human physiology, but overall

indicates she's on track. She has returned to work and her compliance was excellent. Let's see. Her pain score that day was -- it's here somewhere -- 4 out of 10.

Q. So continuing to go down at that point.

A. Correct. So she's making progress. Again, lumbar surgery is a big deal. I mean, a fusion is a big deal.

Q. Okay. Doctor, let's go to the next monthly visit on June 11th of 2013.

MR. ROBERTS: Page 39, Audra.

BY MR. ROBERTS:

Q. Could you review your notes and tell the jury whether Ms. Garcia was continuing to make progress?

A. A brief note. She was six months out from surgery. Doing very well. Some pain, still working, on track. At that date, I was going to take her off the Norco and switch her to another medication called Ultram. The other name for that medication is tramadol.

Q. Okay. Could you explain to the jury the significance of the switch of medications from Norco to Ultram?

A. Well, like I said previously, Norco, hydrocodone is a Schedule 2 medication. I think Ultram

is Schedule 4. It's a mild analgesic. It's not strong, but it does help. It's not a narcotic. It's a good transition medication and something she can stay on indefinitely if needed.

Q. And at any point in time in your treatment of Ms. Garcia, did you find her to be lazy or noncompliant with your instructions that you were giving her to help her get better?

A. Never.

Q. The Ultram, before we move on from that, is that as addictive as the Norco?

A. It's thought to be nonaddictive. I'm sure you could dig up somebody that found a way, but generally it's considered to be nonaddictive.

Q. Are there differences in the side effects that you would expect Ms. Garcia to experience with the Ultram versus the Norco?

A. Vast majority of people have no side effects. You can totally function on it.

Q. Okay. Let's go to the next visit one month later, July 10th of 2013.

MR. ROBERTS: Audra, page 46.

BY MR. ROBERTS:

Q. Okay. How was her progress at this point?

A. She reported -- she saw my PA that day. She

reported about 70 percent improvement. Pain was fairly well controlled with medications she was on.

Q. There has been a question raised as to the frequency of the visits of Ms. Garcia with you.

Was it really necessary to see her every month at this time?

A. Yes. It's still a dynamic process. Things are changing.

Q. Let's go one month later, August 7th of 2013.

Have any issues developed at this time since her last treatment?

MR. ROBERTS: And we're at page 43, Audra, at the top.

BY MR. ROBERTS:

Q. I think there may be a typo there in that first sentence.

A. Yes. It's more than a month. Should be.

Q. About how many months are we now? Are we close to ten?

A. Yes. Typos do occur, unfortunately.

She's still making progress, having a little increased pain over the last month. We would -- I added Robaxin to her regimen. We're going to have her start physical therapy.

Q. She indicates that she has developed some

pain to her right thigh. It was numb but has now become a bit painful.

Did you see any significance to this new report by Ms. Garcia?

A. Those are new leg symptoms but just bears watching, see what happens with some treatment.

Q. What were your recommendations at this time? Anything new?

A. Physical therapy, back in a month for reevaluation, sent a copy of the record to Dr. Gross.

Q. What were her overall pain levels at this time? Had her pain gone away?

A. No. Pain score was a 5. So it was up a little bit from the previous.

Q. Thank you, Doctor.

Let's go to her next monthly visit September 10th of 2013.

MR. ROBERTS: Audra, let's jump ahead to page 439.

BY MR. ROBERTS:

Q. And how was she doing in September of 2013, Doctor?

A. She was doing a little better from the previous month. So I think the interventions we did, which was just basically add muscle relaxer, had

benefit. We did broach the issue of a spinal cord stimulator with her on that visit.

Q. Okay. Could you explain to the jury what a spinal cord stimulator is? They've heard a little bit about the -- the trial stim from one of the other doctors. But if you could just explain.

This is the first time a spinal cord stimulator is mentioned in your records; correct?

A. Correct.

Q. And was this your idea, or did it come from another doctor?

A. No. I was just talking about options in the future because she's still having -- she's 10, 11 months out still having some pain. So it might be something we have to look at in the future.

Q. Okay.

A. First introductory discussion.

Q. Very good.

A. So a spinal cord stimulator is a device that gets implanted in the epidural space of the spine to block pain signals from the periphery. The center of the spine is the spinal cord. That's surrounded by spinal fluid, and that's all held in by a tube, a sheath called the dura. Epidural means outside the dura. When a woman has a baby, they put a little

catheter in that space, put in anesthetic agents to block the pain of labor. That's what most people associate epidurals with or with the epidural space.

Anybody bump their shin and then to make it feel better, you rub it? Does that make any sense? But that's what everybody does. That's kind of a weird analogy. But what's happening is by rubbing that area, you're stimulating a bunch of nerves that block pain signals at the level of the spine. It's called counter stimulation. In the most basic sense, that's how a spinal cord stimulator works. There's a lot more to it, but that's the down and dirty version.

This thing is electronic. It will get implanted in the thoracic spine, roughly at about the T8 level. And at that level, if you have the right number of electrodes in there and contacts, there's a lot of programming stuff that goes on, you can block pain signals from the low back and the legs.

The permanent version, when it's implanted, is like a pacemaker. Little battery. I think it's about this big, about that thick. And that typically gets put in the top of the buttocks. And the cables go under the skin, and then it inserts into the mid back area. The programming device is a remote control. You can turn it up, turn it down. They give you several

programs you can switch to.

And there's new technology. There's even technology now that it will change the stimulation from laying flat to sitting up. It's pretty interesting stuff. Years ago, you could only stimulate the legs. So traditionally stims are thought to be only for people with severe radicular type leg pain. Excuse me. But several years ago, the technology improved where if you put multiple rows of leads in, you can cross talk electrodes and cover the low back. And that's where we're at today in the technology. And that's how a spinal cord stimulator works.

Before putting one in permanently, we'd like to know if it's going to work, so we do what's called a trial, a spinal cord stimulator trial. I do those. And I'll typically do it on a Monday, put in three electrodes. Right on the table, when I put it in, I'll light the patient up on the table, turn it on. A representative from the company is there, program it. We'll adjust it. We'll move it up and down till we find the sweet spot, usually it's around T8 somewhere, T9, and try to get the middle contacts over the sweet spot. That gives you a little bit of play if it moves a little bit. We'll take an X-ray so the surgeon knows where to put it in if he needs to put a permanent one

in. And then the patient will go home with wires sticking out of their back hooked up to a remote control box to program it, turn it on, turn it off, turn it up and down.

They'll live with it. They'll try do normal functioning as much as they can. I -- my -- my schedule is put it in on a Monday, take it out on a Thursday. Why? Because I know everything I need to know by Thursday. Most patients know if they like it or not. I tell them personally, If you don't love it, don't get it. It's got to reduce your pain, reduce your meds, improve your level of function, improve your quality of life. If it doesn't do that, that's a pretty invasive procedure for no purpose, no good purpose if it's not helping you. So I tell them personally these exact words: If you don't love this, don't get it.

Q. So put it in Monday, take it out Thursday. Tuesday, Wednesday, Thursday, three days -- worn three days?

A. The reason I don't leave it in over a weekend is because if bad things happen, it's hard to react to it. The longer that thing is in, the greater the risk of infection. If you get an infection in the epidural space, that is very big deal. That means a trip to the

OR to have a laminectomy to have that thing drained and meningitis, all kinds of bad stuff. So I'm very paranoid about infection. Knock on wood, none of my patients have ever had one. But I don't want to leave it in over the weekend.

Having said that, if on Thursday there's still some uncertainty in the patient, I will give them the option to leave it in over a weekend. But with very close monitoring.

Q. Is -- is three days really enough to determine more likely than not whether a permanent stimulator is going to be successful?

A. Yes. Yes, it is. And I think the cost-benefit analysis with infection versus duration. And, again, when I brief the patients, and they get two briefing sessions by me personally on this, if you don't love it, don't get it. In other words, if you come back and say I think this thing is working, no. If -- let's give it a try, see if it works, no. I think it helps some, no.

Most of my patients that go on to permanent say, I love this thing. Please don't take it out. That's a yes. And that's the degree to which I screen patients for this. So they know, without exception, that whether they liked it or not enough to go through

the implantation, they've been briefed where I'm actually trying to talk them out of it. I really want a clean trial to know whether this thing is going to do any good or not. And my implantation rate is -- of the patients that I trial, I screen them pretty good, about 70 to 80 percent go to permanent implantation. Some don't. Some people hate it. They don't like the sensation. Done deal.

Q. Your notes indicate you gave her a video to look at, referring to Ms. Garcia.

A. Correct.

Q. What -- why do you do that? What's -- what's the video about?

A. Spinal cord stimulator is a big deal. It's like surgery. They really need to know what to expect, what it's going to do for them. And so I brief them. I give them a video from the manufacturer. They watch that. They're invited to go the websites, get as much information as they can. Just don't take my word for it. Do your own research.

Q. You mentioned it's surgery to put in the permanent one.

You place the trial stimulators. Do you place the permanent stimulator if the patient selects that option?

A. I can. I typically don't. I have put them in. The ones that pain management guys put in are called percutaneous leads. They're round leads. They're like a piece of spaghetti. So when you put them in, they're a kind of floating around in the epidural space and they can move. The surgeons put in what's called a paddle lead, p-a-d-d-l-e. It's not round, it's flat, and it's got multiple rows of contacts on it. And to put it in, you have to make a hole in the bone. That's called a laminotomy. They make a little hole, put the thing in there. Then they anchor it in place so it doesn't move.

The bottom line is, it's a much better device. You know, what I put in temporary is good. The ones the surgeon put in is even better, so they should get even a better result, gives you more programming options. It's just better for the patient. So I don't put in the leads anymore. I can. I just don't.

Q. What are the benefits of doing a spinal cord stimulator over other treatment options available to a patient with the problems Ms. Garcia was having?

A. Well, all treatment options are to treat the pain, improve function, improve quality of life. The spinal cord stimulator is a nonmedication approach to

doing that. Simply said.

Q. So it helps the patient avoid narcotic drugs?

A. Correct. Or any drugs. They may come meds off meds entirely on a stim.

Q. Let's go now to your next visit, October 16th of 2013.

How's Ms. Garcia doing the next month?

A. She's ten months out from surgery, doing pretty well, has reduced her medications a little bit. Function was improving. Pain control is fairly good. Pain score 4 out of 10.

Q. Still only on the Ultram at that point?

A. I'm sorry?

Q. Was she still on the Ultram at that point?

A. Yes.

Q. Okay. Let's go to the next month, November 13th of 2013.

How's her progress?

A. She saw my PA that day. Indicated pain was constant. Numbness in the anterior thigh on the right. Having a little more spasms over the previous two weeks. Aggravating factor was probably cold weather, which will do that.

Q. Do you know what she was referring to when you note that she was having more spasms in the right

lower extremity?

A. Right. She had this little dysesthesia, what it's called, in the right posterior lateral thigh, having little spasms associated with that.

Q. Okay. Let's go now to the next month, December 11th of 2013, and you're continuing to see Ms. Garcia monthly?

A. Correct.

Q. And did you ask her to come to see you monthly or that was her decision?

A. No, that's what we scheduled it for.

Q. Was that your recommendation?

A. Yes. Again, she's still changing. It's not that she's stable. She's not stable yet. She's doing a little better, but it changes.

Q. Thank you, Doctor.

MR. ROBERTS: Audra, page 450, the office visit of December 11th, 2013.

BY MR. ROBERTS:

Q. How is Ms. Garcia's pain at this time?

A. Neck was still bothersome, not as much as her low back. She's had a little increase in headaches, not sure of triggering event. Again, we discussed about cold weather. Low back was doing a little bit. Still having numbness in the right thigh and some

spasms in right lower leg. Gina indicated that she had an appointment with Dr. Gross in January.

Q. And what's her pain level at this point, Doctor?

A. It is 2 out of 10. Doing pretty good.

Q. Doing pretty good.

So did she report her feelings of how she was doing before -- before and after the lumbar fusion? She --

A. Well, it's continual. We monitor that. I'm not quite sure what you're asking me.

Did I miss something?

Q. Do your notes indicate specifically whether she's -- the lumbar surgery has improved her symptoms?

A. Oh, yes, it has. Yeah. She's gone from miserable down to a 2. That's a pretty good jump.

Q. Okay. January 28th, 2014, does her progress continue?

MR. ROBERTS: Page 461.

THE WITNESS: I saw her that day. Neck was not bothering her. Still on track with her low back. Has some low back pain radiating to her thigh. Taking Ultram. Pain score that day was a 4. So it had come up a little bit.

/////

BY MR. ROBERTS:

Q. But continuing to make progress from prefusion.

A. Correct.

Q. Next visit, February 26th, 2014.

MR. ROBERTS: Page 458.

THE WITNESS: We indicate at this point her back pain is starting to get worse. Pain was increased with extension greater than flexion. Indicated she was a little bit deconditioned. Start her on some physical therapy and get X-rays of her low back. Indicated she may need injections. Her pain score that day was a 4. But she indicated that she was getting worse.

BY MR. ROBERTS:

Q. So, Doctor, you note low back pain that radiates to her right thigh anteriorly.

A. Correct.

Q. What does that tell you?

A. That could be a nerve, you know, L4 nerve maybe. Three.

Q. What about pain with extension greater than flexion?

A. That -- that could be suggestive of facets actually.

Q. All right. Let's go to your next visit,

April 2nd of 2014.

What was her status at that time? Let's start with her neck.

MR. ROBERTS: And, Audra --

THE WITNESS: That was doing well. No pain.

MR. ROBERTS: Page 539 for the jury, Audra.

BY MR. ROBERTS:

Q. So the neck pain is resolved at that point?

A. Correct.

Q. What about her low back and lower extremity?

A. She is now 16 months out from surgery. Initially did well I indicated, but now she's getting a little bit worse. She's had several flares of pain. She's in therapy. Pain is 50 percent low back, 50 percent right leg. It's worse at night. I added Neurontin to her regimen. Neurontin is an anticonvulsive-type medication that in this context is used to treat nerve pain. And I'm thinking her back and leg is -- had a component of nerve pain.

Q. And did you consider any further treatment options for her on this visit given her continued pain?

A. Correct. I indicated that if her symptoms continued to progress that she might need a spinal cord stimulator.

Q. And what was her level of pain on this visit?

A. Five.
Q. Let's look at page 540.
MR. ROBERTS: Audra, if you could pull up page 530 -- let's see. Hold on. Just a second. I apologize. Make sure I found this on my notes.
The bottom of page 540 under Diagnosis.
BY MR. ROBERTS:
Q. And we -- we see that you have listed a diagnosis, and you do this every time you prepare an office visit report?
A. Yes.
Q. And what are the numbers after the diagnosis?
A. Those are diagnostic codes.
Q. Okay. So standard codes?
A. Correct.
Q. And are the descriptions standard?
A. Yes.
Q. And this is the first time that I believe we've seen this last diagnosis code in your records, failed lumbar surgery syndrome.
Could you explain to the jury what that diagnosis means and how you came to believe that it was appropriate to put in Ms. Garcia's report?
A. A little explanation. The fact there are codes for each diagnosis tells you that we're having to

code these things according to a chart or a book standard nomenclature ICD-9 codes. There's a new thing called ICD-10 codes which is a real mess.

But in order to be standardized throughout the industry with insurers, with researchers, whatever, they like us to pigeonhole diagnosis into these codes. Sometimes the codes really don't fit exactly what's going on. But nevertheless, they're out there.

Failed low back surgery syndrome, 72283, is really a garbage diagnosis, to use a frank word. It doesn't accurately describe what's going on. It simply means that somebody has had back surgery, and after a period of time, they continued to have pain. That's all it means. Another name for it is post-laminectomy syndrome. In more specific terms, it can mean leg pain after back surgery, and usually that's thought to be due to fibrosis or scarring around the nerve. But everybody uses it in a more liberalized manner just to describe somebody who has pain despite surgery over time. That's all it means. And I don't like the diagnosis because it doesn't really give you any detail, and people misunderstand what it really means.

It's like the code for facet syndrome, lumbar facet pain. That's a joint in the back that can cause pain. Well, the code that you have to use in the

industry is 7213, which is spondylosis. Well, if you look up the definition of spondylosis, it doesn't say facet pain. It says degeneration of the spine. Nonspecific degeneration. That could mean bone spurs, all kinds of stuff. But in this context, we're forced to use that diagnostic code to satisfy, I don't know, the gurus.

Q. And as you've defined the standard usage of this term, pain that continues despite lumbar surgery --

A. Correct.

Q. -- your use of the code was accurate.

A. Correct. I mean, she was on track, getting better over time, but now she's going the wrong way. Pain's getting worse.

Q. Does this mean that her lumbar fusion was not medically necessary?

A. Oh, not at all.

Q. And -- and in this case, what's the basis for that opinion?

A. Well, she had a structural abnormality that was symptomatic and needed to be repaired, that spondylolisthesis. That thing is not going to get better over time. It's going to get worse, and she was symptomatic. If she was totally asymptomatic, she

would have never come to anybody's attention and nobody would know about it nor would anybody fix it.

However, the fact of the matter remains she is severely symptomatic. That's a large -- a large slippage, and I -- most surgeons would fix that.

Q. So despite the fact her pain is now increasing, and I think we've seen it go from -- from 2 to 4 to 5 --

A. Correct.

Q. -- is that still less pain than she was in before the lumbar surgery?

A. Certainly. No. She had a good result from the surgery. But unfortunately, over a year out, she's starting to get symptoms again, and we're going to have to figure out what to do about it.

Q. Thank you, Doctor.

Let's go to the next monthly visit May 21st of 2014.

MR. ROBERTS: Page 555 -- 544.

THE WITNESS: Which date.

BY MR. ROBERTS:

Q. May 21st, is that the next date of service? Have I got that right?

A. Yes, sir.

Q. Okay. How was her low back pain now?

A. Pain is getting worse with radicular pain down her right leg. Radicular means sciatica-like pain following a nerve going down the leg. She's on Neurontin, 400 milligrams, taking up to 900 milligrams. That's a big dose. That should have helped the leg pain, but she's still having great difficulties.

Q. What's her pain level at this time, Doctor?

A. I'll look that up. Six.

Q. In light of her increased pain, did you discuss switching medications?

A. We discussed -- Gina saw her that day. She had problems with oxycodone in the past. That was discussed. We kept her on Ultram that day.

Q. And Gina is with your office also; is that correct?

A. Correct. She's my physician assistant. And we increased Neurontin significantly to 300 milligrams three times a day.

MR. MAZZEO: Judge, can we approach, please?

THE COURT: Sure.

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

THE COURT: We need a break? I'm not -- I kept watching. I'm not seeing a break from you guys. The attorneys need a break. I need a break.

So 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 about ten minutes.

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

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

Anything we need to put on the record?

MR. MAZZEO: No, Your Honor.

MR. ROBERTS: No, Your Honor.

THE COURT: Okay. 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, Your Honor.

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

THE WITNESS: Yes, sir.

THE COURT: Go ahead, Mr. Roberts.

BY MR. ROBERTS:

Q. Okay. We're on May 21st of 2014.

Did Ms. Garcia express any interest at that appointment in pursuing the spinal cord stimulator?

A. Yes. Apparently she had -- I'm sorry -- had lost the video. She saw my PA that day, so she's actually scheduled to come back the next day to talk to me personally because I like to brief the patients personally on this. And on more than one occasion as well.

Q. And we talked briefly -- Gina, how long has she been with you?

A. Ten years.

Q. Okay. So let's look now to your record of May 22nd.

So she came back the very next day; is that correct?

A. That's correct.

MR. ROBERTS: And, Audra, we're at page 547, top half of the page.

BY MR. ROBERTS:

Q. So what was the purpose for coming back the very next day to see you?

A. Well, again, when I'm briefing somebody on a spinal cord stimulator, I do it personally. So I gave her another video. I discussed it, used skeletons, gave her the full explanation of what it is, what to expect, why, and ordered a CT scan of her thoracic spine because one of the potential complications is trying to shove one of those things up in there and there's not enough room. There's some stenosis. I want to make sure there's no stenosis. And then there's some screening that needs to be done.

And once all that's complete, we'll come back. I'll brief her again, and then we'll schedule

the procedure if she elects to go through with it.

Q. And you gave her another video?

Is that the same kind?

A. Yes.

Q. And why do you reference psychological screening? Is that something you normally do prior?

A. It's an industry standard. You need to do that. It's required.

Q. And what is the purpose of that screening?

A. To make sure that the patients have realistic expectations, make sure there's not problems that having a stimulator could cause.

The best example I can use is somebody that hears the voices, you don't want to put a stimulator in them because the stim might be talking to them. I mean, that's kind of a extreme situation, but that's roughly what it's for. And it's adopted nationwide as a standard. In fact, you could really be criticized for putting one in somebody if you don't use a psychologic screen.

Q. Thank you, Doctor.

She returned for her next visit on, let's see, June 18th 2014, is that correct, according to your notes?

A. Yes, sir.

MR. ROBERTS: Okay. Audra, page 556.
BY MR. ROBERTS:
Q. Had the patient watched the video by the time she returned?
A. Yes. She had CTs -- CT scan, was clearing, was -- was cleared, no stenosis, and clearance was pending. I can't say that fast three times.
Q. And the CT scan was of the thoracic spine?
A. Correct.
Q. And those are the levels that are attached to her rib?
A. Yeah. Again, that had nothing do with her low back pathology. It's just to make sure I have enough room to get that thing in and do it safely.
Q. At this point in time, what -- what are her pain levels?
A. Let's see. Five out of 10.
Q. Let's go to the next month.
Was your next visit with Ms. Garcia July 16th of 2014?
A. That's correct.
Q. And had she received medical clearance to proceed with the stimulator at that time?
A. Yes.
Q. Okay. Let's go to the next month,

August 12th of 2014.

MR. ROBERTS: Audra, page 604.

BY MR. ROBERTS:

Q. Was that your next appointment?

A. Correct.

Q. Okay. Were there any purposes to that visit other than your -- your normal follow-up?

A. The major purpose is for medications. The stimulator was scheduled for August 25th, 2014.

Q. And what medications did she renew at that time?

A. Ultram, Wellbutrin, Zanaflex, and Neurontin.

Q. And what her pain levels?

A. Pain score on that visit was a 5.

Q. Okay. You mentioned that the trial stimulator placement was scheduled for August 25th of 2014?

A. That's correct.

Q. And -- and did you proceed with the placement of the trial stimulator on that day?

A. Yes, I did.

Q. All right. You've told the jury a little bit about the procedure for placing the trial stimulator.

Do you have with -- with you -- let's see. In your -- put it this way. I have got it with me.

So --

A. That's it.

MR. ROBERTS: Did you have any objection to the demonstrative we sent over last night?

MR. STRASSBURG: No objection.

MR. ROBERTS: Thank you.

Audra, if you could put up Demonstrative 11.

BY MR. ROBERTS:

Q. And is this an image from your file from your placement of Ms. Garcia's trial stimulator?

A. Yes, it is.

MR. ROBERTS: Your Honor, may the witness have permission to step down and explain to the -- procedure to the jury?

THE COURT: If it helps, that's fine.

MR. ROBERTS: Thank you.

BY MR. ROBERTS:

Q. Could you explain to the jury what's shown in the image?

A. This vertebrae here is T -- or T12, 11, 10, 9, 8. This is the T8 vertebral body. Remember I mentioned you want to center the contacts over --

THE COURT: Speak up, Doctor.

THE WITNESS: Yes. Want to center the contacts over T8. You see three leads placed here.

The middle one is longer than the other two. That's called a tripolar ray. What I'm trying to do is mimic what the surgeon's going to put in, which is a flat lead with three rows of electrical contacts. These black things are contacts. By doing that, it allows the programmer to interact the contacts across each other to obtain the amount of stimulation --

BY MR. ROBERTS:

Q. Just hold it up very close to your mouth, Doctor. Right up to your mouth.

A. To allow whosever programming this to optimize it to get both back and legs. Again, traditionally, the challenge was you don't want to get legs with these things. But now with three rows of contacts, you can get the entire low back. So that's why I put in three leads because I want to mimic what the surgeon is going to put in.

They're basic -- they're basically like pieces of spaghetti. They're round and they're long and kind of flop around when you put them in. So this is a temporary lead, and it will come out a few days after being put in. And then we'll assess the patient's pain to determine whether she's a candidate for a person implantation or not.

Q. Now, if the patient decides to proceed with a

permanent stimulator, is this used in any way in the placement of the permanent stim?

A. The images are very important because it tells the surgeon exactly where to put it. Again, I want optimal stimulation. So during the course of the trial right on the table, I'll move these leads up and down till I find out where she has the best coverage. My goal is to find the sweet spot and put these middle contacts right on it. That way, the surgeon knows where to put the paddle lead. The middle contacts will be right on top of that. It gives you some programming options later on when things change a little bit. You can stimulate up, stimulate down. You usually don't stimulate all the contacts. You stimulate just a few of them. And you want that to occur with the middle contacts. Again, if something changes, then it gives you options to use the contacts higher or lower.

Does that make sense?

Q. Thank you.

Okay. So this was August 25th that you placed the stimulator; is that correct?

A. That's correct.

Q. And your next medical record --

MR. ROBERTS: Audra, at page 611.

/////

BY MR. ROBERTS:

Q. -- is that August 28th?

A. Correct.

Q. And what was the purpose of a return in three days later?

A. That is lead removal day or evaluation. She's kept track of her pain. She comes back, reports improvement. And, again, to reiterate, we're looking for improvement of not only pain but function, sleep pattern, overall quality of life, and does she like it. Like I say, some people don't like the sensation of the tingling. Some people love it. That's why we do the trial. And she reported 70 percent improvement, cut down on medications, activity level increased. She was interested with the stimulator at that point.

Q. Did you consider that a successful or unsuccessful trial?

A. No, absolutely, it's successful.

Q. Would you consider Ms. Garcia a candidate for a permanent spinal cord stimulator?

A. Yes.

Q. Would that treatment be reasonable based on her condition?

A. It is very reasonable and is completely standard in the industry. Meets all the criteria.

Q. And did you refer her to a spine surgeon to discuss a permanent stimulator placement following the trial?

A. Well, she was already seeing Dr. Gross, so we continued that.

Q. So you asked her to talk to him about it?

A. Yeah. She's -- he's a neurosurgeon, puts them in, does a good job. Does a great job.

Q. Okay. Now, she returned to see you on November 19th of 2014.

MR. ROBERTS: Audra, page 623.

BY MR. ROBERTS:

Q. And at that time, she came with a prescription or recommendation from Dr. Gross; correct?

A. That's correct.

Q. And what was that recommendation?

A. He wanted me to do kind of a denervating procedure. He wanted me to inject her facet joints, hardware, and right sacroiliac joint all at the same time.

Q. And what was the purpose of this, diagnostic or therapeutic?

A. Both. Both. I'm going to inject her, I'm going put some medication in there, try to make her better. Lot of it's diagnostic.

Q. And explain why you're still doing diagnostic procedures here.

A. I probably need to go ahead and indicate that we did this on two occasions. She -- when I did the procedure, she had about 40 percent pain relief right afterward, which was suboptimal. But on the follow-up visit, she was --

Q. And if I could stop you.

That first procedure, was that the one on December 1st of 2014?

A. Correct.

Q. Okay. And she had about 40 percent reduction?

A. She had about 40 percent reduction immediately afterwards, but when I saw her back in the office, she looked like a new person. She was 70 percent overall improved from it. Her pain eventually returned, and I repeated the procedure at the request of Dr. Gross. And, again, same result, except right afterwards she had complete relief of her pain and, again, showed 70 percent improvement on the follow-up visits. And then the following time, 80 percent improvement. So she did really well from this.

I think the reason she had a 40 percent

improvement afterwards is that was a lot of needle sticks, and I probably didn't anesthetize the track adequately on the way out on one of them. My normal practice is if I do an injection, when I'm done, I'll inject local anesthetic as I pull the needle out because I want to anesthetize the entire track because those things hurt. I mean, lot of needle sticks, it hurts.

Q. So some of the reported post-procedure pain is -- can be associated with the injection if you don't numb it properly?

A. If you'd like to see it, I can show you the needle I use for those procedures just to give you an idea of the caliber of it.

MR. ROBERTS: Any objection, Counsel?

MR. MAZZEO: No objection.

MR. ROBERTS: Thank you, Your Honor.

THE WITNESS: This is a 22-gauge Quincke tip spinal needle. This one's 5 inches long. For this, I typically use a 5- or a 7-inch needle. One, 2 inches long. You make a bunch of holes with this, something's going to get sore. So that's why I think there's a difference in the follow-up visit because the second time I made a concerted effort to make sure I laid a big track of local anesthetic on the way out through

the surgical site.
BY MR. ROBERTS:
Q. And to make sure that we've got all the dates in the record, you just went through two different injection cycles?
A. Correct. You have to explain that to explain the radiofrequency. It's -- it's a complicated thing.
Q. Okay. So the first injections were on December 1st?
A. That's correct.
Q. The follow-up from that was 16 days later on December 17th?
A. Correct.
Q. And that's where she reported the 70 percent reduction in her pain.
A. Correct.
Q. Had pain in her right leg subsided at that point?
A. Yes.
Q. Had her functioning improved?
A. Yes. Like I said, she looked like a new person.
Q. And then did you have -- you mentioned repeat injections.
Did those take place on March 16th of 2015?

A. That's correct, sir.
Q. And is that where she reported complete resolution of pain post procedure?
A. Correct.
Q. Again, you mentioned a follow-up visit.
Was that on April 6th of 2015?
A. Yes, sir.
Q. And that's where you said she reported a 70 percent reduction in pain?
A. Correct.
Q. And what about her functioning at that point?
A. Function was improved. I mean, she looked great.
Q. Okay. Let's -- let's now go to May 4th of 2015, another month later.
MR. ROBERTS: Audra, page 657.
BY MR. ROBERTS:
Q. So we're now even further out from the last injections which were back in March.
How is her -- how's her improvement from her pain?
A. She had reported 80 percent after the second injection lasting about two months, but her pain was starting to return. We discussed stimulator again. She was apprehensive about that after having such a

good improvement from these injections. If faced with putting an implant in versus pursuing this route, she was leaning more towards this route, which is appropriate. I would probably do the same thing.

Q. Was it just the -- the surgery associated with the implant that she was expressing concern about?

A. I think it's the whole notion of having something implanted in your body for the rest of your life that goes into your spine. It's electrical. You have to do battery changes, you know, every so often. You can't have MRIs because of -- the device currently is not FDA approved for MRIs. It will at some point, but right now, it's not. So those are all legitimate concerns. And she enjoyed tremendous benefit from those injections.

So the discussion with the patient and with Dr. Gross went towards radiofrequency rhizotomies of the area.

Q. So -- and we'll blend some of the records together now instead of going one by one. But let's focus on this time from May of 2015, just last year through July of 2015, and you're having these discussions about alternatives to the stimulator.

A. Right.

Q. What alternative did Dr. Gross suggest might

be appropriate to try at this time based on the success of these injections?

A. Well, this is one of those occasions I actually learned something. So I'll share that with everybody.

Dr. Gross suggested doing a radiofrequency rhizotomy, L3-4, L4-L5, plus right SIJ. A radiofrequency rhizotomy is called a neurodestructive procedure. What that means is I take an electric needle and I cauterize the nerve and burn it. The nerve will grow back. Takes about a year. It's a standard procedure for the treatment of facet pain, facet joint pain.

So I got on the phone with Dr. Gross because I -- he proposed we do rhizotomies at the levels where we had the fusion. And he made a very cogent argument, one I hadn't considered nor that I know about. He told me, personally, that when they do the fusion, they do electrocautery of the nerves that go to the facet joints. It's the same thing we do when you do a radiofrequency rhizotomy, but they're in there with the Bovie cutting tissues and they actually ablate the entire track of the facet nerves as part of the procedure.

A bell went off -- I mean a light went off in

my head. Well, that certainly explains to some degree why she did well for 14 months or so and then her pain returned. The whole theory being he ablated those nerves, the nerves grew back, and now she's experiencing pain. Plus the SIJ, sacroiliac joint, was symptomatic as well, and I can radiofrequency that.

So after Dr. Gross explained that to me -- I never knew that they ablated those nerves during a fusion. I never attended a fusion except as an anesthesiologist doing the anesthesia, but I haven't watched the procedure. I never knew that. I don't think most people know that. So that was an educational moment for me, and we agreed that if the patient wished to proceed with that procedure, we'd do it. So we did that procedure. It's a big one, took about an hour to do it.

Q. And that was on September 24th of 2015?

A. Correct, yeah. Did the procedure. It worked. She did really well from it, just like she did from the diagnostic injections previously. So I don't know how long it's going to last for. The average duration proven from a rhizotomy is about a year.

Q. And before we go on to the follow-up and the results of the rhizotomy --

A. Sure.

Q. -- I'd like to walk the jury through what you did, you know, what was entailed, the type of rhizotomy that she received.

MR. ROBERTS: Any objection to the demonstratives?

MR. MAZZEO: No.

MR. ROBERTS: Thank you.

Audra, if you could put up No. 1. And this image is dated September 24, 2015, 3:28 p.m.

Could you -- Your Honor, may the witness step down again?

THE COURT: That's fine.

MR. ROBERTS: Thank you.

BY MR. ROBERTS:

Q. Let me give you this.

A. I feel like Cher.

This is her hardware. That's what Dr. Gross put in to fuse her spine, these big bolts and a plate. This is what I'm doing. These are the radiofrequency needles, and if you look carefully, you can see there's a bifurcation. It's like a -- like a snake's tongue. That's called a venom needle. That's a special radiofrequency needle, new technology I've been using for two years. The reason I use it, it makes a bigger burn. And that's especially important for the

sacroiliac joint region because traditionally to do a radiofrequency ablation of a nerve, you have to lay the needle parallel to the nerve. The energy doesn't come out of the tip. It comes out on the sides. To get on the SIJ, you can't really get those needles parallel to the nerves --

(Clarification by the Reporter.)

BY MR. ROBERTS:

Q. Hold it all the way up to your mouth.

A. -- can't get them parallel to the nerves.

But this new technology, the energy is not only off to the sides, but it's off the tip. So it allows me to place needles perpendicular to nerves and burn them. You'll see that on the SIJ films. This works really well. It's new technology that I will say I've been doing for two years now. Maybe more. It is -- it's kind of a game changer as far as doing sacroiliac joints. But it also makes a bigger burn, which is the bigger the burn, the bigger the lesion on the nerve, the longer time it takes for it to grow back because nerves grow back a millimeter at a time.

MR. ROBERTS: Audra, the next image, No. 2.

THE WITNESS: That's a lateral view looking from the side. And what I'm looking for -- again, this is Dr. Gross's hardware that he put in, the screws and

the plates. The needles are mine, and I have to work around these things. What I'm looking at in this is to make sure I'm not doing something wrong. The bad thing about this procedure, the major complication is that that needle tip here goes into where that hole is, that's where the big nerve is that goes to your leg. You don't want to burn that. That's a bad day.

So we're very careful to take X-rays to make sure we're not too deep. We do some other testing, electrical testing. But there's a lot of safety checks that go in to make sure that you're doing the right thing and not doing the wrong thing.

So this view is to confirm my position in the lateral view and make sure I'm not encroaching upon the big holes here, here, and here where the motor nerves goes down to the -- sensory nerves go down to the leg. Don't want to do that.

MR. ROBERTS: Demonstrative 3, Audra.

BY MR. ROBERTS:

Q. And these are all live films that you're taking during the procedure?

A. Yes. We take tons of films. We keep a few of them just to represent what we did.

That's the same procedure looking top to bottom, you know, front to back on the right side.

Again, you can see the hardware from the fusion, and then you can see the needles that I placed.

MR. ROBERTS: Image 5.

THE WITNESS: This is the -- one of the views of the sacroiliac joint injections. The burning needles are here, here, here, and here. These two little needles I put in to mark the neural foramina where the big motor nerves are that I don't want to be encroaching on. So I mark those to make sure I don't encroach on them, and I leave them there during the procedure.

MR. ROBERTS: Image 5, Audra? Oh, no that is 5. Go to six. Sorry.

THE WITNESS: This is a front-to-back view of the sacroiliac joint. This is the L5 nerve, and this is -- some of the sacral nerves. In total, you see through all the pictures, I get a total of 12 burns across here. What I'm trying to do is create a continuous burn along this axis because the nerves that come out of these holes and go to the sacroiliac joint over here are variable. You don't know exactly where they are. They could be above the frame, to the side or below. So you have to burn everything along this axis. Again, this is the sacroiliac joint here in this little crack.

MR. ROBERTS: Image 7.
THE WITNESS: This is another lateral or side view of the procedure where the needle is placed in a different position.
MR. ROBERTS: And Image 8, Audra.
THE WITNESS: Again, top-to-bottom view of sacroiliac joint. This is another four burns I'm doing. Again, the lesion's about this big, and so these are going to join together to create a continuous strip lesion. Lesion means burn, a burn across that track.
BY MR. ROBERTS:
Q. Okay. How's that? Any more you wanted to show?
A. No, they all look alike.
Q. Thanks, Doctor.
How long does this total procedure take?
A. Forty-five minutes to an hour. It's a long one.
Q. Is this a fairly significant rhizotomy procedure compared to the ones you usually do?
A. Yes.
Q. And do you use the same type of anesthesia and conscious sedation for this procedure as you were describing to the jury for the nerve root?

A. No. It's a little different.
Q. Can you explain that?
A. My goal throughout this procedure is to have her conscious but comfortable. I don't care about her having no analgesics on board at the end of the case. In fact, I want her to have some narcotics on board when I'm done because these things hurt like hell. It's not a diagnostic tool. It's a treatment. It's basically a surgery of -- in a sense. So for my sedation, I will typically use fentanyl which lasts a lot longer than Alfentanil. It lasts a couple of hours. And Versed, again, for anxiety. Sometimes a little propofol if necessary.
Q. Okay. Did Ms. Garcia come see with you one week after the rhizotomies on September 30th of 2015?
A. Yes. Let me pull that up.
MR. ROBERTS: Page 694.
THE WITNESS: Correct.
BY MR. ROBERTS:
Q. Okay. How did the rhizotomies do?
A. Well, she's a week out. She was 60 percent improved. Her SIJ pain had pretty much resolved as had her right leg symptoms.
Q. That's sacroiliac joint?
A. Sacroiliac joint, SIJ, yes.

Q. And her lower extremity symptoms, the -- the radiating pain gone?
A. Pretty much resolved.
Q. And what about her low back pain?
A. Overall, I would say 60 percent better. She was doing really good. And that's really good for a week out.
Q. Is she still going to be experiencing post-procedure pain at this point?
A. Oh, yes.
Q. How long does that last following the rhizotomy?
A. Anywhere between two and eight weeks.
Q. Do the nerves like it when you burn off their end?
A. Nerves don't like being burned.
Q. Would you consider the rhizotomy to have been a success?
A. I really don't consider rhizotomy a success or failure till we're eight weeks out. So we'll see what happens, you know, weeks down the line. And she did well.
Q. Okay. So let's go forward to October 14th of 2015.
MR. ROBERTS: Audra, page 702.

BY MR. ROBERTS:

Q. How is she doing at her next visit?

A. Doing great. She did very well till about four days previous. She had a little pain. The pain was above and below the sites. Interestingly enough, I examined her right on the sites, and she really wasn't having pain or tenderness there. It was above -- above the site where I did the lesioning, and then over the buttocks. I thought it would just represent increased activity because she was feeling better and doing more, which is normal human being. Period.

Q. Okay. You -- you burn off the nerves, is it possible that they've grown back since you did this procedure?

A. No.

Q. Okay. So how many -- how far out are we from the procedure now?

A. We're a month.

Q. We're a month.

So the nerves have not grown back; right?

A. Correct.

Q. So the jury was told in opening statements that she had a return of pain so, therefore, the rhizotomy could not have addressed her source of pain and could not have been successful.

Do you agree?

A. Not at all.

Q. Explain to the jury how you could have a successful rhizotomy and yet she's still reporting pain a month later.

A. In my note, and I still agree with this, she indicated that she had been more active than usual. She felt better. She was doing more. And then probably developed some muscle pain because of it. That's like me. I'm a couch potato. If I get a wild hair and go out and start lifting weights, I'll be miserable for two weeks because I'm out of shape. This is normal human. This is predictable.

Q. And did your examination determine that the pain she was reporting was from the rhizotomy sites or some other location?

A. No, it was above and below. Rhizotomy sites are pretty much dead.

Q. So what were your recommendations for Ms. Garcia on October 14th, 2015?

A. Start physical therapy. Basically see her back in a month.

MR. ROBERTS: Okay. Let's go to page 712 of Dr. Kidwell's records, Audra.

/////

BY MR. ROBERTS:

Q. I see you have another follow-up with her on November 11th of 2015.

A. Correct.

Q. How's she doing?

A. My PA saw her, indicated she had a flare of symptoms that we documented, put her on Naproxen. She's doing better.

Q. Flare of usual pain, does that mean that her pain preprocedure had returned?

A. No. No. The pain that we were addressing on the last visit.

Q. All right. Let's move to December 9th of 2015, just a couple of months ago.

MR. ROBERTS: Audra, page 721 of the doctor's records.

BY MR. ROBERTS:

Q. Okay. Top of the page, your notes indicate that she was recently evaluated by Dr. Gross who was recommending repeat radiofrequency rhizotomy to lumbar spine and sacroiliac joint region up to two times per year if needed.

And this is from your record; right?

A. Yes, sir. My PA saw her that day.

Q. Did you agree with Dr. Gross's recommendation

that repeat rhizotomies were advisable for Ms. Garcia moving forward?

A. Correct.

Q. Now, Dr. Gross says up to two times per year if needed.

Do you agree with his estimate of frequency?

A. Absolutely, with a caveat.

Q. Okay.

A. You do it when the pain comes back. If you look in the literature, the standard average duration of improvement is 10 to 14 months. The range is six months to about two years. It's pretty standard in all the literature, and that's what I see in clinic. Most of my patients fall in the 10- to 14-month category. Some a little less, some a little more. I've actually seen two and a half years. But most people fall in right around a year. It could be six months, and we won't know until we see when her pain comes back and have to do it again. And then we establish a pattern. But invariably, you do it when the pain comes back. I've been doing this for years and have many patients that come back on an annual basis and get it done.

Q. So when Dr. Gross says up to six months -- up to every six months, you don't agree it's more likely than not she's going to need it every six months;

right?

A. Well, I don't know yet. We haven't reached six months yet. We're at five.

Q. Based on what you know now and based on the average duration that you've seen -- just for foundation, how many rhizotomies do you do annually?

A. I don't know. I do about three a week. So you do the math.

Q. Okay. So -- so three a week.

So it's fair to say that you do hundreds annually?

A. Correct.

Q. And thousands over the course of your career?

A. Correct.

Q. And on average, more likely than not, how -- what range do your patients fall in where they need a repeat rhizotomy?

A. Ten to 14 months.

Q. Okay. More likely than not, is Ms. Garcia going to need the rhizotomies in order to have pain relief for the rest of her life?

A. Yes.

Q. If Ms. Garcia does continue to receive rhizotomies for the rest of her life, is it more likely than not that she will still need the stimulator that

we've talked about, the permanent stimulator?

A. If --

MR. MAZZEO: Objection, Your Honor. Foundation. Speculation.

THE COURT: I think he's laid the foundation I'm going to allow it.

THE WITNESS: If she obtains satisfactory results from the rhizotomy, then that would be her preferential treatment going forward. She's indicated pretty clearly she would rather do rhizotomies and having a fabulous result from it than have an implanted stimulator. If for some reason something changes and the rhizotomies no longer work for her, for whatever reason, there's a whole laundry list of things, then the stimulator would be her next best option I think.

BY MR. ROBERTS:

Q. Okay. But that's if she stops the rhizotomies.

A. Right. I wouldn't do both.

Q. So more likely than not, she's going to need the rhizotomies; therefore, more likely than not, she's not going to need the stimulator.

A. Well, I don't know. I mean, lifetime's a long time. But as far as treatment algorithms, she's doing well from this. If something works, you go with

it. This is the least invasive approach for her. But if for some reason the rhizotomies are not working any longer and no other cause can be found, stimulator is a very good option. I would -- I would -- I would say it's a distinct possibility.

Q. Doctor, the -- the jury's now heard about just about monthly visits over several years now with Ms. Garcia; correct?

A. Correct.

Q. Was it necessary to see her that often in order for you to treat her medical condition?

A. Yes.

Q. What about moving forward? Do you see that same frequency of monthly visits for the rest of her life?

A. No.

Q. Tell the jury what you expect more likely than not she's going to need in terms of future care from you moving on into the future?

A. I would expect once --

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

THE COURT: Come on up.

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

THE COURT: We're going to go ahead and let you have your lunch, folks. Go till about 1:15 again.

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

See you back at 1:15.

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

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

Let Dr. Kidwell leave also and then put it on the record.

All right. So the issue is whether or not

I'm going to let Dr. Kidwell testify as to what he believes the plaintiff's going to need in terms of future care from him. My initial thought was I think with regard to a treating doctor, they can talk about diagnosis and prognosis and usually necessity of their own care as -- even if they haven't done an expert report. But I do have an issue because I can't let an expert -- or a treating doctor come in and talk about, by the way, I saw this patient 30 days ago, and my prognosis is I'm going to have to do another fusion surgery on them and it's going to cost another 3- or $400,000 and nobody knew about that till the testimony.

So how do I deal with that?

MR. ROBERTS: Well, I think this may be less insidious than your example because we -- we know from the patient's actual records and his actual recommendations for the patient over the last three years that he told the patient he wanted to see her every month. And that's the status of the record right now, I need to see you every month.

What he's going to say is that necessity to see her every month he hopes is going to go away after her next rhizotomy and she stabilizes and she'll no longer need to see her [sic] every month. So we're actually using this in order to help the defense and to

show them that he's not going to need to continue with the recommendations shown in his records from past treatment.

So I -- I wanted to do this out of fairness to them because I knew he wasn't going to keep seeing her every month. And I'm not going to ask the jury for something I know he doesn't think she needs. So in light of that, maybe -- maybe the objection is different, but even if they still object, I think given what his testimony is and that it's not something brand new that they weren't aware of, they've known all along about his monthly treatments, they contend his monthly treatments are unreasonable despite his recommendation, I think it's -- it's tied closely enough to his continuing treatment that it's within the scope of what I should be able to explore.

MR. MAZZEO: It sounds benign coming from Mr. Roberts, so -- I mean, that -- that might be okay because it may be consistent with Dr. Kidwell's most recent record that was disclosed to us December 9th of 2015 where in his treatment plan, he -- he recommends two things: One is continue current physical therapy regimen, and then to return one month for medications. So I mean, if that's what Mr. Roberts is -- is saying that Dr. Kidwell will testify to, that he actually

doesn't have a life-care plan or regimen for endless medication and treatment for this patient, then I'm fine with that, if that's what he's going to suggest.

THE COURT: Sounds to me like the expectation is the doctor's going to testify that the treatment isn't going to last forever. So I mean, based on that proffer --

MR. ROBERTS: I think he's going to say four times a year.

MR. MAZZEO: Visits with Dr. Kidwell four times a year?

MR. ROBERTS: Yeah.

MR. MAZZEO: Just for what, for management?

MR. ROBERTS: For management, and to manage the need for her next rhizotomy.

But as you can see, I don't think I need it. Dr. Oliveri is going to opine and has given opinions on the treatment -- on the number of office visits she's going to need for pain management. I'm happy just to rely on Oliveri, but ...

MR. MAZZEO: Yeah, that's fine. We can rely on Oliveri.

MR. ROBERTS: Right.

THE COURT: You don't want to have this doctor limit his future care?

MR. MAZZEO: Well, he hasn't said anything about future care at this point, so ...

THE COURT: What Mr. Roberts is saying is the records at this point show that she's going to continue to come every month. And what he's apparently going to say is that's -- in the future that's not what's expected.

MR. ROBERTS: Not likely. And -- and Mr. Smith maybe pointed out something that I overlooked. He did say, I think, that they were going to reduce without objection. So he's already on record without objection saying that they're going to reduce in the future. So maybe he should be entitled to explain what that reduction is since that's come in without objection.

MR. MAZZEO: And so is he saying that he'll need to see her four times a year for the rest of her life?

MR. ROBERTS: Yes.

MR. MAZZEO: That's his recommendation?

MR. ROBERTS: That's what he told me last night.

MR. MAZZEO: If you can -- if you can say that that's his -- or if you can give an instruction to the jury that that's his best guess or that's merely

speculative, because he doesn't know whether he'll have to see her for the rest of her life obviously.

THE COURT: Why don't we do this: Why don't you ask the question something to the effect that you indicated that in the future, your treatments are going to reduce in frequency. Can you explain that? Just leave it at that. And that way, we're not getting some new opinion that there's additional treatment that he hasn't talked about --

MR. ROBERTS: Only an opinion that's going to reduce.

THE COURT: You can let Dr. Oliveri talk about what the future needs are as far as his life-care plan. And that way, we can guarantee that we're not getting a new opinion from him as far as additional treatment that's needed. If anything, he's going to reduce it. But that allows him to explain it, I think.

Is that fair?

MR. ROBERTS: That sounds fair to me.

THE COURT: You guys okay with that?

MR. MAZZEO: That's fine. That's fine.

THE COURT: Anything else on the record?

MR. MAZZEO: No, Your Honor.

MR. ROBERTS: No, Your Honor.

THE COURT: All right. Off the record.

Thanks, guys.

(Thereupon, the proceedings concluded at 12:09 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 Friday, February 19, 2016, at 9:20 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 19th 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

PROCEEDINGS

BEFORE THE HONORABLE JERRY A. WIESE, II

DEPARTMENT XXX

DATED MONDAY, FEBRUARY 22, 2016

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

APPEARANCES:

For the Plaintiff:

GLEN J. LERNER & ASSOCIATES
BY: ADAM D. SMITH, ESQ.
4795 South Durango Drive
Las Vegas, Nevada 89147
(702) 977-1500
asmith@glenlerner.com

- AND -

WEINBERG, WHEELER, HUDGINS, GUNN & DIAL,
BY: D. LEE ROBERTS, JR., ESQ.
BY: TIMOTHY MOTT, ESQ.
BY: MARISA RODRIGUEZ-SHAPOVAL, ESQ.
6385 South Rainbow Boulevard
Suite 400
Las Vegas, Nevada 89118
(702) 938-3838
lroberts@wwhgd.com

For the Defendant Andrea Awerbach:

MAZZEO LAW, LLC
BY: PETER MAZZEO, ESQ.
BY: MARIA ESTANISLAO, ESQ.
631 South 10th Street
Las Vegas, Nevada 89101
(702) 382-3636

For the Defendant Jared Awerbach:

RESNICK & LOUIS
BY: ROGER STRASSBURG, ESQ.
BY: RANDALL W. TINDALL, ESQ.
5940 South Rainbow Boulevard
Las Vegas, Nevada 89118
(702) 997-3800

* * * * * * *

I N D E X

LAS VEGAS, NEVADA, MONDAY, FEBRUARY 22, 2016;

10:28 A.M.

P R O C E E D I N G S

* * * * * * *

THE COURT: Let's go on the record, Case No. A637772. We're outside the presence of the jury.

What do we got?

MR. MAZZEO: Well, do you want to go first?

MR. TINDALL: Sure. I don't know if Your Honor has gotten a copy, but we filed this morning a trial memorandum regarding the use of the videotape deposition in lieu of live testimony.

I got word that maybe plaintiffs were going to, instead of examining Mr. Awerbach, just play his videotape deposition. And we submit, pursuant to NRCP 32(a)(3)(A), that's not allowed because he's in the jurisdiction; he's sitting right here; he's not unavailable. A deposition can be used only for impeachment, and you can't use it in lieu of live testimony.

MR. MAZZEO: We join in that argument, Judge.

MR. SMITH: Well, that ignores -- they skipped right over 32(a)(2), which specifically says

that the deposition of a party may be used by an adverse party for any purpose. We can play it at any point we want to in trial.

MR. TINDALL: But that can only be read in conjunction with the next part. There's only certain situations in which it can be used for that purpose: 100 miles from the jurisdiction, unavailable for some other reason, dead, or trying to hide the guy.

He's sitting right here. It can't be done.

Also, they cannot do what they did with the DMV representative, which is play a snippet of someone else's deposition testimony in the question and then essentially ask that person, "Is what you just heard right?"

That's what they did with the DMV rep, played Andrea Awerbach's deposition snippet, essentially asked her, "Do you agree with that?" That's -- that's impermissible.

MR. SMITH: 32(a)(3) applies to the use by any party. 32(a)(2) applies to the use by an adverse party. So we are an adverse party. We can use the deposition for any purpose.

That is not an ambiguous provision, and it does not say subject to the sections -- or subject to the provisions of 32(a)(3). It specifically says "for

any purpose." And -- and it has to do with the use by an adverse party as opposed to whether they could use potentially their own client's deposition or a codefendant's deposition if the codefendant was not available for one of the reasons laid out in 32(a)(3).

THE COURT: So what section are you referring to, Mr. Smith?

32(a)(2) talks about officer, director, managing agent under 30(b)(6). I don't think that's what you are referring to.

MR. SMITH: You're right. Maybe I don't have the right statute -- or the right provision.

THE COURT: I mean, it does say that if you have a 30(b)(6) witness --

MR. SMITH: Oh, that is the right provision.

THE COURT: -- that the deposition -- that it may be used by an adverse party for any purpose.

MR. SMITH: Now, if you read the first sentence, Your Honor, it says, "The deposition of a party or of anyone who at the time of taking the deposition was an officer, director," et cetera.

So I was reading the right provision. And it's an "or" provision. So we can use the deposition of a party or of a 30(b)(6) witness, which is obviously not relevant in this case, for any purpose as long as

they're adverse.

THE COURT: How do I read that in conjunction with (3)?

MR. SMITH: So (3) says, "The deposition of a witness, whether or not a party, may be used by any party for any purpose if one of these things applies."

So 32(a)(2) applies to the use of the deposition of an adverse party. 32(a)(3) applies to the use of any deposition of a witness if that witness is unavailable.

So if we were trying to say that Mr. Awerbach was unavailable and maybe Ms. Awerbach wanted to use his deposition, she would have to comply with 32(a)(3). Since we are an adverse party, we may use his deposition for any purpose.

And 32(a)(2) does not say subject to the provisions of 32(a)(3) or subject to the unavailability of the witness. It says, "The deposition of an adverse party may be used for any purpose."

THE COURT: It does seem to say that. I haven't looked at your brief yet.

This doesn't have to be decided this morning; right?

MR. TINDALL: I don't think so, unless they're about to call Jared Awerbach.

THE COURT: You guys are going to call Dr. Oliveri today?

MR. ROBERTS: We are.

When they were thinking their cross might not last quite as long as some of the other doctors, we'd indicated that, if we had some time at the end the day, we might play Jared's deposition. So I think that's what triggered this.

MR. MAZZEO: Right.

MR. ROBERTS: But it doesn't look now like we're going to have that extra time. So we probably don't need to address it.

THE COURT: I'll look at your brief later.

MR. TINDALL: Thank you.

MS. ESTANISLAO: Your Honor, there's one more. I understand they may be calling Dr. Smith tomorrow. I did -- we did file a motion regarding -- or a trial brief regarding Dr. Smith's testimony. He has been recently excluded by Judge Johnson in another case.

THE COURT: I read that. That's in a binder; right?

MS. ESTANISLAO: Yes.

THE COURT: Yeah. That was in a binder.

MS. ESTANISLAO: Yes.

THE COURT: I read that one last week. I don't know that that has to be dealt with right now either while our jury is waiting; right?

MR. MAZZEO: Do you want to -- because he's being called tomorrow morning, Judge, do you want to designate a time, either when we break at noon or when we come back from lunch, as to when we can discuss that?

THE COURT: Maybe. Maybe I'll give the jury an hour and 15 minutes and just give you guys an hour for lunch and we can talk about it then.

MR. MAZZEO: Okay.

THE COURT: Fair enough?

MR. ROBERTS: Fair enough.

MR. MAZZEO: Yeah.

THE COURT: Other than that, are we ready to go?

MR. MAZZEO: Yes.

MR. ROBERTS: We are, Your Honor.

THE COURT: Let's see if we can get a witness done today.

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.

Do the parties stipulate to the presence of the jury?

MR. ROBERTS: Yes, Your Honor.

MR. MAZZEO: Yes, Your Honor.

MR. TINDALL: Yes, Your Honor.

THE COURT: Sorry for the delay, folks. My calendar ran a little later than I had hoped this morning.

Have we finished Dr. Kidwell this week? We did not.

MR. ROBERTS: We did not, Your Honor.

THE COURT: We had to break halfway through the day Kristy got sick. And we can't go forward without a court reporter. So sorry for doing that to you on Friday. Hopefully it didn't bother anybody that bad that we gave you an early out on Friday.

We will finish Dr. Kidwell eventually. We've done that with several different doctors now. I don't believe he's coming back first thing this morning. I think we have a different doctor today that will be taken out of order. So just remember what all these people say. You'll get a chance to hear the ending of

their testimony eventually. I'm sure that will happen.

So who's your next witness?

MR. ROBERTS: Thank you, Your Honor.

Plaintiff would call Dr. David Oliveri.

THE COURT: Good morning, Doctor. I'm going to have you step all the way up on the witness stand, if you would. Once you get there, please remain standing and raise your right hand to be sworn.

THE CLERK: Do you 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: Once you take your seat, please state and spell your full name for the record.

THE WITNESS: Dr. David Oliveri. D-a-v-i-d. Last name, O-l-i-v-e-r-i.

THE COURT: Thank you. Go ahead.

DIRECT EXAMINATION

BY MR. ROBERTS:

Q. Thank you, Your Honor.

Dr. Oliveri, could you tell the jury about your education, starting with college.

A. Sure. I have a bachelor's degree in biology

from the University of Washington in Seattle, 1985. I then attended medical school at the University of Southern California in Los Angeles, completing medical school in 1989.

I then did my internship at the veteran's hospital in West Los Angeles, which is a one-year program, completing in 1990. I then did my residency training at Stanford University in Northern, California, completing that in 1993.

I moved to Las Vegas in 1993. I have been a practicing physician in my specialty of physical medicine and rehabilitation since that time.

Q. And did you have any position in your last year of residency at Stanford University?

A. I did. I was the chief resident at Stanford during my last year, which is a -- a title where you, in addition to being a -- being a physician training, I also had an administrative role to supervise the other residents for that year.

Q. Thank you, Doctor. Could you tell the jury about your board certifications?

A. Yes. I am board-certified in my field of expertise, which is physical medicine and rehabilitation. I have been board-certified since the first year possible, which was 1994.

Board certification is the highest level that a physician can attain in their field. It means that you've completed your training. It means you've been in practice for a certain period of time, you have submitted examples of your work to the entity, which is called the board. It's a group of physicians that are the top of your field where they review that work.

You then sit for an oral examination and a written examination. And if you pass those, you are deemed board-certified for a period of ten years. After ten years, you have to repeat the certification process. And I have repeated that twice in my main field.

I am also board-certified in a subspecialty called electrodiagnostic medicine. Electrodiagnostic medicine is a subspecialty that involves the study of nerve disease and disorder as well as muscle disease and disorder. It involves doing nerve testing on the body. And I've been board-certified since the first time possible, which was 1995. And I have been recertified twice in that field as well.

Q. Thank you, Doctor. Could you tell the jury a little bit about what a physiatrist does, a doctor who specializes in physical medicine and rehabilitation?

A. Physicians in my specialty are trained to

diagnose and treat individuals that have orthopedic, musculoskeletal, and neurological disorders, injuries, and illnesses.

I will tell you what I have done in my specialty with that training. I have been a physician associated with a rehabilitation hospital since I have been in practice. The name of that hospital currently is called HealthSouth. It's a rehabilitation hospital on Valley View Boulevard.

My association with that hospital has been as medical director -- associate medical director initially, medical director for 15 years. And then I stepped down a few years ago, and I have been the president of the medical staff since that time.

During my time with that hospital, I admitted and treated thousands of patients that have had problems such as spinal cord injury, stroke, traumatic brain injury, orthopedic injuries, neurological disorders, multiple sclerosis, Parkinson's. The patient would be admitted to me or the doctor such as me, managed medically, and then treated by therapists in order to maximize their level of function and hopefully return home.

I've had an active outpatient practice since 1993 coming to Las Vegas where I diagnose and treat

patients with spinal injuries, spinal pain, orthopedic problems, evaluate patients that have had injuries at work, injuries outside of work. I've also been involved evaluating patients with disabilities, doing impairment ratings for workers' compensation or work-injured individuals, doing nerve testing, diagnosing and treating nerve problem.

And then also I've been interested over the years in forensic evaluations, which is a medical-legal analysis of injury and illness determining if a person was injured in a particular event, determining -- determining appropriateness of care, the appropriateness of their medical billing, whether they have ongoing limitations relative to an injury, whether they have future medical needs associated with that injury.

Q. Thank you, Doctor. You mentioned a subspecialty certification as a certified independent medical examiner.

Could you tell the jury a little bit more about how you use that in your practice?

A. The certification as an independent medical evaluator is a specialized training in order to assist in performing impairment evaluations, determining the percentage of impairment an individual has relative to

an injury, and also in receiving training in how to properly perform forensic evaluations, which is what I did here with Ms. Garcia evaluating some of those items that I just mentioned: injuries that were potentially caused by an accident, future medical needs, appropriateness of care and billing.

Q. Could you -- you mentioned that you do work with people who have spine injuries?

A. Yes.

Q. What percentage of your practice has been in helping people with injuries to the spine?

A. Well over half of my practice over the last 23 years has been dealing with spinal injuries.

Q. Could you tell the jury what a life-care plan is?

A. A life-care plan is a report that provides an analysis pertaining to the future medical needs of a patient relative to a particular diagnosis or event.

So, for example, if a person has an injury and they have a particular problem or problems from that injury, a life-care plan is research regarding what future medical care that person will need relative to those diagnoses. It tells the reader of that report the exact items of care that the person will likely need in the future, the cost of that care, when the

care will be provided, and the duration of the care.

It will provide only those items that are likely to occur, that are reasonably certain to occur, and it will provide some information as to the basis for that opinion and the basis for how those items were obtained and the costs obtained.

Q. Doctor, do you regularly prepare life-care plans as part of your practice?

A. I do. As part of my forensic work, I perform life-care plans on a regular basis, and I have been doing so for probably 15 years.

Q. Approximately how many life-care plans per year do you estimate you prepared over that 15-year period?

A. I -- I perform them on a weekly basis. So I probably perform maybe 40 a year, something like that.

Q. Thank you, Doctor.

MR. ROBERTS: Your Honor, we'd ask the Court to recognize Dr. Oliveri as an expert in physical medicine and rehabilitation as well as life-care planning.

MR. MAZZEO: No objection, Judge.

MR. TINDALL: No objection, Your Honor.

THE COURT: He'll be so recognized.

MR. ROBERTS: Thank you, Your Honor.

BY MR. ROBERTS:

Q. Doctor, the jury's heard from several of Ms. Garcia's treating physicians who've already testified here in court.

Are you a treating physician for Ms. Garcia?

A. I am not.

Q. Okay. What is your role in -- in this case?

A. My role has been that of a medical expert, an evaluator to perform a forensic evaluation. I was asked to evaluate Ms. Garcia initially back in -- excuse me -- 2013.

I was asked to see her face-to-face. I was asked to review voluminous medical records and bills, and I was asked to provide my opinions about whether or not she had any injuries in the subject accident, whether she had medical care that was reasonable, whether the bills were appropriate, whether she had any need for future care.

Q. Thank you, Doctor. Could you tell the jury a little bit more detail about your foundation for the opinions you're going to give today?

In other words, what were the things that you did and looked at in order to provide the opinions that you're going to share with them later?

A. Certainly. I have done many things since I

initially evaluated Ms. Garcia in June of 2013. So we're going on almost three years since the first time I saw her.

But initially I had her come to my office. She completed some intake forms, so I was able to get some information about her perception of symptoms and problems that she had before and after the motor vehicle accident that occurred in January of 2011. I spent time with her face-to-face. I spent approximately one hour with her face-to-face asking questions about her history, her symptoms, her problems. I did a physical examination on that day, and then I reviewed a number of medical records that were available up until that point in time.

Do you want me to explain what records I had at that time?

Q. Yes. If you could summarize for the -- for the jury what records you've reviewed.

A. I reviewed records such as the traffic accident report, the emergency room records, chiropractic records after the accident, X ray and MRI studies, records of Dr. Cash, records of Dr. Gross, records from Dr. Lemper, records pertaining to injections that Ms. Garcia had, records from Dr. Kidwell, records pertaining to the lower back

surgery that she underwent in December of 2012.

MR. MAZZEO: Excuse me, Your Honor. I would object to the witness reading from a report that's not in evidence. He can use it to refresh his recollection only.

THE COURT: No, that's true, but I think this is foundational in nature. I'm going to let him do it.

MR. ROBERTS: Thank you, Your Honor.

THE WITNESS: I also reviewed medical billing associated with that medical care that I just mentioned. I then considered all of that information and developed opinions in those categories that I had mentioned earlier.

I came to conclusions about whether or not I thought Ms. Garcia was injured in the accident. I came to conclusions about what injuries I thought she had as a result of the January 2011 accident. I looked at what medical care I thought was reasonable. I looked at the billing. I looked at her current status. I looked at her future medical needs.

BY MR. ROBERTS:

Q. Doctor, when you say you looked at her medical billing from her treating physicians, what sort of background, experience, or data do you apply in order to determine if a medical bill you're looking at

is reasonable and customary?

A. As a practicing physician for almost 23 years, I have reviewed thousands of medical bills over that period of time. In addition, as part of my forensic work, my medical-legal work, I have been asked by many parties, by plaintiffs and defendants, over many years, to scrutinize medical bills and consider whether they were reasonable for what was done.

I have employed information consisting of database information to assist in my analysis of those bills. I have looked at databases that tell me where those charges sit in terms of percentiles. Are the charges somewhat in the middle of the community for what they did? Are they on the low side? Are they on the high side? Or are they higher than the high side of what the charges are?

I have databases that look at hospital charges for our community as well as other communities throughout the United States. I can tell if hospitals are charging what similar hospitals charge for that same type of work on a particular diagnosis. So that's the methodology that I use to come up with my conclusions about whether bills are reasonable for the work that was done in the community where it was done.

Q. You mentioned that you did work or you're

asked to do work for both plaintiffs and defendants in litigation?

A. Yes.

Q. Approximately what percentage of your practice as an expert would you say is for plaintiffs versus defendants?

A. I definitely spend more time in my practice doing work -- the amount of hours that I spend is more time consuming on the plaintiff work because of the time I spend doing the life-care plans. I would say, though, that the number of actual forensic cases I do is probably maybe 60 percent plaintiff, 40 percent defendant. I spend a little bit more time on the plaintiff work, however.

Q. And have I retained you on cases in the past?

A. I think your office has, yes.

Q. And in those cases, were you being retained for the defense or the plaintiff? Do you recall?

A. For the defendant.

Q. So you mentioned the physical examination of Ms. Garcia. Let's go back and talk a little bit more about that. Did you perform what you term a comprehensive medical examination of Ms. Garcia?

A. Yes.

Q. And could you explain to the jury what the

findings were based on your evaluation of Ms. Garcia at the initial medical examination of June 4th, 2013?

A. She had a well-healed scar on the midline of her lower back that measured 8.5-centimeters. I measured her lower back range of motion. I used an electronic device that gave me specific degrees of motion. She had some decreased range of motion in her lower back. Her lower back extension bending backward was 18 degrees. And her lower back flexion was 38 degrees. That's about a 50 percent reduction in her lower back motion. She had some symptoms of tension and pulling at the end range of both directions. She had had some tingle to touch sensation over the thigh on the right side. She was having some complaints of numbness and pain in her right leg. She had normal strength in her right lower extremity. She had normal reflexes, and she had a normal gait. Gait is analysis of her walking.

Q. Thank you. And just for context, at the time you first examined Ms. Garcia, had she already undergone her spinal fusion surgery?

A. Yes.

Q. Did you ever see her before her surgery?

A. No.

Q. Did Ms. Garcia take any pain questionnaires

during her initial medical evaluation?

A. Yes.

Q. Could you explain what that is to the jury and the questionnaires that you had Ms. Garcia fill out.

A. Yes. I had her complete some questionnaires that help me with the forensic evaluation to assist in looking at how Ms. Garcia perceives her symptoms. So, for example, I had a pain diagram where she placed marks on the pain diagram where she's having symptoms of pain. I used that particular test to see if this is a patient who accurately portrays the areas where they have pain. Are they putting marks just in the area of the lower back and in the leg where they say they have pain, or are they marking it up front and back all over as a person that might magnify or overstate pain would do? And she had markings that were very specific for the lower back and the right leg in an appropriate manner.

Q. And what did that tell you, Doctor?

A. That she wasn't a magnifier of symptoms. She appropriately portrayed her symptoms on that test.

I had her complete a pain diagram. This is where you ask on a scale of 0 to 10, tell me where your pain is today, and tell me over the last 30 days what's

your lowest and what's your highest. I do this to see, again, whether the person is portraying their symptoms in a reasonable fashion based on what's wrong with them. Are they portraying their symptoms too low or too high? And her score was a 4 out of 10 when I saw her with a range of 4 to 9. I thought that was appropriate.

Q. And the first questionnaire that you described to the jury, is that -- what is that known by?

A. Pain diagram.

Q. Okay. Any other questionnaires that you had Ms. Garcia fill out that day?

A. I had her fill out a McGill Pain Questionnaire, which is a self-reporting test where a person circles words that describe their pain. Her score was 8, which was a relatively low score, again, meaning that she is not magnifying her symptoms.

Q. Do you still use the McGill Pain Questionnaire?

A. I have actually decided not to use that anymore. I was having a hard time finding a -- a reference to validate the scores, and that's the reason why.

Q. Okay. Any other ones? I see one more here

on my notes.

A. I had a low back disability questionnaire. It's called the Oswestry, and I had her complete that. Her score was 32 percent. And the score for 32 percent is someone who perceives moderate disability because of their lower back condition, which I thought was a reasonable or appropriate score for her lower back problem.

Q. And is this a fairly detailed exam or relatively short and quick? The Oswestry.

A. It's -- it takes a few minutes for the patient to -- to complete. It has a total of ten items. They have to read five -- five or six different items on each of those ten items. It takes -- it takes a few minutes.

Q. Do you find that to be reliable?

A. It is. It's highly validated. It's been in the spine literature for a long time.

Q. Okay. As part of your medical review, did you attempt to determine whether Ms. Garcia had any injuries or known medical problems with her lumbar spine or lower back prior to the collision of January 2nd, 2011?

A. I did assess that issue, and to the best of my knowledge, she had no symptoms or injuries or

problems with her lower back before the accident.

Q. Based on your review of her medical records and your physical examination, did you reach any conclusions as to Ms. Garcia's physical condition and any injuries she might have sustained on January 2nd, 2011?

A. I did.

Q. Could you tell the jury about that.

A. Of course. My final conclusion is -- was and is that, as a result of the January 2011 accident, that Ms. Garcia sustained a lumbar or lower back injury involving the L5-S1 segment, and specifically I determined that it was a motion segment injury to the L5-S1 level.

And specifically what I mean by motion segment is that she had injury to both the disk at that level, and the facet joints, which are the small joints at the back side of that -- of that motion segment.

She also had a secondary problem of some neck pain which was a relatively minor problem. I thought that it may have been just soft tissue injury. It may have been something more significant. But it was a relatively minor problem.

Q. The jury has heard about the spondylolisthesis that Ms. Garcia had shown on her MRIs

from after the accident. Did you make a determination more likely than not whether Ms. Garcia's spondylolisthesis was preexisting? Was it present before her accident?

A. It was my conclusion that, at least to some extent, she had a spondylolisthesis, meaning where the anatomy -- the L5 was offset compared to S1 to some extent before the January 2011 accident. However, it was my conclusion that this was not causing her symptoms before the accident.

I did not rule out the potential that the motor vehicle accident caused that offset to become more as a result of the accident, but she had the offset before.

Q. When you say she had the offset before, more likely than not?

A. Yes.

Q. And is it -- is it possible for anyone to determine the extent to which that offset or slip had occurred prior to the accident?

MR. MAZZEO: Objection. Speculation. Foundation.

THE COURT: I'm going to let him testify what his understanding is.

THE WITNESS: The only way that you can tell

for sure is if there was an X ray done or an MRI scan done right before the -- the motor vehicle accident.
BY MR. ROBERTS:
Q. Okay. And is there one?
A. No.
Q. You told the jury that in your opinion, the spondylolisthesis was asymptomatic prior to the automobile collision.
A. Yes.
Q. Could you tell the jury what that's based on.
A. It is based on three things: It's based on Ms. Garcia telling me by history that she did not have problems, symptoms, injuries with her lower back before January 2011; it's based on the absence of reviewing medical records that identify or show me that she had problems before; and it's based on my education and experience and understanding of medical research where it is known that individuals commonly have this type off offset and have no symptoms whatsoever. So those three factors.
Q. How common is it for someone with a spondylolisthesis to have no symptoms?
A. It's exceedingly common. Patients can have X rays done of their pelvis or their body for unrelated reasons, and have such a finding identified. There

have been a number of medical studies that identify that phenomenon.

Q. And when you say it's common to have no symptoms, are you just talking about pain or are you talking about any symptoms, such as weakness, irritation, soreness?

A. Bless you. I'm talking about lower back pain. I'm talking about radiating symptoms into the legs. I'm talking about things that would be associated with a problem associated with that offset.

Q. So more likely than not, most people with a spondylolisthesis are not going to have any of those things?

A. Correct.

Q. As part of the scope of your assignment as an expert, were you also asked to review reports that were issued by experts hired by the defendants?

A. Yes.

Q. And could you tell us which reports you reviewed.

A. I have reviewed reports from a Dr. Klein, I have reviewed reports from a Dr. Poindexter, I have reviewed reports from a Dr. Odell, and --

Q. I think that's --

A. Correct me if I'm wrong, I think that's it.

Q. I think that is it. And is it correct that Dr. Poindexter agrees with you that a person can have spondylolisthesis without pain?

A. Yes.

Q. So this preexisting spondylolisthesis, which you believe that Ms. Garcia had, even though it was asymptomatic, in your medical opinion, would this structural phenomenon have increased her risk of developing symptoms in an automobile collision?

A. I want to make sure I understand your question. Are you asking me if she was potentially more susceptible to injury at that level because of this accident or because of having it?

Q. Yes, because of having it.

A. Yes.

Q. Okay. Could you explain that to the jury, Doctor.

A. Sure. And I think this is probably a -- physicians could probably differ on this, but the -- the most resilient spine is a spine that has perfect anatomy. It's the spine that is perfectly aligned. It's the spine that has no age-related change of any sort of wear and tear. It's probably the young, perfect spine.

If the spine has some alteration anatomically

to it, whether it's some offset, whether it's some age-related change to either the disks or the facet joints, there is at some point more susceptibility to injury or a problem following trauma.

Q. We've heard evidence that Ms. Garcia reported no injury at the accident scene and reported no significant pain until three days after the accident. Is that significant, in your opinion, with regard to whether the collision caused her aggravation in symptoms?

A. It is certainly a -- a factor or a piece of information that I considered. But looking at all of the pieces of data, it -- it does not concern me, given the type of ultimate injury and type of ultimate diagnosis that was made. And I can further elaborate, if you wish.

Q. Please -- please tell the jury the conclusions you reached as to whether or not the pain and the medical treatment that Ms. Garcia received after the June 2nd, 2011, collision was caused by the collision.

A. Okay.

Q. January. Correct the record. January 2nd, 2011.

A. Very good.

Q. Thank you.

A. There are some types of injuries from trauma that develop immediate symptoms. There are, for example, fractures; somebody breaks a bone in a motor vehicle accident, that person is probably going to have immediate symptoms. Somebody has a dislocation of part of their spine, that person is probably going to have immediate symptoms. A person has a disk injury to their lower back where the disk actually ruptures and herniates, and there's compression on a nerve root, that person is probably going to have immediate onset of symptoms.

However, Ms. Garcia did not have one of those types of problems that developed immediately. She had a different type of injury that involved the disk that would not be unusual to gradually develop symptoms over time. And I actually brought a small model of a disk that I could show the jury, if -- if that's possible.

MR. ROBERTS: Your Honor?

THE COURT: Go ahead.

MR. ROBERTS: Thank you.

THE COURT: If that will help.

THE WITNESS: So what I have in my hand is just a small model of part of the lower back. So the orientation of this would be in this position. And I'm

going to hold it in this position. So my finger right here is on the front side of the fifth lumbar or lower back vertebrae. And then the fourth, third, second, and first. So this is all the lumbar spine of the lower back.

This is cut away so you can see some of the -- the inside part of the bones. And then, in between the individual bones -- the individual bones are the disks. And I've got my finger resting on one of the disks in the lower back.

So if you just imagine that I'm going to pluck that disk out and -- and show you what it looks like in my hand, I've got a disk model that shows an example of a disk that actually is ruptured and herniated. Okay?

So this disk would be in the position where my hand is located. And what you'll see is the outer fibers of the disk are made up of a very rigid type of material. It's called the annulus fibrosis. And you can see on this model almost rings that are represented by that model. The inner part of the disk is the nucleus, and the nucleus is more of a gel-like substance. On this model, you can see that on the side where my index finger is located, the annular fibers are completely torn through and through, and the

nuclear material has actually herniated through, and there's a big glob that I'm holding.

If a person has an acute injury to the disk that involves a rupture and it's something that's this large, it is going to actually compress immediately a nerve root. And that person, at the scene of the trauma, is going to have that nerve that it's compressing become painful, and they're going to develop immediate symptoms down their leg.

So that's going to be an example of someone who, after a motor vehicle accident, is going to have the onset of symptoms, terrible pain down their leg, and they actually might -- depending on how much compression, might have weakness, they might have foot drop, they might have a very serious problem that might even be a surgical emergency.

Ms. Garcia's injury was an injury in part to those fibers, but it didn't tear all the way through. In fact, we know from medical research that it's just the outer third of these fibers that receive nerve supply. And it's the outer third of these fibers that allow us to sense pain.

So we knew -- we know from the eventual -- eventual studies that were done on Ms. Garcia that she had eventually tears that reached almost to the edge of

the disk, but not through. It was never through.

So it made sense to me that she was in this accident, she began to develop tears of the disks, the tears have to start somewhere. And they worked their way out to the edge. And the working out to the edge process can take hours, it can take a day, it could take a couple of days, and so the gradual onset of developing symptoms and then going to the emergency room at three days is consistent with the type of injury that she had to the disk.

MR. MAZZEO: Your Honor, may we approach, please?

THE COURT: Sure.

MR. MAZZEO: Thank you.

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

THE COURT: At this point, the objection's overruled.

BY MR. ROBERTS:

Q. And, Doctor, we were talking about your comprehensive medical examination of 2013. The jury has heard that Ms. Garcia continued to treat after that date of your examination.

A. Yes.

Q. Tell the jury what you did to keep up with

her ongoing treatment as she continued to treat for these problems.

A. I did many things. I received medical records pertaining to her ongoing treatment. I had the opportunity to reevaluate her on a face-to-face basis. I had the opportunity speak to her by telephone on more than one occasion. And as I received the -- these new pieces of information, I would update my findings.

Q. And did you draft a report which we shared with the defendants after your initial comprehensive medical examination?

A. Yes.

Q. And as you continued to review records, did you periodically update your reports with the new information?

A. Yes.

Q. How many supplemental reports did you issue in this case, Doctor?

A. Many. I have ten supplemental reports.

Q. In the course of your practice, is that a lot? Is that unusual?

A. I have never -- in the probably 18 years I have been doing forensic work, I have never had a file I have worked on that has had that many reports.

Q. Based on your review of the records, I'd like

to go through the treatment that Ms. Garcia received and have you give the jury your opinion about whether it was reasonable and causally related to the motor vehicle collision.

A. Okay.

Q. So let's start with MountainView Hospital, the emergency room. Did you review the records of that treatment?

A. I did.

Q. And do you recall what the clinical impression of the treating physician at MountainView was of Ms. Garcia's condition?

MR. MAZZEO: Objection to the expert reading from a report before he gives an answer, Judge.

THE COURT: Sustained.

BY MR. ROBERTS:

Q. So my question is, do you recall?

A. I would have to look at the record to reflect -- refresh my recollection.

MR. ROBERTS: Okay. Your Honor, permission for the witness to refresh his recollection from the record.

THE COURT: That's fine.

THE WITNESS: (Witness reviewing document.)

The clinical impression was that of low back

strain and motor vehicle --

MR. MAZZEO: Objection. Your Honor, the doctor can't read from an expert report that's not in evidence. He can refresh his recollection only.

THE COURT: That's true. Sustained.

BY MR. ROBERTS:

Q. So were you quoting from the record of MountainView or from your notes regarding that?

A. I refreshed my recollection, and I was telling you what that was.

Q. Okay. And it was low back strain?

A. Yes.

Q. And do you agree with that diagnosis?

A. Well, ultimately, she was found to have more than a low back strain. "Low back strain" is a general term that's commonly used in the emergency room setting when an individual is not found to have a fracture or something more severe, so it was an appropriate diagnosis at that time. Ultimately, she was found to have something much more significant.

Q. And strain, is that muscle or ligament?

A. It could be either. Something in the soft tissues.

Q. Did MountainView Hospital take any MRIs or X rays of Ms. Garcia's spine?

A. I would have to glance at my record, if that's okay.
Q. To refresh -- you need to do that to refresh your recollection, Doctor?
A. Yes. I don't recall them taking any radiographic studies.
Q. Okay. Have you reviewed the records of a chiropractor, Dr. Gulitz?
A. Yes.
Q. And could you tell the jury, in general, what type of treatments the chiropractor provided to Ms. Garcia?
A. Sure. The chiropractor did chiropractic modalities, which were things like hot packs, and things to make the symptoms feel better. And also provided chiropractic adjustments. Bless you.
Q. Did the chiropractor do anything which could have caused the spondylolisthesis?
A. No. Not at all.
Q. Did the chiropractic treatment resolve Ms. Garcia's pain?
A. It did not.
Q. Was it reasonable treatment based on Ms. Garcia's symptoms?
A. Absolutely. At that stage, it was a

reasonable treatment in an attempt get her symptoms better. When the symptoms didn't resolve, then it was appropriate to move on to the next step.

Q. So when Ms. Garcia's symptoms didn't resolve, have you reviewed the records where the chiropractor referred Ms. Garcia to Dr. Cash?

A. I did.

Q. Okay. And are you aware of the recommendations made by Dr. Cash at that time?

A. Yes. My recollection is that Dr. Cash identified that this was something more than a back strain, and made a recommendation for a pain management referral.

Q. Was it appropriate for Ms. Garcia to -- to see a -- a spine surgeon like Dr. Cash at that point in her treatment?

A. Absolutely.

Q. Did you review the records of the second spinal surgery opinion provided by Dr. Gross, a neurosurgeon?

A. I did.

Q. Okay. Was it appropriate for Ms. Garcia to seek a second opinion with regard to the recommended surgery?

A. Of course.

Q. Could you explain what standard practice is in the community for a significant surgery like this.
A. Certainly. Depending on the individual patient, it's certainly reasonable for a person to get a second opinion by a different surgeon. They can get three opinions. It really makes no difference to me when it comes down to choosing a surgeon.
Q. So this is a reasonable and customary charge for a patient to incur?
A. Absolutely.
Q. Now, the jury's heard about Dr. Gross's recommendation, that he also recommended that Ms. Garcia proceed with a fusion surgery, just like Dr. Cash.
A. Okay.
Q. And do you know if Ms. Garcia proceeded immediately to get that surgery?
A. Surgery was not until 2012. Dr. Gross saw her in 2011, so was there a -- a waiting period. She tried some other things first.
Q. Okay. And one of the things she tried was with Dr. Lemper. Are you familiar with his records?
A. Yes, absolutely.
Q. Was it -- was it reasonable for Ms. Garcia to go see Dr. Lemper and incur those charges rather than

proceeding immediately with the surgery?

A. Of course.

Q. Tell the jury why you believe that.

A. Dr. Lemper tried some injection therapy. The injections had consisted of injecting some medication that may have given her some therapeutic benefit. It may have helped her decrease her pain to the point that perhaps she didn't need surgery. Unfortunately, it didn't work. So having her try that route, initially, was a reasonable attempt.

Q. The records from Dr. Lemper indicate that he performed nerve root blocks, among other items. Are nerve root blocks indicated for myofascial sprain-strain?

A. No.

Q. Why not?

A. Myofascial sprain-strain is a type of injury that just involves -- so, for example, just involves the muscles and soft tissues that overlie the deeper structures of the spine.

The types of injections that Dr. Lemper performed were deep injections that were guided by an X ray machine to actually address the structures around the disks, and so you're performing injections that Dr. Lemper performed to address injury to a disk. That

does not have anything to do with soft tissues that overlie this area. So you would never perform a nerve block for a person that just had a soft tissue sprain or strain. You're treating separate -- separate problems.

Q. You indicated to the jury initially that you believe there was a motion segment injury. Could you tie that in again to the nerve root blocks, what that's treating versus the facet blocks? And just -- I don't believe the jury's heard that term before, "motion segment," by the other physicians.

A. The term "motion segment," it's -- it just simply means that -- what you can't see on the model that I showed you earlier is that the lower back vertebrae and disks actually have movement. That movement is accomplished because there is movement at the disk itself, and there's movement at the small joints on the back side of the spine, which are called facet joints.

So every segment -- a segment is two vertebrae that are held together basically between -- with one disk and two facet joints, that is one motion segment. So when I say that there was evidence of motion segment injury, I mean that there is evidence of injury to a disk and evidence of some injury at the

accompanying level to the facet joints.

Q. After seeing Dr. Lemper for about a year, the jury's heard that she went to Dr. Kidwell prior to her surgery. And have you reviewed Dr. Kidwell's records?

A. I have.

Q. Do you believe that Dr. Kidwell's treatment was reasonable and appropriate?

A. I do.

Q. Prior to surgery, should a patient try to exhaust conservative treatment?

A. Depends on the diagnosis. There are some problems that emergent surgery is necessary. But if it is not emergent, then most people should exhaust conservative treatment measures.

Q. I believe it was Dr. Lemper mentioned aggressive conservative treatment. It sounds a little bit like an oxymoron.

But what is aggressive conservative treatment?

A. Well, I think that you -- the umbrella of conservative treatment includes things such as observation of a patient, reassurance. It involves medication. It involves physical therapy or chiropractic care. And then it involves interventions such as injections, where you're sticking needles into

the spine. That's a little bit more on the aggressive side.

So there's a full spectrum. And the closer you get to doing an elective surgery on a patient that's significant, you want to try to explore all of those conservative options that are even more interventional.

Q. And to a reasonable degree of medical probability, do you believe the conservative treatment, even the aggressive conservative treatment that Ms. Garcia received, was reasonable and appropriate?

A. I do, yes.

Q. Is it your opinion that surgery was indicated by the time Ms. Garcia elected to go forward with it?

A. Yes, it was.

Q. Why do you believe that the surgery was reasonable and appropriate at that time?

A. Enough time had passed at that point where she was not going to resolve on her own.

When a person has that level of symptoms, and she was, I think -- the accident happened in January of 2011. If she continued to have those symptoms for six months to a year and had tried some of this conservative care without success, the problem wasn't going away.

It was also affecting her quality of life, and it got to the point where I believe she wanted to try some other option. So it was a reasonable decision for her to make at that point in time, and I would be supportive of that decision as a physician and say that it's reasonable.

Q. Are you familiar with the reports issued by defense expert, Dr. Klein?

A. Yes.

Q. And you're aware that he believes surgery was inappropriate?

A. In so many words, yes.

Q. Do you agree with Dr. Klein's opinion that she should have lost weight and, if she'd lost weight, her pain would have resolved?

A. Well, I certainly agree that attempt --

MR. MAZZEO: Objection. Your Honor, that's misstating the opinions of a defense expert.

MR. ROBERTS: I will -- I will rephrase.

THE COURT: Okay.

BY MR. ROBERTS:

Q. Could you explain to the jury, Doctor, your interpretation of Dr. Klein's opinion with regard to Ms. Garcia's weight as it affected her need for surgery and treatment.

MR. STRASSBURG: Objection. Foundation, Judge.

Approach?

THE COURT: Come on up.

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

MR. STRASSBURG: Thank you, Judge. I will withdraw that objection.

THE COURT: All right. Thank you.

BY MR. ROBERTS:

Q. Okay. Could you explain to the jury your understanding of Dr. Klein's opinion with regard to Ms. Garcia's weight as it related to her need for treatment?

A. My understanding is that weight loss would be a solution -- would have been a solution to Ms. Garcia's problem. That is my understanding.

Q. Okay. And did you review the studies that Dr. Klein cites in support of his opinion?

A. Yes.

Q. Could you explain to the jury what those studies are and whether you believe they support Dr. Klein's opinion on this?

A. I'd have to look at those individual studies. I recall reviewing each of the studies that he cited

and determining that the studies that he cited did not support his -- his ultimate conclusion. It just did not support what he was claiming the studies claimed.

Q. The jury has heard from Dr. Kidwell, who discussed a diagnosis in one of his reports of failed back surgery syndrome.

Are you familiar with this diagnosis?

A. Yes.

Q. And do you agree with this assessment in the case of Ms. Garcia?

A. It's an appropriate diagnosis to make. It just basically means that a person still has ongoing symptoms that are in need of treatment after a spine surgery.

Q. Does this diagnosis mean that the surgery was not necessary?

A. Of course not.

Q. Does it mean the surgery was not successful in some ways for Ms. Garcia?

A. Of course not. It just means that there are some symptoms that remain that are substantial enough that the patient wishes to have treatment for those symptoms.

Q. Did you review the records from Dr. Kidwell and Dr. Gross with regard to the trial spinal cord

stimulator?

A. Yes.

Q. Did you reach an opinion as to whether a permanent spinal cord stimulator would provide a medical benefit to Ms. Garcia?

A. Yes. Based on the trial stimulator, the temporary one, I thought that the implant of the permanent stimulator would probably give her benefit.

Q. Okay. The spinal cord stimulator technology, is this something that you deal with as a regular part of your practice?

A. I do.

Q. Could you tell the jury a little bit about your background and experience with spinal cord stimulators both with regard to the medical need, their effectiveness, and the cost?

A. Sure. It's something that was part of my training as a resident. It's been part of my medical practice for the last 23 years. I counsel patients as to the potential need for this type of technology and treatment.

I'm involved in the decision-making with the patients. I am involved in researching costs associated with the implantation of the stimulators and the replacement of the device.

It's something that is a significant part of my practice over the years.

Q. Thank you, Doctor. After Ms. Garcia had the trial stimulator placed, the jury's heard that she received facet joint injections by Dr. Kidwell.

Do you believe that that was reasonable and appropriate treatment?

A. Of course.

Q. Okay. And explain -- explain why you believe that was reasonable under the circumstances.

A. You're talking about after the surgery?

Q. After the surgery, after the spinal cord stimulator, and before the rhizotomies.

A. Sure. Ms. Garcia had this stimulator, the temporary one, that provided her some benefit. And there was discussion about her having an implant performed.

However, it's my understanding from speaking with her and reviewing records that she was a bit hesitant about having the implant performed and wanted to look at some other options. And so Dr. Gross and Dr. Kidwell looked at other options that may provide -- may have provided her some relief of her ongoing symptoms that she had at that time, which was lower back and right leg pain.

So the facet injections and other injections that Dr. Kidwell performed were reasonable in an attempt to give her some relief at that time.

Q. And next the jury heard about the rhizotomy that Dr. Kidwell performed.

Do you believe that the rhizotomy was reasonable and appropriate at the time it was performed by Dr. Kidwell?

A. I do.

Q. Could you explain the basis for that opinion to the jury?

A. Sure. It was -- it was based on a successful temporary -- temporary response to the injections that Dr. Kidwell performed leading up to the rhizotomy. And with those successful injections, Dr. Kidwell thought that he could provide her longer-lasting benefit, which is what a rhizotomy is expected to provide.

So performing the rhizotomy with the expectation that you can provide this patient months of relief or -- not necessarily relief but months of pain decrease is an appropriate treatment option.

Q. Explain to the jury how often you deal with patients undergoing rhizotomies as part of your private practice.

A. Rhizotomies are one of those treatments that

are reserved for patients who have ongoing symptoms from complicated spinal injuries. It's something that I discuss with patients on a regular basis. It's something that I have to understand how they work. I have to understand what the medical literature says. And I also have to understand the costs associated with them for purposes of life-care plans as well.

Q. Could you explain to the jury what you rely upon for the opinion you're going to provide as to how often Ms. Garcia may need repeat rhizotomies moving out into the future?

A. To a certain extent, clinical experience of my own. But to a larger extent, there have been medical studies that look at that particular issue. Those medical studies have identified the frequency of repeat procedures in the patients that had it done. And the range is somewhere around 6 months to about 18 months.

And so when I look at patients who've had a rhizotomy done, the ideal situation would be if they've had multiple rhizotomies and I can look at their pattern of how they respond.

In Ms. Garcia's case, I believe she's only had one. So I have to rely on my understanding of the literature. And in that particular case, I usually

will say it's about once a year for a repeat.

Q. If Ms. Garcia has only had one rhizotomy, how can you say to a reasonable degree of medical probability that she's going to continue to benefit from rhizotomies in the future?

A. I think that in your question, there is part of my answer. My response to that is to a reasonable degree of medical probability.

I don't know 100 percent that she's going to need them once a year ongoing, but I am -- I'm reasonably certain or I think it's reasonably probable to occur in the future at that frequency. Again, there's -- there has been medical research that looks at how often people typically have these things done. There's been medical research that looks at whether the frequency of those procedures changes over time. In other words, after they have two or three, do they stretch them out farther in the future? And those studies have shown that they don't. They typically need them at about the same frequency year after year.

So based on those pieces of information, I feel comfortable saying today that it's probably going to be once a year.

Q. And if Ms. Garcia got relief at her first rhizotomy, is she likely to get similar relief from

later rhizotomies?

A. Yes. Correct.

Q. Doctor, I'm now going to put up a board of Exhibit 43, which has previously been marked. And this is a chart of -- summarizing the invoices from the medical records which have been marked as an exhibit --

A. Okay.

Q. -- previously in this litigation. I'll move it where you can see it and the jury can see it.

Okay. Doctor, as part of your expert assignment, were you provided with the supporting medical billings for all of the providers that have been summarized here on Exhibit 43?

A. Every single one of them.

Q. And were you also provided with the associated medical records so that you could compare the billing with the treatment that was performed?

A. Yes.

Q. Okay. Let's start up at the top. Fremont Emergency Services, $250.

Did you find that to be reasonable and customary?

A. Yes. That's the emergency room physician that saw her on the day -- three days postaccident.

Q. MountainView Hospital, 1/5/11.

Did you review that?
A. I did.
Q. Is that a reasonable and customary charge for the services Ms. Garcia received?
A. Yes.
Q. Okay. Neck and Back Clinic, $5,390.
What does that represent, Doctor?
A. That's Dr. Gulitz, the chiropractor that treated her after the accident.
Q. Do you believe his charges were reasonable and customary in the community?
A. Yes.
Q. Primary Care Consultants, 2,715.40.
MR. ROBERTS: Can you see that?
BY MR. ROBERTS:
Q. What was that, Doctor?
A. This is a primary care physician that saw her for a period of a couple of months after the accident in conjunction with the chiropractor.
Q. And was this all care that was related to the automobile collision?
A. Yes.
Q. Desert Institute of Spine Care, let's see, $4,120.
What is that, Doctor?

A. This is Dr. Cash for consultation, X rays, and providing her a technologically advanced lower back brace.

Q. And the jury previously saw a line-item breakdown of that number.

Did you find Dr. Cash's charges to be reasonable and customary for the community?

A. Yes.

Q. Comprehensive Injury Institute, and the bills that you reviewed total $9,970.

A. Yes.

Q. Tell the jury what that is.

A. These are office consultation and follow-up charges and report preparation charges for Dr. Gross.

Q. Okay. Did you find the total amount billed by Dr. Gross for these charges of $9,970 to be reasonable and causally related to the accident?

A. I found the office visit charges to be reasonable and appropriate. I did not find his charges for report preparation to be typical for the community. So I thought that those would be sort of a separate charge not associated with this accident.

The total I came up with was based on his office charges alone, which was $5,810.

Q. And the reports you -- you found that that

was related to his expert work rather than treatment?
A. Correct.
Q. Okay. The next line item, Medical Strategy Management, 77,537.35.
Could you explain to the jury what the charges you reviewed were for Medical Strategy Management?
A. Sure. These are the -- almost all of these are the surgical bills from Dr. Gross. So this is associated with the actual operation that occurred in December 2012.
Q. This is the spine fusion?
A. Yes.
Q. And did you find those charges to all be causally related to the collision of January of 2011?
A. Certainly the work that was done is all related to the accident. I had some comment about some of the individual line items.
Q. Okay. Tell the jury what your comment was and what effect it had on your opinion as to whether the total charge was reasonable.
A. Okay. There were some of the bills in this ledger that had nothing to do with the surgery. There was some billing that was actually related to review of records, more of a forensic analysis. And I believe

that was about $2,500 worth of those charges.

There were some of the line items that -- that I reviewed when I looked at the surgery itself that were a bit of outliers in terms of the medical community in which the charges were incurred.

Q. And when you say "outlier," you mean higher than normal?

A. Higher than typical, yes.

Q. Okay.

A. So I basically went through line by line. In my opinion, I removed or adjusted things that I thought were higher than typical. And I have a new total.

Q. Okay.

A. The new total is $59,649.24.

Q. 59,000?

A. 649.24.

Q. Okay. The next line item I have is Lemper Pain Center, 21,421.

A. Okay.

Q. Could you tell the jury what those charges were for?

A. These charges were for Dr. Lemper and his physician assistant and for the injections performed.

Q. And did you find those charges to be reasonable and customary?

A. There were also some charges here that were a little bit higher than typical for what was done, and I made some adjustments.

Q. Okay. What was your adjustment to the Lemper Pain Center total invoices?

A. I guess I should add there was also one charge for a second back brace in a very short period of time after Dr. Cash's back brace, so I removed that charge as well. The new total is 17,191.

Q. 191?

A. Yes.

Q. Now, when you tell the jury that you found the charges to exceed customary charges in the community are not related, are you saying that Ms. Garcia doesn't owe the money?

I know. That's a hard question.

A. Okay. Thank you. Here's -- here's my assessment. I think that --

MR. TINDALL: Objection. Exceeds the scope of his report.

MR. ROBERTS: Withdrawn, Your Honor.

THE COURT: Okay.

BY MR. ROBERTS:

Q. Select Physical Therapy. Did you review those charges?

A. Yes.
Q. What is that for, and did you find them reasonable and appropriate?
A. It was for physical therapy that she had in August and September of 2011. I found it to be reasonable and appropriate.
Q. Nevada Imaging, $4,434.56.
What was that for, Doctor?
A. Those were for imaging studies, MRI scans that were done in August and September of 2011.
Q. Okay. We've seen those.
Is that charge reasonable and customary?
A. It is.
Q. The Center for Surgical Intervention, $21,081.25.
A. This is the surgical center for where Dr. Lemper performed injections, and I thought that those charges were usual and customary for the community.
Q. So is it customary to have both a surgeon charge and a facility charge for a procedure such as those performed by Dr. Lemper?
A. It is.
Q. The nerve root blocks?
A. Correct.

Q. Facet injections?
A. Yes.
Q. Millennium Laboratories, $1,357.57 -- what -- oops -- 75 cents.
What is that for, Doctor?
A. This is a company that assists pain management physicians in doing drug screening for patients that are being prescribed narcotic medications. Those charges are typical for the service that is provided.
Q. And is it reasonable and customary for a physician prescribing narcotics to do drug screening as part of their work?
A. Yes, it is. And this is also related to the motor vehicle accident in question.
Q. Okay. The Pain Institute of Nevada, which doctor is that?
A. This is Dr. Kidwell and his office.
Q. The summary is $34,325.60.
Did you independently add up those invoices?
A. Yes.
Q. I'm sorry. I've got $64,325.60.
A. That's what I have, as well, as the total.
Q. Very good.
And is that amount reasonable and customary

in the community?

A. I found with Dr. Kidwell's charges that his procedural charges were within the usual and customary for the community. His office visit charges were a little bit high. And so I made an adjustment to his total based on that analysis.

Q. Okay. So you reduced each office visit by a small amount?

A. Yes. I think it was around $100 per office visit, and I came up with a total of $57,225.60.

Q. 225.60?

A. Yes.

Q. What about the -- the frequency of the visits? The jury has seen that, for an extended period of time, Dr. Kidwell was seeing Ms. Garcia basically monthly.

Did you find that to be reasonable or excessive based on the treatment he was providing to her?

A. I don't think it was unreasonable. I think he has been actively treating her for complicated problems for a long time.

As you will hear from me, I think going forward, I think that her ongoing treatment can be managed with a lesser number of visits. I think I had

made a plan for three visits a year. But I don't think it was unreasonable for her to be seen more frequently during all of this complicated treatment.

Q. Thank you, Doctor.

MR. ROBERTS: Your Honor, I think it's noon. If this is a good time for the Court, I'm ready to take a break.

THE COURT: All right, folks.

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.

I'm going to have the lawyers come back at 1:00. I'm going to have you guys come back at 1:15.

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

THE COURT: All right. We're outside the presence of the jury. I know that we talked about arguing some stuff when we came back after lunch.

Anything else need to be put on the record now?

MR. MAZZEO: No, Your Honor.

MR. ROBERTS: No, Your Honor.

THE COURT: Okay. Off the record. See you back at 1:00.

(Whereupon a short recess was taken.)

THE COURT: Let's go back on the record. Case No A637772. We're outside the presence of the jury. You want to do Stan Smith, or do you want to do the video deposition?

MR. TINDALL: Video deposition.

MS. ESTANISLAO: First.

THE COURT: Okay. I looked at the defendant's trial brief regarding the exclusion and use of video deposition and live -- in lieu of live testimony. I think I agree with Mr. Roberts, though, that I think that subpart (2) and subpart (3) of Rule 32 are different, and I think that subpart (2) says that an adverse party can use a deposition of

another party for any purpose. If you wanted to use your own client's deposition in lieu of their live testimony, I think subpart (3) would apply.

And I think that they're different.

MR. TINDALL: May I?

THE COURT: Sure.

MR. TINDALL: So the first question I would ask this Court is this: Has this Court ever seen that happen?

THE COURT: Seen what happen?

MR. TINDALL: Where an adverse party uses a person's deposition testimony even though that person is --

THE REPORTER: I'm sorry, "where an adverse party uses a"?

MR. TINDALL: Let me start all over because I don't even remember what I said.

Has this Court ever seen a situation --

MR. ROBERTS: Would you like the clerk to swear the judge?

MR. TINDALL: Has --

THE COURT: Go ahead, Mr. Tindall.

MR. TINDALL: Has this Court ever seen a situation where a live adverse party was ready, willing, and able to testify and the other side just

played their videotape deposition?

THE COURT: I have.

MR. TINDALL: Okay. And -- and here's why 32 --

THE COURT: It's usually Mr. Eglet that does it.

MR. TINDALL: Here's why 32(a)(2) -- (a)(1) rather -- excuse me -- (a)(2) does not mean what the Court thinks it means. They can't use a deposition for any purpose. And we have a prime example of that in the opening statement. Remember how they played snippets and the Court required them to disclose to us what snippets they were going to play so we could put into our opening whatever we wanted to put in.

If you look at 32(a)(4), it reads, "If only part of a deposition is offered in evidence by a party, an adverse party may require the offerer to introduce any other parts which ought, in fairness, be considered with the part introduced."

So when I argued this before openings, I argued to the Court they are required to show what we want them to show which, in fairness, ought to be considered. And the Court ruled no, because that's not in evidence. They wanted to use that deposition for a purpose then, but it wasn't allowed. And that would be

under the same rule.

So this -- this is not the way it's applied in the Eighth Judicial District. If you look at subpart (E) of 32(a)(3)(A) -- it would be (a)(3)(E) -- and with the case law that we cited in our memorandum, there has to be a compelling reason for them to be allowed to put on testimony from a deposition rather than have the party testify live. Submitted.

THE COURT: I don't think so. I'm going to let them do it. Sorry. I think subsection (2) allows it.

MR. TINDALL: Then we would respectfully choose the option in (4), if that happens, to force them to play parts which ought, in fairness, to be played. Because that's now our choice because at that point it will be offered into evidence.

THE COURT: I think they're probably true; I think they're correct about that. If you're going to play a video deposition of a party -- now, if it's being used to offer it into evidence, yeah. I mean, if you're not going to call the defendant, you want to use the deposition instead. And you're going to play that for the jury just to have them listen to the deposition, any part that they want to add, I think for the rule of completeness, they get to include.

MR. SMITH: I think that's untimely. We provided them in our pretrial disclosures with the deposition testimony that we intend to use. There was not an objection or a cross-designation or any discussion of what they think would make that testimony complete at trial.

THE COURT: Okay.

MR. SMITH: And they have 15 days pursuant to 16.1 in order to do that, and they didn't do it.

THE COURT: I'm still going to let them do it because I think it's fair. Sorry.

MR. SMITH: Okay.

THE COURT: Now, if you want to play a snippet of a deposition when you have somebody else on the stand and you have them comment on that, that's not -- I don't think that's being offered for the same purpose. So I'm not going to -- if they say -- or, you know, they have one witness on the stand and they want to play a clip that takes, you know, three lines or five lines from a deposition and have a witness comment on that, I think that's different. And I'm not going to make them play the whole deposition and then go back and say, okay, now, what I really wanted to ask you about, Doctor, was this line. I'm not going to make them do that.

MR. TINDALL: If that is about to occur again, then we need to have advance notice of that because we would want to object because we don't know what deposition's getting played.

Let's take the example of the DMV rep. Andrea Awerbach's deposition was used to preface a question. We would argue that that wasn't being used against an adverse party. It's not against anybody. It's being used for that DMV record. That shouldn't have been allowed anyway. We did not object. But in the future, we will want to. And to do that, we're going to need to have advance notice because they just can't hit play and we don't know what comes out of the speaker.

THE COURT: If they say we're going to play a video deposition now, I agree.

MR. ROBERTS: And we did provide advance notice. The clip that we used with the DMV rep was provided to them as part of our opening clips. And before the DMV rep got on the stand, I said we may play a clip, but it will be one of the ones from the opening designation.

MR. TINDALL: Right. And all designations have been for openings, so I think that's part of the issue on our side.

THE COURT: All right. Let's move on.
MS. ESTANISLAO: Stan Smith.
THE COURT: Trial memorandum regarding Stan Smith.
MS. ESTANISLAO: Your Honor --
THE COURT: I read Judge Johnson's order where she didn't allow it. I read your brief. What else do you want to add?
MS. ESTANISLAO: I just want to reiterate for expert testimony coming in, has to be -- assist the jury, and it will only assist the jury if it's based on particularized facts.
His statistics, as he admits on page -- it's on page 9 of my report, I quote from the deposition, the statistics he used are based for an average person. And he said -- he's not even saying this applies to Ms. Garcia. He says he's not saying that she's an average person; he's not saying it applies. It says if the jury thinks this applies, these are the figures. He's not saying she's the average person.
So, I mean, besides all the cases I cited, I mean, this clearly is not helpful to the jury in that way. He just gives figures for an average person, and there's no testimony linking the plaintiff as the average person.

THE COURT: Okay.

MR. SMITH: Both defendants in this case brought motions to exclude this testimony. Both of those motions were denied. This is simply a late motion to reconsider. And Judge Johnson's order is not intervening authority that would allow this Court to -- to overturn its own district court order, and the proof of that is very simple.

If her district court order is binding precedent, then this Court's district court order was already binding precedent, and Judge Johnson couldn't have entered the order she already entered.

This is just simply a motion to reconsider things that have already been argued. I'm not going to reargue the specifics, because we've argued them and they have been denied. It's an untimely motion to reconsider, and it also has to be denied.

MS. ESTANISLAO: I agree that it's not binding authority, but I understand it is persuasive.

THE COURT: It could be persuasive. I probably give some judges' orders more weight than other judges' orders. There's no way for you to know which judges those are.

MR. MAZZEO: Do you want to share with us, Judge?

MS. ESTANISLAO: I just want to know, is Judge Johnson one of them?

THE COURT: Well, here's the problem. I think it is essentially a motion for reconsideration. And it's not timely as a motion for reconsideration.

What I'm going to tell you to do is when Stan Smith comes -- I'm not going to exclude him at this point because there's already been a ruling saying that I'm not going to exclude him. If he comes and there is not foundation for the testimony that he attempts to offer, then you object to it at that time based on lack of foundation. And I'll rule on it based on what he says. Okay?

MS. ESTANISLAO: Thank you, Your Honor.

MR. TINDALL: We may voir dire him outside the presence?

THE COURT: I doubt it. But we'll see. See what he says in the presence. Okay? Anything else?

MR. MAZZEO: No, Judge.

THE COURT: Let's bring the jury back in.

Dr. Oliveri, if you want to come back up, you can.

THE MARSHAL: Jury entering.

(The following proceedings were held within 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 are 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.

MR. TINDALL: Yes, Your Honor.

THE COURT: Ladies and gentlemen, let me just ask you a real quick question -- actually, a couple. The first one, I know the line for Capriotti's downstairs was horrible today, and it usually is on Mondays. If I give you an hour and 15 minutes, does anybody find that's not enough time? It's enough time for everybody? Okay. Good.

Next question I have -- and this is for planning purposes for Friday. On Friday, I have a niece that's getting married that afternoon, so we have to leave early. We probably need to be done by 2:00 o'clock that afternoon. So the question is -- we're trying to get as much testimony in as we can. We will probably start at nine that morning.

It was -- it was suggested that maybe we could go from nine to two, take a couple of short breaks, but not take lunch and just have you guys have

lunch when we break at 2:00 o'clock. If there's -- I mean, I know there are some people that have issues where they need to eat on a regular basis.

Does anybody feel like we need to have lunch? And it's okay if you raise your hand. If -- if you raise your hand, we'll take lunch probably from 11:30 to 12:30 or 12:00 to 1:00. We'll come back for at least an hour. Anybody want to have lunch on Friday? Not seeing any hands. Everybody's good pushing through and just eating when you leave?

Okay. That's what we'll plan on doing. Hopefully that helps you guys as far as scheduling witnesses and stuff.

MR. STRASSBURG: Message received, Judge.

THE COURT: What's that?

MR. STRASSBURG: Message received.

THE COURT: Okay. There you go.

Dr. Oliveri, just to be reminded, you're still under oath.

Go ahead, Mr. Roberts.

MR. ROBERTS: Thank you, Your Honor.

BY MR. ROBERTS:

Q. Dr. Oliveri, I believe we left off by -- you had just talked about Pain Institute of Nevada. What does the bill summary for Medical District Surgery

Center represent?
A. This is one of the surgery centers where an injection was performed in September 2012.
Q. Okay. Which doctor performed those injections?
A. I would have to look at the record to refresh my recollection. I don't recall as I sit here.
Q. Was it one of the pain management doctors?
A. Yes, it was.
Q. Dr. Kidwell perhaps?
A. I think so.
Q. Okay. Pacific Hospital of Long Beach. This is a big one.
A. Yes.
Q. $281,351.20. Did you review all of the support that makes up that billing?
A. Yes.
Q. And tell the jury if you found that amount -- the total amount to be fair and reasonable.
A. I did.
Q. The jury has already heard from Dr. Gross, who said that the markup on the hardware that was placed in Ms. Garcia's spine appeared somewhat excessive to him. Did you see the hardware charge on there?

A. I did.
Q. Did you also find it to be excessive?
A. My analysis of the medical billing for hospitals is one of looking at the total charge. And the way that I do that is by use of database information.
I have a subscription to a directory that looks at hospital charges for any hospital in the United States that subscribes and then looks at charges per diagnosis. And so I can -- I can look at various hospitals and their diagnoses and see how they compare to their neighboring hospitals.
I don't have a way personally of analyzing charges for hardware specifically or carving that out. So that type of analysis is beyond my area of expertise, and I wouldn't be able to even have a comment.
Q. How many hospital charges have you personally reviewed for a lumbar fusion over the last ten years?
A. Well, I have probably personally reviewed hundreds of fusion charges over the last ten years.
Q. And have most of those been in Nevada?
A. Most in Nevada, but certainly other states where patients have had surgeries, I have also reviewed those as well.

Q. As you have reviewed hundreds of charges from hospitals, do you find that hospitals tend to -- to make more of their profit in certain line items?

A. I don't know. That's another thing that's beyond my scope of expertise.

Q. The 281,351.20, does that charge appear to be more than it would have cost to have the same surgery done in a Nevada hospital?

A. There is a range of charges for Nevada hospitals, as you can imagine. And I will tell you that the range of charges that I see in reviews -- in bills that I review ranges from the high 100,000 range up to the mid $300,000 range.

When I do life-care plans and map out the charges associated with a lower back fusion surgery, I will usually put in a charge of approximately $225,000 for the cost of the hospital for that component. That's what I currently do.

Q. When you say high 100s, you mean 180s, 190s?

A. Correct. Closer to 200,000 in that $100,000 range.

Q. But you also see bills over 300?

A. Yes.

Q. National Intraoperative Monitoring, 11,178. What is this charge for?

A. This is what is called intraoperative neuromonitoring. These are technicians that assist the surgeon to monitor nerve and spinal cord function during the back surgery.

Q. Is that reasonable and necessary?

A. Yes.

Q. Is this an appropriate charge?

A. It is.

Q. Ronald Fillmore, RN-FA. What does the FA stand for again at the end of RN?

A. I actually don't know. I -- I know what Mr. Fillmore is, but I don't know the initial.

Q. Okay. What is Mr. Fillmore?

A. He is a surgical assistant for Dr. Grover during this lower back surgery.

Q. Dr. Grover or Dr. Gross?

A. I'm sorry. Dr. Gross. Thank you.

Q. We have another fine surgeon in town named Grover; right?

A. We do.

Q. The charge here of 33,924.44, did you find that to be reasonable and customary?

A. I thought that it was high. This charge -- let me explain the basis for the charge. Assistants in surgeries are based on percentages of the primary

surgeon's charges. So Nurse Fillmore is charged at approximately 50 percent of Dr. Gross's surgical charges for each of his components.

What I have determined from looking at many bills from surgeries over many years is that a more typical and what I would consider a reasonable percentage would be 25 percent of the primary surgeon's charge for the individual components. And so I looked at each of the line items, and I multiplied by 25 percent to come up with a different number of 14,427.66.

Q. 66?

A. Yes. I will state, though, that there is no mandated percentage that every surgeon must follow. However, this is my opinion of what I think is customary for the community.

Q. Okay. The next we have on the list is Luke R. Watson, M.D. Do you know what services Dr. Watson performed?

A. Yes. Dr. Watson was the pathologist with the hospital who did the laboratory billing while -- while Ms. Garcia was in the hospital.

Q. Do you find his charge of $360.69 to be customary and reasonable?

A. Yes.

Q. Dr. Alla Gartsman. What did Dr. Gartsman do for Ms. Garcia?

A. She was the medical doctor who assisted Ms. Garcia from a internal medicine standpoint while she was admitted to the hospital during the lower back surgery.

Q. Is it customary for a doctor with her specialty to attend to a patient after this type of surgery?

A. It is.

Q. Do you find her charge to be fair and reasonable in the amount of $1,462?

A. Yes.

Q. And I don't know if I can say that. Diogenes Anesthesia Medical Group, Inc.

A. Sounds good to me.

Q. Okay. That is a charge for $5,200. Did you review that charge?

A. I did.

Q. What is that for?

A. This is the anesthesiologist that put Ms. Garcia to sleep and, more importantly, woke her up after the surgery.

Q. And this was for the lumbar fusion surgery?

A. Yes.

Q. And do you find her -- or this charge for the anesthesia group to be reasonable and customary?
A. Yes.
Q. The last one on this board is a medical billing from Louis Mortillaro, PhD --
A. Yes.
Q. -- in the amount of $5,300. Did you review that?
A. I did.
Q. Could you tell the jury what this is for?
A. Yes. Dr. Mortillaro did what is called pain counseling. He is a PhD who assists individuals who have problems with pain to try to have them manage that and deal with their pain better.
Q. Did Dr. Mortillaro also do the prestimulator psychological screening?
A. Thank you. Yes, he did.
Q. Okay. Do you find the charge to be customary and reasonable?
A. I do.
Q. All right. It is not on this board, but as preadmitted Trial Exhibit 37, there are invoices from Matt Smith Physical Therapy. Did you review the charges from Matt Smith Physical Therapy?
A. I did.

Q. And could you tell us what the total charges are from your review that you found to be related to the automobile collision of January 2nd, 2011?
A. $4,500.
Q. Okay. 4,500?
A. Yes.
Q. Did you find that amount to be fair and reasonable?
A. Yes.
Q. Trial Exhibit 39 are the records of Surgical Arts Surgery Center. Did you review those bills?
A. I did.
Q. And explain to the jury what the Surgical Arts Surgery Center did for Ms. Garcia.
A. These are charges from one of the surgery centers where Dr. Kidwell performed procedures in 2014 and 2015.
Q. And what is the total amount of those charges?
A. $37,145.
Q. Did you find those charges to be fair and reasonable?
A. Yes.
Q. And finally, Trial Exhibit 30 [sic] are the records of the Valley View Surgery Center. Did you

review those records?
A. Yes.
Q. And what did that surgery center do for Ms. Garcia?
A. This is where Dr. Kidwell performed injection procedure September of 2015.
Q. And what were the total amount of invoices from Valley View?
A. $11,417.30.
Q. And did you find those charges to be fair and reasonable?
A. Yes.
Q. Okay. Did I leave any bills out that you reviewed?
A. No.
Q. Okay. Doctor, just to summarize, all of the invoices now that you've opined on as far as her past care, did you find all of those charges, as modified during your examination today, to be related to the automobile collision of January 2nd?
MR. MAZZEO: Foundation. Speculation.
THE COURT: Overruled.
THE WITNESS: Yes, I did.
BY MR. ROBERTS:
Q. Thank you, Doctor.

Okay. We've talked about life-care plans. Did you formulate a life-care plan for Ms. Garcia?

A. Yes.

Q. And in connection with that life-care plan, did you calculate a life expectancy for Ms. Garcia?

A. I determined an average life expectancy for someone Ms. Garcia's age based on governmental life expectancy tables.

Q. And what was the purpose of determining the average life expectancy for someone of Ms. Garcia's age?

A. There were some items that Ms. Garcia will need on an ongoing basis. So I needed to determine what the duration of that length would be or how long she would need those items.

And while I don't know how long an individual person will live, I can't predict that, I can use information that's available from the government to determine what the average length of time an individual lives based on their sex and their current age.

Q. And based on the life expectancy tables, you're coming to a conclusion, as far as more likely than not, how long is she going to live?

A. Correct.

Q. And what did you calculate Ms. Garcia's life

expectancy to be for the purposes of your analysis?

How old did you think she was going to live?

A. One moment, please.

MR. TINDALL: Objection to the comment how old does he think she's going to live. It's all based on the table, not his opinion.

MR. ROBERTS: I can rephrase.

THE COURT: That's true. I think the prior question said "based on the life expectancy table." So why don't you rephrase it?

MR. ROBERTS: Thank you, Your Honor.

BY MR. ROBERTS:

Q. Based on the life expectancy table, more likely than not, how long is Ms. Garcia going to live?

A. The life expectancy table has indicated an additional 48 years.

Q. And that was as of what date?

A. That was as of October 2015.

Q. You've told the jury you prepared ten supplemental reports?

A. Yes.

Q. Did I remember that correctly before lunch?

And in each of those supplemental reports or in some of them, have you updated your life-care plan?

A. Yes.

Q. Okay. And as you updated the plan, has the cost of the plan changed over time?

A. Yes.

Q. Has it gone up or gone down?

A. It's gone up.

Q. Okay. Could you explain to the jury why your plan has gone up over time as you've issued additional supplements?

A. When I first evaluated Ms. Garcia, it was just a few months after her lower back fusion surgery. She was still having symptoms. And I mapped out, to the best of my ability, what I thought was going to be her future medical care at that time based on what I knew.

However, since then, I have had the ability to then follow her ongoing treatment for an additional two and a half years and see that her treatment has evolved to include recommendations for some much more advanced medical treatment in the future.

And primarily the reason why the medical care dollar amount has gone up is that there has been a recommendation initially for a spinal stimulator. And then subsequently there was a recommendation for the radio-frequency procedures, which Dr. Kidwell has called the rhizotomies. Those are very specialized

procedures that are expensive to perform and require expensive medical tools to administer.

I've added those to her medical life-care plan because they are reasonably certain to occur. That's why it ended up costing more.

Q. Thank you, Doctor. When you added in the rhizotomies, did you take anything out?

A. Yes. I removed -- initially, it appeared that there was going to be this neurostimulator as part of her future needs, and then the direction changed when she went in the direction of the rhizotomy.

So because the rhizotomy was providing her decent relief, I removed the stimulator from her main life-care plan. So I -- I've made adjustments both ways to reflect as best I could what was likely to occur in the future.

MR. ROBERTS: All right. Your Honor, permission to display the table from the tenth supplemental report of Dr. Oliveri as a demonstrative. This is just what itemizes the elements of his life-care plan. Tenth -- oh, ninth supplemental report.

MR. MAZZEO: Approach, Your Honor?

THE COURT: Come on up.

/////

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

THE COURT: All right. Based on our bench conference, I think he's going to -- we've agreed you're going to use the summary page; right?

MR. ROBERTS: Yes, Your Honor.

Your Honor, could we have the --

THE COURT: Just gave it to you.

MR. ROBERTS: Oh, there it is. Excellent.

Okay. Can we just highlight each line and bring it up as big as we can do it? That's really not much bigger.

BY MR. ROBERTS:

Q. So, Doctor, let's first talk to the jury about Line Item 1 from your life-care plan, "physician visits."

Can you explain to the jury what type of physician visits you foresee for Ms. Garcia?

A. Sure. She needs a physician to coordinate her care, see her for prescription medications, see her to prescribe any type of rehabilitation. That role is being provided by pain management right now, which is Dr. Kidwell. So someone like him in that type of specialty or with that type of expertise would be appropriate ongoing.

I've listed what I think is a reasonable amount or frequency ongoing, which is three times a year, for that purpose. And based on what I think is a usual and customary fee for that service of $218 per visit, at three times a year is $654 per year in that item, what I've listed there.

And I think I misspoke earlier. I said 48 years. It's actually 49 years from October 2015. And then you multiply those two values to come up with the yearly charge of $32,046 on a lifelong basis.

Q. So the 32,000 is for her lifetime, three visits a year with Dr. Kidwell or someone like him?

A. Correct.

Q. What about Line Item 2, the spine surgeon physician visits? What is that for?

A. This is a one-time charge for a follow-up consultation in the future. The reason for this is that Ms. Garcia has had a lower back fusion at the L4 to S1 level. She is a relatively young individual at this time.

And I'm not sure if Dr. Gross spoke about this previously, but because of the fact that she's had a fusion surgery at this level and because of her young age and because of the fact that she is likely to live for a number of decades, she needs to have a provision

to have another surgery at the level just above, at L3-4.

There is a phenomenon called adjacent segment pathology that occurs after lower back fusion surgeries where there's additional stress and strain placed on that level just above the fusion. And over a period of time, typically about 20 years or so, the disk above the fusion will have problems to the point that an additional surgery will be required.

Q. Is that the same phenomenon that some surgeons refer to as adjacent segment breakdown?

A. It is.

Q. Let's look at line 3, "palliative physical therapy."

Could you explain to the jury why you're including this line item in your life-care plan?

A. Just as you will see in, I believe, the next couple of pages where I have included a provision for Ms. Garcia to -- to take some pain medications, I've also included this line item, which is allowing her to periodically go see a physical therapist or someone like that, if she's having a bad week or a bad period of time, to get some treatments to temporarily make her feel better. So this is a provision for her to go see a therapist for some electrical stimulation, for some

hands-on physical therapy to update her program of exercises.

I've made a provision for 12 visits a year on an ongoing basis and used usual and customary charges for that amount to equal $170 a visit or $2,040 yearly.

Q. Thank you, Doctor. Let's look at Line Items 4, 5, and 6.

And these are medications that you believe Ms. Garcia's likely to need in the future; is that correct?

A. Actually, it's -- lines 4 and 5 are the likely needed medications. Line 6 is a medication that she was taking that I have removed the cost because I don't think it's likely to occur.

Q. Could you explain those lines to the jury?

A. Sure. Line 4 is an analgesic class of medication. This is a painkiller. And she's currently using that class of medicine, a medicine called tramadol. And based on her use of the medication, I researched the cost and came up with a yearly cost of $1,071.

In the spasm medication class, she's using a medicine called Zanaflex. And based on her use, the yearly cost is expected to be $925. And then, I have written the total lifelong cost in the last column.

Q. And with line 6, what is a neuroleptic class of medication?

A. She was taking a medicine called gabapentin or Neurontin. And this is a medicine that we sometimes use for people who have nerve-type pains into their arm or leg.

However, she wasn't using it that often. And I thought, based on her intermittent use, I didn't feel comfortable saying that it was likely to occur for the rest of her life. So I listed it to remind myself that it was something she was taking, but I didn't include it because I wasn't reasonably certain it was going to continue.

Q. The jury has seen that, over a course of her treatment, Ms. Garcia was taking Lortabs and later Norco.

Do you have any medications of that class in her future life-care plan?

A. That class is in the first category I mentioned, which is analgesic medicine. It happens to be a narcotic analgesic, which is stronger than what I included the provision for and -- but I didn't include a provision specifically for the narcotics.

Q. Tell the jury why you don't believe more likely than not she's going to need the narcotic

medication in the future?

A. She expressed an interest to me in not wanting to take narcotics. She seemed to be doing relatively well with this tramadol, which is really a narcotic substitute. And so I thought, you know, looking at that -- that litmus test of what's reasonably probable to occur in the future, that I felt comfortable saying that it was going to be something like tramadol.

Q. Thank you, Doctor. Line Item 7, "radiographic services, MRI, lumbar spine, and X rays." And you've got just one year for that.

Can you explain to the jury why you included one year?

A. Yes. This was an MRI scan to be done in the future before she needed to have that second back surgery. So it would be a follow-up MRI in terms of surgical planning before the future back surgery would occur.

Q. Thank you. Can we go to the next page of the table, page 2.

Okay. Moving on to line 8 under "surgical intervention and procedures," "repeat radio-frequency ablations, rhizotomies."

Could you explain to the jury what provisions

you've made for rhizotomies moving into the future?

A. This is the rhizotomy procedure that Dr. Kidwell performed, and I have listed it as a once-yearly procedure. And as I indicated before, it could be as often as every six months. It could be as infrequently as every 18 months. Average would be once a year.

The cost estimate is based on what the actual costs were for the procedure estimated for Dr. Kidwell and the surgery center at 30 -- approximately $30,000.

Q. The 30,000, how many procedures is that for?

A. One procedure per year.

Q. Line 9, "preoperative medical clearance testing." And you've got one year.

Could you explain the need for that procedure?

A. This would be a preoperative clearance before future lower back surgery. So this would be in the year 2037, her going to the medical doctor to have EKG, chest X ray, blood tests before having a follow-up lower back surgery.

Q. And finally, on this page, line 10, "lumbar reconstruction surgery, one year."

Could you explain to the jury this item once again?

A. Yes. This is the provision for that future lower back surgery that I mentioned earlier at the level just above her current fusion, at L3-4. This is what was -- you mentioned as the adjacent segment breakdown. I mentioned it as adjacent segment pathology.

The provision is for another future back surgery. The cost that I've listed as 289 -- 289,000 to 309,000 includes all of the components. So I think, as I mentioned earlier, I included the hospital charge estimate of about $225,000. I included the surgeon, assistant surgeon, some medication provision, back brace estimate, and added those up to give the range.

Q. Thank you, Doctor. And do you agree that, more likely than not, Ms. Garcia's going to need this second lumbar reconstruction surgery in the future?

MR. MAZZEO: Speculation, Judge.

THE COURT: Come on up for a minute, guys.

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

THE COURT: Objection is overruled. Go ahead.

MR. ROBERTS: Thank you.

BY MR. ROBERTS:

Q. And, Doctor, if I could, before you answer

that question, back up just a little bit and -- and get your foundation.

What education, training experience do you have that would allow you to opine as to the need of a future lumbar reconstruction?

A. As I mentioned earlier, I am very much involved in the diagnosis and management of spinal problems in my own patients. It has occupied more than 50 percent of my clinical work over the last 20-plus years.

I am involved in decision-making regarding spinal surgeries with my patients for that period of time. I am familiar with the literature in spinal surgery. I'm a member of the North American Spine Society, which is a group of surgeons and nonsurgeons that research and are involved in spinal injuries for patients. And I've been a member of that society for a long time.

I've looked at the literature that has been -- that has studied this issue. And the literature suggests that there is a very specific percentage of individuals that go on to have future spinal surgery after having an initial one in the lower back.

And what I've indicated previously with

respect to Ms. Garcia, that there has been research that suggests that at ten years the percentage of individuals that have future surgery at that adjacent segment is 36 percent of the patients. The percentage at five years was half that. It was a linear relationship going from zero to five years to ten years with ten years being 36 percent. And at five years it was 18 percent.

Based on all of those factors that I mentioned and that linear relationship, it is reasonable to conclude that certainly, by 25 years, she's going to tip the scales to -- it's going to tip the scales where it's going to be probable that she's going to have a problem where she needs to have lower back surgery.

I could have even suggested, with a 49-year life expectancy, that it -- that it would have happened even twice, but I didn't. I said it's going to happen once, to a reasonable degree of certainty.

And so that's the basis for me saying that, at the time in 2037, that it was likely to occur.

Q. So in including this in your report, did you just rely upon Dr. Gross or did you rely upon your own evaluation of Ms. Garcia's needs?

A. I relied primarily on my own assessment. But

I did call her surgeon, Dr. Gross, and I asked him his opinion about it. And he was in agreement with what -- well, let me back up.

I asked him -- I told him that I had assessed her. I told him that, in my assessment of the literature, there is a likelihood that she would require a future lower back surgery. And he told me that he was in agreement with that assessment.

Q. Thank you, Doctor. Can we have page 3 of your summary table. Okay. So now we see a grand total here.

Could you explain to the jury how you came up with that grand total?

A. That represents the yearly totals for each of those items that we've reviewed that are simply added up.

Q. During opening statements with Mr. Mazzeo, the jury saw that there was the stimulator in a prior life-care plan.

Is the stimulator included in your most recent grand total?

A. No.

Q. Okay. In your opinion, to a reasonable degree of medical probability, if she doesn't get the rhizotomies, is she going to need the stimulator? Is

it one or the other?

A. I think that she would probably want the stimulator if she doesn't get the rhizotomies because I think she's going to want to have something that gives her relief. And it looks like the rhizotomies are giving her that decent relief right now. If she doesn't get it with the rhizotomies, I think she's going to be searching for something else.

Q. And what would be the cost of the stimulator if the jury is to find that the rhizotomies are not reasonable and necessary and want to provide the stimulator instead?

A. I researched the stimulator, and the cost over that same time frame is 431,000 to 641,000.

Q. And would that include both the placement of the permanent stimulator and the periodic battery replacements and other maintenance?

A. Yes. But that -- keep in mind that total does not include the other items. It doesn't include the physician visits. It doesn't include physical therapy. It doesn't include the back surgery provision. Doesn't -- does not include medications.

That's just the stimulator component.

Q. Thank you very much, Doctor. And now, to sort of wrap up, all of the future life-care needs that

you have priced out for Ms. Garcia in your life-care plan, is all of that stated to a reasonable degree of medical probability?

A. It is, yes.

Q. Okay. Thank you very much, Doctor.

I pass the witness, Your Honor.

THE COURT: You're welcome.

Cross, Mr. Mazzeo?

MR. MAZZEO: Yes, Your Honor. Thank you.

I'll need a moment to set up, Judge.

May I proceed, Your Honor?

THE COURT: Go ahead.

MR. MAZZEO: Thank you.

CROSS-EXAMINATION

BY MR. MAZZEO:

Q. Good afternoon, Dr. Oliveri.

A. Good afternoon.

Q. So -- well, let's start with your first medical evaluation.

As you testified to on direct, that was -- you first examined Ms. Garcia on July -- or June 4th of 2013; correct?

A. Yes.

Q. That was about five months after her fusion surgery in December of 2012?

A. Right.
Q. Okay. And do you agree that your comprehensive medical evaluation and life-care plan was created for litigation purposes?
A. Yes.
Q. And do you agree that it was not designed to be used for -- to be used by a treatment provider for treatment?
A. Agreed.
Q. Okay. And is it correct that your comprehensive medical evaluation contains a complete statement of all the -- strike that.
Is it correct to say that your comprehensive medical evaluation and all of the nine supplemental reports contain a complete statement of all the opinions that you have expressed and the basis for those opinions?
A. Yes.
Q. And is it correct to say that your -- these reports, including the first one and the nine supplements, identify all the data and other information that you relied on in forming the opinions you expressed here today?
A. I don't know about that. I would suppose that my education, my experience, those sorts of things

are not necessarily articulated in every single report or in total in the reports. I have tried to lay out the foundation for my opinions as best I could.

Q. Okay. So other than your education and experience, though, is it correct to say that those reports that you had provided to Ms. Garcia on behalf of her legal claim contains all the data and other information you relied upon?

A. I would agree with that.

Q. Okay. And I believe you said on direct examination that about 60 percent of your work -- well, strike that.

Is it correct to say -- I'm not sure you testified to this yet.

Is it correct to say that about 50 to 60 percent of your work that you do as -- in your profession is -- is done with respect to -- you perform forensic medical -- medical-legal evaluations?

A. Yes, I think that's right.

Q. And -- and I take that number -- I got that number from when you had testified at your deposition in July of 2014.

But isn't it a fact, Doctor, that, as you sit here today, that that number is probably higher, that the amount of forensic work you do is probably greater

today than it was back in 2014?

A. I think it's still probably in that range. I don't know if it's greater. I don't know that I have that information.

Q. Okay. And isn't it a fact that you've -- at least as of 2014, that you were performing anywhere from three or four to eight or nine forensic evaluations a year for clients of Glen Lerner's law firm?

A. I think that -- you asked me in the last few years. That was probably the range at that time, yes.

Q. Okay. That was the range per year, though?

A. Yes.

Q. Okay. And so that would come out to anywhere from 15 to 45 forensic evaluations for clients of Glen Lerner's firm over a period of five years; correct?

A. In the preceding five years.

Q. Yes?

A. Yes.

Q. Okay. And now, as of 2014, I -- I understand that your total bill at that time for the forensic work that you performed in this case was $15,015.

And has that amount gone up?

A. It has.

Q. And it's gone up because you have performed

and provided additional medical records reviews and -- and drafted additional reports; correct?

A. Correct.

Q. So, as you sit here today, what is the total bill for the work that you've performed on this case for Ms. Garcia?

A. I don't have the -- the actual billing in front of me. Can you tell me the date of my deposition again?

Q. So that would be July 23rd, 2014.

A. I'm going to estimate that, since that deposition, I have done an update of the life-care plan on two occasions. I have reviewed expert reports. I have probably done a lot of work. I'm sure it's well above $20,000, but I don't know for sure.

Q. Okay. Because at the time of your deposition in July of 2014, at that point, you had provided the initial comprehensive medical evaluation life-care plan and then a first and second supplement. Correct?

A. Yes.

Q. Okay. And then your third supplemental report was done in October of 2014.

A. Okay.

Q. Okay? So for those additional -- I believe it's an additional seven reports, or is it an

additional six reports?

A. Okay.

Q. You're saying that your bill is around 20 or significantly greater?

A. Well, I'm -- I'm telling you it's got to be -- it's probably significantly greater than $20,000, but I don't know what it is. I -- as I said, I have done a lot of work in this case and more than any other file.

Q. And for your trial testimony today, you're going to be here for the entire day, what do you bill -- what's your -- what are you billing for the time that you're here for a full day of trial testimony?

A. I'm billing $7,000.

Q. Now, as you testified to on direct, you have not been retained in this case as a medical provider for Ms. Garcia; correct?

A. As a treating physician, no.

Q. Correct. And -- and now, based on what you've testified to, which is essentially -- well, strike that.

Based on your medical record review, which you talked about in your direct examination, your physical examination that you performed on June 4th of

2013 as well as your interview with Ms. Garcia where she gave you information about her history of present illness, past medical history, et cetera, based on that information, the conclusions that you reached are -- collectively from your testimony appear to support -- you're saying they support her claim for -- for these damages that are attributable -- for all the medical treatment that she needed that is attributable to the subject accident; is that correct?

MR. ROBERTS: Objection. Form.

THE COURT: I'm going to sustain that because I didn't understand it.

MR. MAZZEO: I know. I went -- I was a little wordy with that, and I kept going on. I was trying to add too much.

All right. Thank you for the objection.

BY MR. MAZZEO:

Q. All right. The conclusions that you -- that you testified to today to say that all of the medical treatment -- and you were shown this board and then you were shown some other records, this board right here, your conclusion that -- that all of this medical treatment, based on records that you say you reviewed, that -- that they're all related to the subject accident, that's based -- this conclusion is based on

your review of all the medical records, your interview of Ms. Garcia, and your physical examination. Does that sum it up?

A. Yes.

Q. Okay. Now, would you agree that -- that in all of the -- with all of the cases that Glen Lerner's office had provided -- of the clients that you had evaluated for forensic evaluation, that there is not one case where you drafted a comprehensive medical evaluation that was not favorable to the client of Glen Lerner's office?

A. Oh, I don't think that -- I don't think that's the case.

Q. Okay. And in any event, would you agree that it's a pretty -- it's a pretty -- the relationship -- professional relationship that you -- your office has with Glen Lerner's office is financially profitable for both yourself and for Glen Lerner's office?

A. Clearly I have a -- a business in which I have many referral sources from many different attorneys and third parties in Las Vegas, and I've had that for many years.

Q. But, Dr. Oliveri, I'm just specifically asking you about in this case, because Ms. Garcia's a client of Glen Lerner's office, your relationship with

Glen Lerner's office, and not just with this case but all the other cases that you have worked on, it's -- it's a -- it's financially profitable to have that relationship?

A. Of course.

Q. Okay. And now, with regard to your medical evaluation that occurred on June 4th when you performed the examination, would you agree that a patient's self-report, what a patient reports to you, is important in assessing the relatedness of treatment, injuries, diagnoses to a subject accident?

A. Depending on what that item is, the self-reporting can have varying degrees of importance, but the self-reporting is oftentimes an important factor.

Q. Okay. And when Ms. Garcia came to you on June 4th of 2013, do you agree that she knew she came to you for an evaluation with respect to her medical-legal claim?

A. I don't recall if she voiced that. I can tell you that I always explain to the individual coming to my office why they are there in my office, that I'm there to evaluate them in reference to a particular accident or injury, regardless of who's referring them.

Q. So regardless of who's referring them, but is

it fair that there was an understanding when she came to you on June 4th of 2013, that she knew that you were retained on her behalf with respect to her medical-legal claim?

MR. ROBERTS: Objection. Foundation.

THE COURT: I'm going to let him testify what he knows. Overruled.

THE WITNESS: Again, I don't recall. I think that most people seem to be aware of what's going on to know who referred them to my office. But, again, I explain to them that -- why they're there in my office.

BY MR. MAZZEO:

Q. And you agree that patients, when they come to you for a forensic evaluation, that they're self-reporting to you, that it's subjective in nature?

A. Of course.

Q. Okay. And do you agree that there are plaintiff patients -- so combined when we're talking about patients who have medical-legal claims so that there are plaintiff litigants, that certain plaintiff litigants who are -- come to you for an evaluation might minimize the extent of prior injuries or symptoms because it might adversely affect the present value of -- the value of their present case?

A. I think that might occur.

Q. Okay. And would you agree that there is -- because the self-reporting is subjective, that there's no way to definitively confirm what a patient said to you is -- whether a patient is candid in their self-reporting, I should say?

MR. ROBERTS: Objection. Overbroad.

THE COURT: I'm going to let him answer. Overruled.

THE WITNESS: I can only work in the realm of being a physician. So I look at what a person says, and then I compare and contrast their statements to what is in the medical records and what I know in terms of medical diagnoses.

And then if there are discrepancies, I try to either reconcile it, and if it's not reconcilable, I can have problems with their statements. So I go through that process to try to determine if it's -- if they're being candid or not. But I'm not a human lie detector.

BY MR. MAZZEO:

Q. Absolutely. And -- and -- and so that's what I was asking. So you're not -- you're not sitting here today vouching for Ms. Garcia's credibility in reporting her past medical history; correct?

A. No. I'm just -- I'm telling -- I'm trying to

explain the process that I went through to come up with my medical opinions but certainly not vouching in general for a person's credibility. That's not my job.

Q. And isn't it a fact that you've known patients and you've probably had a number of patients who have had long-standing chronic symptomatic conditions who have not sought treatment for a symptom in the past; correct?

MR. ROBERTS: Objection. Irrelevant. Hypothetical not based on any facts in this case.

THE COURT: Yeah, based on the fact he did a life-care plan, I'm going to allow him to answer. Overruled.

MR. MAZZEO: Thank you, Judge.

THE WITNESS: Yes.

BY MR. MAZZEO:

Q. Okay. And -- and, Doctor, just because you've testified that there was -- you didn't see -- review any preaccident medical records of prior treatment showing symptomatology to Ms. Garcia's neck or back from the past doesn't necessarily mean that she was asymptomatic prior to the motor vehicle accident; correct?

A. Agreed.

Q. Now, let's talk about your initial report.

And I know in preparation for trial, you have reviewed -- reviewed your reports; correct?

A. Yes.

Q. And when did you review them in relation to your testimony today?

A. I started reviewing them last week. I have looked at them periodically. Last time was this weekend.

Q. And then in preparation for your testimony today, is it correct that you've spoken with plaintiff's counsel in this case?

A. Yes.

Q. And when did you speak with him or her?

A. Last Monday.

Q. And how many attorneys were present at the time?

A. Three attorneys.

Q. Okay. And would they be the attorneys in this courtroom?

A. Yes.

Q. Okay. And how long was your meeting for, for the preparation you had?

A. Four hours.

Q. Okay. And during those four hours, is it correct to say that some of the issues and topics that

were discussed would include some of the testimony of the treating doctors who had testified already in this case; correct?

A. I don't recall us talking too much about that. It was mostly about my reports, my deposition testimony. I think that was the bulk of it.

Q. Okay. Now, the preinjury status section you have in your report -- and you have reviewed it, so I just wanted to ask you a question about it. You don't have to look at it yet.

A. Okay.

Q. So, now, that's -- that's a section of -- of the report regarding what Ms. Garcia told you were her -- her condition regarding her spine?

A. Before the -- before the motor vehicle accident.

Q. Correct.

A. Yes.

Q. Okay. And -- and the information contained in this section was entirely provided to you by Ms. Garcia's self-report; correct?

A. Correct.

Q. And -- and then under -- you also have a -- you had a -- I guess it's -- the consultation and interview would be interchangeable words; right? You

had a consultation or an interview, you spoke with Ms. Garcia about various items that are contained in your report?

A. Yes, and all that's in the History section.

Q. Okay. And your physical examination, which you testified you had performed, that consisted of looking at her active low back range of motion, you assessed her sensation in the lower extremity, and also you assessed her gait. Correct?

A. And her reflexes and her strength.

Q. One of the reports that you reviewed in connection with your medical evaluation included Dr. Cash's February 16th, 2011, record; correct?

A. Yes.

Q. And that was a consultation record, that record that you reviewed?

A. Yes.

Q. Dr. Cash only conferred and consulted with Ms. Garcia on that one day; right?

A. Yes.

Q. Okay. And so do you recall that in that record, Dr. Cash noted the physical examination that he performed on Ms. Garcia?

A. I don't recall what he said.

Q. Okay. Well, do you recall that he had

performed a range of motion testing of her cervical and lumbar spine?

A. I don't remember.

Q. Okay. And -- well --

MR. MAZZEO: Your Honor, can I have the ELMO, please?

BY MR. MAZZEO:

Q. I'll just show it to you rather than quote from it. Okay. So I'll bring it down so you can see the date. This is Andrew Cash, 2/16 of 2011, initial consultation.

A. Okay.

Q. Okay. And so I'll go down to the Physical Examination section of the report. And so you have Physical Examination, two paragraphs. I'm directing your attention to the physical examination of the lumbar spine, which is the second paragraph.

A. Okay.

Q. And so Dr. Cash noted that she was severely limited, 20 degrees flexion, 10 degrees extension --

A. Okay.

Q. -- right?

And, now, as a physiatrist, the physical examinations are very important for you, correct, in evaluating a patient?

A. I think for any physician.
Q. Okay. But my understanding is that for a physical medicine rehabilitation doctor, you -- that's a -- of course, for any physician, but very important for a physiatrist as well; correct?
A. I don't think there's any additional significance to the examination for doctors in my specialty unless they happen to have special training in manual medicine or something like that.
Q. Okay. So would you agree that with this -- with this finding by Dr. Cash -- the 20 degrees flexion, 10 degrees extension -- that's pretty limited flexion -- or movement from the waist; correct?
A. Yes.
Q. Because extension is going backwards; correct? So it's -- 10 degrees is very slight movement backward; right?
A. Normal is 25. So it's about a third normal.
Q. Okay. And then flexion or -- flexion is forward movement from the waist; correct?
A. Yes.
Q. And it's -- you can -- you can have more -- a greater movement forward with -- with flexion than you can with extension; correct?
A. Probably the way he measured it, normal would

be 90 degrees.

Q. Okay. And that's where if you bend forward, you're basically -- your head and your torso is horizontal to the ground?

A. Right.

Q. Okay. So what he noted was a 20-degree flexion; right?

A. Right.

Q. So a 20-degree flexion is not -- probably not much more than what I'm showing you here. It's tilting forward, but certainly this would be 45, I guess.

A. Maybe not quite. It's somewhere in between those two. It would be more like 20, I would say.

Q. But in any event, would you agree that Dr. Cash's findings of 20 degrees flexion, 10 degrees extension would indicate that she had severely limited mobility --

A. Agreed.

Q. -- from the waist?

A. Yes.

Q. And would you agree that if she, in fact, had that, if that was an accurate assessment, that she would have extreme difficulty engaging in activities of daily life; right?

A. Not necessarily.

Q. Would you agree that she would have extreme difficulty in bending over to tie her shoe?

A. If -- most people don't bend over to tie their shoes with their knees straight. And physicians do these tests of spinal motion with a person's knees completely straight. So we're just trying to put force and motion just on the lower back. So I don't know.

She may have had extreme difficulty bending over and tying her shoes, bending her knees. She may have been able to figure out a way to do it and protect her lower back. So I'm not sure. She certainly wouldn't have been pain-free doing daily activities.

Q. And -- and would you -- I just gave you two examples -- examples of, I think, dressing and -- and tying shoes. But would you agree, though, that we engage in -- people engage in a lot of activities on a daily basis, not just those two examples that I gave you?

A. Correct.

Q. That's anywhere from washing and showering and dressing and -- and any sorts of movements that require bending, lifting, pushing, pulling, require a lot of mobility in the waist; right?

A. Varying degrees, I would agree with that.

Q. Okay. And so -- and so did you -- were you

aware that after this accident that Ms. Garcia had -- the day after the accident, were you aware when she first went back to work?

A. I don't recall as I sit here. I would have to look at the records.

Q. And if I was to tell you that she went back to work the -- the next day after the accident, would that refresh your recollection?

A. That sounds about right.

Q. Now, it sounds about right, but I don't believe that you had indicated anything in your -- in your report, your comprehensive medical evaluation, as to whether she -- how much time she missed from work or whether she was able to, you know, continue working and whether she was able to complete all of her duties that are expected of her in her job position; is that correct?

A. I would have to look at my report. I don't remember as I sit here.

Q. Feel free. And we're just looking at that first report of July 4th of 2013. And if I can -- if I can assist -- direct your attention to page 4, there's a section on occupational history, but there may be -- you can look at any page in the report.

A. I would agree that I did not analyze what she

did right after the accident in my report.

Q. Well, as a matter of fact, at the time of your evaluation, you did note that she was working full duty; correct?

A. Correct.

Q. And -- and the other thing you noted was what her occupation was. She was a cage cashier at Aliante Casino --

A. Correct.

Q. -- right?

And then also you had indicated the time that she missed, that she missed about four months of work post accident --

A. Yes.

Q. -- right? But you didn't -- you didn't specify when she missed those four months; right?

A. Agreed.

Q. Isn't it a fact that those four months that she missed came after the fusion surgery in December of 2012?

A. I think that's correct.

Q. Okay. So would it surprise you to learn that she went to work the next day after the accident and worked a full day?

A. No, I think that's probably consistent with

what I had indicated in the report about her time away from work as that four months after surgery.

Q. Okay. And that Ms. Garcia continued working with the exception of those four months after the fusion surgery, and that was at the end of 2012. So she was off for four months in the early part of 2013, that -- do you also know that Ms. Garcia continued working for -- from the time of the accident for the next three years, three months, with the exception of those four months after the surgery?

A. I don't remember the exact time frame. But I know that she did continue to work for quite some time, and the way you're characterizing it sounds about right to me.

Q. Okay. And did you understand that Ms. Garcia had an opportunity to -- to request reasonable accommodations at Aliante to accommodate any physical condition she might have that would limit her ability to perform her duties?

A. I am not aware of that.

Q. Okay. Then -- then is it -- then I would presume that you're not aware that she never made a request for reasonable accommodations for those three years and three months that she worked at Aliante after this accident; correct?

A. Correct.

Q. Okay. So getting back to Dr. Cash's physical examination. By the way, he didn't use a goniometer when he performed this range of motion evaluation of her lumbar spine. He testified to that last week.

So would you agree that if this is accurate, 20 degrees flexion, 10 degrees extension, that that would -- that that restricted range of motion in the waist would severely impede her ability to not just -- to both work and to engage in all sorts of activities?

A. I would say -- I would say it would be expected to create difficulties for her, but I would not necessarily equate that to impeding her difficulties. Because, again, this is a -- a range of motion done with the person's knees straight. And the actual functional activities that -- that you discussed or we discussed involve dynamic movements that include bending of the knees that make it easier on the back.

Q. Doctor, you today, this morning, testified about -- you gave an opinion about Ms. Garcia's physical injury, and you had -- one of the first things you had mentioned was a motion segment injury. Do you recall that?

A. Yes.

Q. And, now, you had defined that for the jury

that that was an injury to both the facet joints and to the disks --

A. Yes.

Q. -- correct?

Now, you have reviewed a whole bunch of medical records in this case; right?

A. Yes.

Q. And would you agree that there was no other doctor -- none -- strike that.

Would you agree that none of Ms. Garcia's treating physicians had identified or made a diagnosis of a motion segment injury or pathology as a result of this accident?

A. I guess I need you to clarify if you're asking if they used that specific terminology of motion segment injury.

Q. Yeah, let's start with that. Isn't it a fact that no other doctor in this case made a diagnosis in any of the records you reviewed of motion segment injury or motion segment pathology?

A. Probably not. I don't think I saw that exact terminology used.

Q. And as a matter of fact, with respect to -- with respect to the facet joints and the disks, at the time that you performed your evaluation in June of

2013, isn't it a fact that -- that no doctor had yet identified whether there was a facet and/or disk involvement, there was only a -- an impression made, but no one actually identified that there was both a facet joint and a disk involved at that point?

A. I don't know about that.

Q. Okay. Well, from your review and preparation for trial, can you tell me if you recall reviewing any medical opinions from any doctors in this case that they -- it was their belief that there was both a facet injury and a disk injury of June of 2013?

A. Well, I think -- I think it was clearly implied medically that there was based on all the tests that were done. She had procedures to the facet joints that gave her temporary benefit. She had procedures near the disks that gave her temporary benefit.

And so I think that the doctors, by virtue of their procedures and what's implied by those, would have stated it was both facet and disk. I don't think that the doctors were interviewed for a definitive opinion at that time. And so it may not be in a report or filed as such, but I think it was -- it was obvious to me.

Q. Well, you had testified on direct that you thought -- when referring to Dr. Lemper's selective

nerve root block -- that was the first one that he gave, August 30th of 2011 -- you said you thought there might have been something therapeutic -- therapeutic benefit.

She got relief for about one or two days; right?

A. Yes.

Q. But on your direct examination -- you wouldn't consider that as being diagnostic of a pain generator?

A. You're going to have to clarify this for me.

Q. Okay. You essentially -- on direct examination earlier today, you basically said that didn't work. You did not consider that Dr. Lemper -- Dr. Lemper's selective nerve root block worked. There might have been some therapeutic benefit, but you didn't see that as a diagnostic tool that identified a pain generator.

A. No, I don't think that's -- that was not my direct testimony.

I think I -- I indicated to the jury that his procedure did not resolve her problems, but I didn't say anything about the -- specifically the diagnostic benefit. I don't believe that was my testimony.

Q. And what your testimony was -- from what I

wrote down, you said there was some therapeutic benefit.

A. That's correct.

Q. Okay. And then after that, I wrote down but you didn't -- you didn't consider that to have worked; you said it didn't work.

A. Right. So it didn't work in resolving her problems. So she continued to have ongoing problems that then required the physicians to look for other alternatives to treat her.

Q. Okay. Okay. Well, we'll come back to Dr. Lemper's selective nerve root block in a little while.

THE COURT: Hold on a second, Mr. Mazzeo.

Anybody need a break over there? Let's take a 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.

Take about ten minutes, folks.

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

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

Anything we need to put on the record, guys?

MR. ROBERTS: Not us, Your Honor.

MR. MAZZEO: No, Your Honor.

THE COURT: Okay. Off the record.

(Whereupon a short recess was taken.)

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

THE MARSHAL: The jury is present, Judge.

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

We're back on the record in Case No. A637772.

Do the parties stipulate to the presence the jury?

MR. ROBERTS: Yes, Your Honor.

MR. MAZZEO: Yes, Your Honor.
MR. TINDALL: Yes, Your Honor.
THE COURT: Doctor, just be reminded you're still under oath.
THE WITNESS: Yes.
THE COURT: Mr. Mazzeo, you may proceed.
BY MR. MAZZEO:
Q. Doctor, by the way, with -- when you have a condition known as a spondylolytic spondylolisthesis, to determine whether this condition is stable or unstable after an incident, trauma, or traumatic event, is it correct to say that one -- one way of ascertaining whether it's become unstable, this condition, is by way of flexion and extension and X rays?
A. Yes.
Q. Okay. And based on your review of the records, you know that Dr. Cash had performed -- had -- had plaintiff -- or Ms. Garcia submit to X rays in his office on February 16th of 2011.
And I'll -- I'll put up the report for you. I just -- it's Plaintiff's 23, page 3. And I'm directing your attention to the radiology and lab reports down at the bottom.
And what he notes -- so he did X rays, fore

view cervical. And then he referred to a slow, sweeping, gradual kyphotic deformity, stable in flexion and extension with little, if any, spondylosis, including the facet joints.

Do you see that?

A. Yes.

Q. And then he -- of the lumbar spine.

He noted he did not identify -- so he didn't identify any instability to the neck or to the lumbar spine; is that correct?

A. The flexion extension he's referring to here, it looks like that's just for the cervical. And he's not specifically talking about it with the lower back X ray unless there's something on the next page.

Q. But what I'm -- what I'm referring to -- no. It's on that page, Doctor.

What I'm referring to is that Dr. Cash did not identify or note that there was any instability to the spondylolytic spondylolisthesis at the L -- L5-S1 juncture; correct?

A. I guess what I'm saying is, I don't think that this page even comments on his analysis of that. I'm not seeing that.

Q. Okay. Fair enough. Now, part of your -- part of your evaluation was to -- to -- was to

ascertain mechanism of injury; correct?
A. Yes.
Q. And you actually have a section in your report identified as Mechanism of Injury; correct?
A. By history, yes.
Q. By history. Okay.
And -- and when we talk about mechanism of injury, we're talking about the event or circumstances that cause the alleged injuries; correct?
A. Yes.
Q. Okay. And -- and one of the reasons for understanding and identifying the mechanism of injury -- injury is to medically and biomechanically understand the injury which occurred and the appropriate treatment for such injury; correct?
A. Yes.
Q. And as you just indicated, your understanding of the mechanism of injury in this case was based on Ms. Garcia's self-report to you?
A. Yes.
Q. And isn't it a fact that you don't know what part of Ms. Garcia, if any, struck the inside of her vehicle, if at all, at the time of the impact?
A. Agreed.
Q. And isn't it a fact that you don't know the

manner in which Ms. Garcia's body moved as a result of the impact from this accident?

A. Agreed.

Q. And you don't know the -- is it fair to say you don't know the severity of the impact that Ms. Garcia -- that that occurred to the vehicle or to Ms. Garcia as a result of this impact?

A. Well, I've seen the traffic accident report. But I certainly don't have that level of expertise to analyze the accident reconstruction and those sorts of things.

Q. Well, okay. Fair enough. And isn't it a fact that the traffic accident report does not allude to or indicate that -- the severity with which the impact occurred to Ms. Garcia as a result of this accident?

A. Agreed.

Q. Another section in your report is -- is "chief complaints"; is that correct?

A. Yes.

Q. And the chief complaints are the symptoms that Ms. Garcia reported to you was -- were her symptoms that she reported to you on the date of your evaluation; correct?

A. Yes.

Q. Okay. Now, moving on to "history of present illness," the history of present illness was based on your -- the self-report by Ms. Garcia to you; correct?

A. Yes.

Q. And what she reported to you as of June of 2013 was that she had an initial 70 percent improvement after the surgery?

A. Yes.

Q. That had -- that had diminished to 50 percent by May of 2013?

A. Yes.

Q. And so this -- this -- strike that.

Typically -- one second.

Typically, based on your experience as a -- as a treating physician and a forensic expert, when you have a two-level fusion, the optimal result is about an 80 percent improvement; correct?

A. When I counsel patients, I will tell them that -- depending -- certainly depending on how long they've had the problem, we can give realistic expectations. But a 50 percent reduction in symptoms is considered a good outcome. An 80 percent reduction in symptoms would be considered an excellent outcome.

Q. Okay. Now -- so -- and at the time of your evaluation, Ms. Garcia told you that she had ongoing

symptoms with constant low back pain that were worse in the morning --

A. Yes.

Q. -- right?

Constant numbness in the right thigh?

A. Yes.

Q. Okay. And -- and with respect to her reduction in activities of daily living, did you indicate that in your report within -- based on the self-report of what Ms. Garcia told you?

A. To a certain degree, on page 3 of my report, I discussed some of those things.

Q. Okay. And those things that you discussed on page 3 were her limitations at the time of your evaluation; correct?

A. Yes.

Q. And did -- did Ms. Garcia tell you that as of -- let me just find the correct page -- I believe as of April of 2013, so about two months before your evaluation, that she had driven to Texas to see her mom?

A. I don't recall discussing that.

Q. Okay. Did Ms. Garcia ever tell you -- aside from the exact date, did she ever tell you, though, that she drove to Texas to see her mom?

A. I don't remember discussing that with her at all.

Q. Okay. Okay. Now, you also took a social history from Ms. Garcia as well. And that section, the information that Ms. Garcia reported to you, that was her self-report?

A. Yes.

Q. And at that time Ms. Garcia told you she was not psychologically stable?

A. Correct.

Q. And that's a subjective statement; correct?

A. Correct.

Q. And, however, at the time of your evaluation when she told you this, you had not determined the nature or scope of what she was referring to --

A. Right.

Q. -- correct?

So you didn't attribute that statement that she was not psychologically stable to the motor vehicle accident; correct?

A. Right. I didn't know necessarily one way or the other.

Q. Now, you also -- oh, on direct examination, you were asked questions about -- about the treatment she received -- well, actually, the evaluation she had

at MountainView Hospital; correct?

A. Yes.

Q. Because she didn't -- she wasn't treated at MountainView Hospital.

She was just evaluated for her alleged complaints; correct?

A. Well, I -- I think there was a treatment recommendation for some medications, and I think they gave her a prescription. So I think that falls in the umbrella of treatment.

Q. Okay. Aside from the prescriptions they gave her when she was released from the hospital, she wasn't otherwise treated with any -- any form of therapy at the hospital?

A. Agreed.

Q. Okay. And I believe on direct examination you were asked by Mr. Roberts about any radio-diagnostic testing and -- that she had submitted to.

And I believe on direct you said you don't recall that -- MountainView Hospital taking any radio-diagnostic studies; right?

A. Right.

Q. I believe -- and this might refresh your recollection -- if we look at your report for

January 5th of 2011, she, in fact, had an X ray of the chest on January 5th and a CT scan of the brain on January 5th.

And I'll just direct your attention to page 5.

A. Right.

MR. ROBERTS: Objection, Your Honor. Mischaracterizes the record.

MR. MAZZEO: Your answer was?

THE COURT: I don't know if it mischaracterizes the record. Let's let him answer and see what he says.

THE WITNESS: I see that summary in my report.

BY MR. MAZZEO:

Q. Okay. And that -- that summary would indicate that -- unless -- unless you can articulate otherwise, that would indicate that she had that -- these diagnostic studies at MountainView Hospital?

A. Something tells me that this CT scan may have been an error, that it may have been the wrong patient.

Q. Is that based on a record you were given by Plaintiff's counsel?

A. Or a discussion that I had with them in preparation for today. But I'm not sure.

Q. Okay. Fair enough. All right.

You also testified on direct examination that the chiropractic treatment that she received and the physical therapy didn't resolve her pain.

A. Correct.

Q. But based on your review of the records by the chiropractor and the physical therapist, would you agree that she had an improvement from the treatment she was getting?

A. Agreed.

Q. Okay. And -- and you gave an opinion today regarding the reasonable and -- reasonableness of the charges from the physical therapist.

Who was the physical therapist she treated with in August and September of 2011?

A. It was Select Physical Therapy, I believe.

Q. And I didn't see -- maybe you can show me -- direct my attention where in your report you actually reviewed records from Select Physical Therapy.

A. I didn't have those records when I authored that first report.

Q. Okay. So you had those records -- you referred to billing, I know, later on. And I see that you had -- you were given billing records from Select Physical Therapy. But I didn't see in any of your

reports that you actually reviewed Select Physical Therapy records, if at all.

Can you tell us if you did?

A. I don't know if I did. I thought that I had reviewed the physical therapy treatment records from Select, but I'm not sure. I've done a lot of different reports.

Q. Okay. Now, I note in -- in your second -- in your second report, which is your first supplemental report, dated July 23rd of 2013, on page 2, you have -- you received a bill, in any event, from Key Health, physical therapy charges.

That might have been the biller for Select Physical Therapy?

A. Yes, that's correct.

Q. Okay. So you had the billing.

But as you -- as you said a moment ago, you're not sure if you actually reviewed the Select Physical Therapy records?

A. I guess I'd have to look through each of my reports to tell -- to give you the answer. I don't know.

Q. Fair enough. Well -- so you've said that that treatment -- it didn't resolve her pain.

Can you tell us how much treatment she

receive at Select Physical Therapy?

Not just the dates, the -- the first date and the ending date. I want to know how many dates she actually sought treatment for.

A. I think it was around ten treatments or so during that time frame.

Q. Okay. And -- and what's your understanding as to the improvement she received at Select Physical Therapy?

A. I could not tell you.

Q. Okay. Now, also you testified about questionnaires during the course of your comprehensive medical evaluation.

You had administered various questionnaires to Ms. Garcia; correct?

A. Yes.

Q. And you identified them -- I guess they were basically pain questionnaires; correct?

A. Yes.

Q. And in this case -- I know you don't use this questionnaire anymore, but you referred to the McGill Pain Questionnaire.

A. Yes.

Q. And this questionnaire -- this questionnaire was based on -- or the responses by the -- by the

patient is -- is based on the -- the patient's own perception of their own pain, which is a -- which is subjective; correct?

A. Yes.

Q. And with this McGill Pain Questionnaire, that's where the patient chooses words from a list of 20 different categories; correct?

A. Yes.

Q. And do you agree that a person without any pain could ascribe pain to a condition which does not exist?

A. Sure.

Q. You had -- there's -- and that -- and that's because, with this pain questionnaire, McGill Pain Questionnaire, there's no validity indicator for this test; correct?

A. Tell me what you mean by that. I don't understand.

Q. Well, there's no indicator, meaning that -- that a patient could basically identify any words to indicate that -- any level of pain.

And McGill Pain Questionnaire does not have any way to validate or verify the patient's perception?

A. I would agree with that.

Q. Okay. And I think that's one of the reasons

why you no longer use this pain questionnaire.
A. That is correct.
Q. Okay. And the pain -- this McGill questionnaire -- the validity of the test depends on the accuracy or honesty of the person answering the test; correct?
A. Yes.
Q. And -- and so you also agree that this test can be manipulated to exaggerate the degree of pain?
A. It could.
Q. You talked about the Oswestry Low Back Pain Disability Questionnaire as well; right?
A. Yes.
Q. And that's to -- to assess pain related to disability in persons with low back pain; right?
A. Yes.
Q. I believe on direct examination you said that Ms. Garcia scored a 32 percent on this; correct?
A. Yes.
Q. And -- and that -- that 32 percent falls between a perception of moderate disability?
A. Correct.
Q. Now, this test, it's self-administered questionnaire, subjective questionnaire with ten categories; right?

A. Right.
Q. And most patients complete this in about five minutes or less?
A. Probably.
Q. And it's the measure of the -- a patient's perceived disability, but it's not an actual disability reflection; correct?
A. Agreed.
Q. And the limitations with this test is that it's very subjective; correct?
A. It is. All of these tests are that we're talking about -- or, I'm sorry, questionnaires.
Q. And would you agree that a patient with a medical-legal claim has the ability to exaggerate the results of disability for monetary gain?
A. They could.
Q. And you agree that -- that the answers to the questions that are in this Oswestry Low Back Pain Disability Questionnaire could be influenced by a party's interest in a litigation?
A. If a person were savvy enough to understand what the questionnaire was, they could manipulate the answers one way or the other.
Q. Okay. Now, let's move on to -- you had testified that MountainView Hospital -- there was a

diagnosis -- let me -- give me a moment. I just need to turn to my notes.

Okay. So, Doctor, you -- you had testified that you reviewed various medical records in this case including those from MountainView Hospital; correct?

A. Yes.

Q. And you saw that the diagnosis or impression was of low back strain --

A. Yes.

Q. -- correct?

And -- and you also know that Dr. Gulitz diagnosed Ms. Garcia with cervical lumbar sprain and strain?

A. Yes.

Q. And sprain and strain, for the jury, is -- is basically myofascial muscular pain causing spasms?

A. Spasms or pain.

Q. Okay. And if you have myofascial muscular pain, that doesn't necessarily indicate disks or facet joints; right?

A. Correct.

Q. So let's go to -- I believe you offered an opinion regarding -- you -- you -- your opinion -- one of your opinions in this case. And I guess your diagnosis was a L5-S1 motion segment injury with

aggravation of a previously asymptomatic spondylolytic spondylolisthesis; correct?

A. Right.

Q. And the word you used was "spondylotic," which is synonymous with spondylolysis; correct?

A. Right.

Q. And when we talk about spondylolysis, we're talking about a pars defect?

A. Yes.

Q. And that's a defect in the interarticular joint; it's part of the facet joint?

A. It's part of the bony structure that goes to the facet joint.

Q. And a pars defect usually occurs or develops from a young age or from a -- an injury causing a fracture, correct, or a defect?

A. Congenital usually. It could be trauma in childhood, but most of the time, it's just congenital; you're born with that defect.

Q. Okay. And your testimony in this case was that -- by the way -- strike that.

You had -- I don't think you reviewed actual MRI films in this case, but you reviewed the MRI reports; is that correct?

A. Initially in 2013, just the reports.

Eventually, as you know, I looked at the MRI scans directly.

Q. Okay. So -- and the MRI report showing the condition of the spondylolytic spondylolisthesis, the -- your assessment was that it had predated the subject motor vehicle accident?

A. The offset at L5-S1 I thought probably did predate at least to some degree.

Q. And when we talk about the offset, we're talking about the pars defect and the slipped vertebrae?

A. Correct.

Q. Okay. And it's -- and you can state that confidently to a reasonable degree of medical probability that the spondylolytic spondylolisthesis existed prior to the motor vehicle accident?

A. Yes.

Q. Your understanding was that -- from Ms. Garcia's self-report was that she was asymptomatic in this location prior to the accident?

A. Correct.

Q. Okay. And so your determination of this, of the fact that -- strike that.

Okay. All right. What I wrote down from your direct examination, Doctor, was that there were

three things. You determined that -- that she would have been asymptomatic -- or you believed that she was asymptomatic if -- in this with regard to the area of the L5-S1, the pars defect and the slipped vertebrae, because, No. 1, she reported to you that she was asymptomatic prior to the motor vehicle accident; right?

A. Right.

Q. And then you -- No. 2 was the absence of any prior medical records. You didn't review any other records that would indicate that she was symptomatic; right?

A. Right.

Q. And then the third thing you said was that it's common for patients who have a spondylolisthesis to be asymptomatic -- to be not symptomatic or asymptomatic?

A. Right.

Q. Those three things. Okay.

And would you agree, though, that there was -- none of the reports that you reviewed, the MRI reports that you reviewed at the time of your evaluation on June of 2013, indicated that she sustained an acute injury to this pars defect and spondylolisthesis?

A. The terminology of acute injury has to be defined because MRI has limitations in identifying acute injury. There wasn't any evidence of hemorrhage. There wasn't evidence of dislocation at that level. And so I did not see any of those findings of acute injury at that level.

Q. Okay. And also neither Drs. Cash or Dr. Gross ever identified any objective finding of an acute injury from their review of any diagnostic study?

A. I don't think that I saw in their records anything like that.

Q. Okay. Now, you had mentioned that the motion segment -- that you -- well, you had told us that motion segment injury involves both disk and the facet joints; right?

A. Yes.

Q. And -- and I believe you came to a determination that -- your opinion regarding this diagnosis of motion segment injury was, in part, based on the injections given by Dr. Lemper?

A. Right.

Q. Okay. Okay. Let's talk about Dr. Lemper's selective nerve root block for a minute. You contend that Ms. Garcia received relief from the selective nerve root block which was now -- his selective nerve

root block was to the disks and the interarticular facet joints; is that correct?

A. He initially did the injections to the nerve blocks -- or I'm sorry. He initially did nerve block injections and then subsequently did facet block injections.

Q. That's correct. So I'm -- so initially he did the selective nerve root block to identify whether the source was discogenic on August 30th of 2011.

A. Correct.

Q. And then he subsequently, on September 14th of 2011, did what is referred to as a medial branch block or facet joint block --

A. Correct.

Q. -- correct?

Okay. And he -- and when he did those blocks, he did it at -- he did it at three levels. Let me -- let me be more specific.

The selective nerve root block he did at the levels L3-4, L4-5, and L5-S1 bilaterally; correct?

A. Yes.

Q. Bilaterally -- bilaterally means right and left side?

A. Yes.

Q. Okay. And so three levels on both sides

would be six different sites or six different joints that he injected --

A. Yes.

Q. -- correct?

And that was to identify whether the source of pain was discogenic; right?

A. There were two components. One was to potentially provide some benefit to Ms. Garcia by injecting some medicine into those joints. And the next potentially was to get some information as to whether a problem existed at those levels because he put some numbing medicine in the areas as well.

And if the problem existed, at least in part, to those facet joints, or to -- if we are talking about nerve roots, the numbing medicine would numb up the painful area, and you could assess in the first 30 minutes to few hours whether the person had any reduction in their pain and get some information about the pain generator.

Q. And we've already discussed the fact that she received one to two days of relief after the selective nerve root block; right?

A. Yes.

Q. But because it was performed at three levels bilaterally, is it fair to say that Dr. Lemper was not

able to identify the pain generator, whether it was right or left side, and which level?

A. Right. He wasn't -- you can't narrow it down to one particular side or one particular level. You can just say that there's something going on with one of those lower back disks.

Q. Right. And, now, Ms. Garcia -- Garcia had reported a 60 percent resolution of low back pain and lower extremities and 30 percent reduction in hip symptoms.

A. At the time the injection was done, yes.

Q. Right. And when we say "at the time," we're talking immediately post procedure she reported this?

A. Correct.

Q. And -- and then she also reported a complete resolution from the interarticular facet blocks; correct?

A. Yes.

Q. And that was also at the time -- immediately following the procedure; correct?

A. Yes.

Q. Before she was released from Dr. Lemper's facility, that's when she reported it; correct?

A. Yes.

Q. Okay. Now, you also know that, when

Ms. Garcia had the selective nerve root block performed, that she was given a sedative --

A. Yes.

Q. -- correct?

And -- and do you agree that relief reported within 30 minutes or even 45 minutes of -- of post procedure could be due to the effects of the anesthesia and narcotics used for the procedure?

A. I would agree that sedatives can influence the reporting of a patient after an injection. I think that I have seen that happen in my patients sometimes.

Q. And that's because the effects of the sedative remain in the body for a certain period of time after the procedure.

A. Depending on what sedative is used, it remains in the body for some period of time.

Q. And we know in this case that Dr. Lemper had used -- well, actually, his anesthesiologist with him had used the general anesthesia of midazolam and there's a local anesthetic of marcaine that was used.

A. Okay. I actually don't remember what they used, but they used something.

Q. Okay. So -- and Dr. Lemper already testified, so that's already in evidence and -- and in the record.

So would you agree that the sedative effect from the general anesthesia midazolam and the local anesthetic marcaine might -- might account for some of the reporting of resolution of symptoms following this procedure?

A. I think it's a potential that it could report -- I'm sorry -- could be responsible for some of the change.

Q. And would you agree that following the procedure, if Ms. Garcia's in a non-weight-bearing position before discharge, that might account for some of the resolution?

A. It might.

Q. And isn't it a fact that you cannot, as you sit here today, state to what extent the sedative and the prone position that Ms. Garcia was in, to what -- to what extent that accounted for 60 percent of the resolution of her low back and lower extremity symptoms?

A. I -- no, I think that I could tell you that I would agree with you that it might have contributed -- contributed to some of that perceived improvement, but certainly not all of it, and probably not even half of the improvement.

Q. Isn't it a fact, Doctor, that you have no

basis to say that, considering that -- well, strike that.

How long does the midazolam -- how long are the effects in the body for?

A. I don't know exactly. It's a medicine. It's benzodiazepine. It's short acting; probably a matter of an hour or two.

Q. And local anesthetic marcaine?

A. Well, the marcaine lasts for hours.

Q. For about four to eight hours?

A. Yes.

Q. Okay. And so you would agree that if she reported a resolution of symptoms within 30 minutes post procedure, even 45 minutes post procedure, and she's sitting on a gurney, sitting or lying down, that she's still feeling the effects of this local anesthetic that was injected into her, this marcaine?

A. Well, let's be clear. The marcaine was injected as part of the medicine that was injected either at the nerve root level or at the facet joint level, which is where they wanted the medication for diagnostic purposes.

So any effect that the marcaine would be, because it's -- it's placed in the area of pain generation. I think the potential influence that could

confuse the results would be the effect of the midazolam, which is used as a sedative, and the fact she's not weight bearing or moving around. I think those are the two things that could confuse some of the results.

Q. And so isn't it fair to say that you do not know to what extent -- you can't sit up there and say, well, you know, I know to a reasonable degree of medical probability that her reporting of resolution of pain following this procedure that 33 percent was attributable to this and 60 is other -- 66 percent is attributable to something else? You can't say that, can you?

A. Of course I'm not going to give you a percentage like that. But I can tell you, I mean, this is something that is commonly done by pain management physicians. And I realize that it's not -- I realize that this -- this point you're bringing up as a factor, that always has to be considered and reconciled when you're evaluating the results. And I'm -- I'm telling you that while I can't give you a percentage, I think that -- that the influence is probably potentially present, but I don't think it's up to half of the -- the results.

Q. Let's move on to the -- to the imaging

studies that you reviewed in this -- in this case. And specifically you had the reports -- the X rays that were done on January 17th of 2011, cervical thoracic lumbar spine, you have the 1/26/11 MRI report as well; correct?

A. Yes.

Q. Okay. And you also had the Nevada Imaging report from August of 2011.

A. Yes.

Q. Okay. So the -- referring to the 1/26/2011 MRI report, several findings in that report in addition to the 4-millimeter anterior subluxation at L5 over S1; correct?

A. Yes.

Q. So -- and by the way, when I reference -- the term "subluxation" is -- also refers to spondylo- -- it's a slipped vertebrae; right?

A. You could use the word "slip." I guess I -- I used the word "offset" earlier. The word "slip" implies that you got something that's sort of actively moving. But -- and I don't think that that's what was happening. It wasn't like it was up unstable, about ready to slip off the edge. That's why I usually don't -- I refrain from using the word "slip." I usually use the word "offset."

Q. Okay. Thank you for that clarification.
So -- so "subluxation" refers to an offset?
A. Correct.
Q. Okay. And then on -- also this MRI showed an L4-L5 disk desiccation; correct?
A. Yes.
Q. Which represents, as we have heard in trial, a drying or dehydration of a disk?
A. Yes.
Q. Okay. And this -- this is a chronic radiographic finding predating the motor vehicle accident?
A. Yes.
Q. And then the L5-S1 shows disk desiccation with a 2-millimeter annular disk bulge --
A. Yes.
Q. -- right?
And also a facet -- at this level, a facet joint hypertrophic change; right?
A. I didn't summarize that, but that would not surprise me if it's in the report.
Q. Okay. Well, let me ask you about that. Before I move on to the next question, let me just show it to you. So we're -- since you didn't have it in your report.

So we're looking at the January 26th, 2011, MRI report from Las Vegas Radiology for the lumbar spine; correct?

A. Yes.

Q. Okay. And then we -- it ends at referencing no abnormalities at L1-2, 2-3 or 3-4; correct?

A. Correct.

Q. And that's Plaintiff's 195. Going to move on to Plaintiff's 196. And this continues at the top, and I just want to direct your attention to the L5-S1. It says there are facet joint hypertrophic changes; right?

A. Yes.

Q. Okay. And you have no reason to dispute those findings by the radiologists in this report; correct?

A. Correct.

Q. Okay. And would you agree that facet hypertrophic change is a -- facet joint hypertrophic change is a age-related, degenerative-type finding to the facet joint?

A. Yes.

Q. And it's something you would probably expect to find in a person who has a spondylolisthesis?

A. Yes.

Q. Why is that?

A. Because when there's that developmental change of this small area of bone, there is a change to the associated facet joint that's right nearby. So it's not unusual to see a reported finding where they say hypertrophic change. Hypertrophic just means that the joint just looks like it has maybe a little bone spurring to it.

Q. And the report also shows a -- let's see, "a combination of the findings causes mild narrowing of the lateral recess and neural foramina."

Do you that see that?

A. Yes.

Q. Do you have any reason to dispute that these findings that were present -- that the radiologist identified as present, that the combination of them caused mild narrowing of the lateral recess and neural foramina?

A. No reason to dispute it.

Q. Okay. And would you agree that this foraminal narrowing is -- it most likely predated the subject accident?

A. Probably to at least some extent. I think it was probably there before.

Q. Okay. And also the mild narrowing -- mild narrowing of the lateral recess neural foramina --

well, that also predated the accident; correct?

A. Yes. Same answer.

Q. Right. Okay. And -- oh, would you agree that there was no indication from your summary or -- of the MRI report -- or from the MRI report itself, there was no indication on the image that this -- this particular imaging study of any traumatic or acute changes in the structures at L4-5, L5-S1?

A. Same answer as I gave earlier. The MRI can identify certain acute changes, like a fracture, bleeding, hemorrhage, dislocation, and none of those findings were identified on this report.

Q. Okay. And there was no evidence of any hemorrhage or specific finding of edema --

A. Correct.

Q. -- on this?

And -- and the -- the MRI -- was this one of the MRIs that you actually reviewed later on? You actually looked at the film?

A. Yes.

Q. Okay. And -- and then so -- and also looking at the film, you didn't change any opinions with regard to the findings by the radiologist; correct?

A. I think my measurement of the offset was a little bit different, but other than that measurement

difference, I didn't have any alterations to her findings.

Q. Okay. So even after reviewing the actual imaging study, you didn't note any evidence of any hemorrhage or finding of edema on the film; correct?

A. Correct.

Q. Okay. And -- and edema is also known as an increased collection of fluid?

A. Yes.

Q. And would you agree that if there was a finding of edema, that it would be a -- indicative of a change resulting from an acute trauma?

A. It could be.

Q. Now, you're familiar with the term "degenerative disk disease"; correct?

A. Yes.

Q. And that term is something that's used to refer to the deterioration of a disk as we age, which is a -- which is progressive in each decade of life; correct?

A. Yes.

Q. Meaning, for some examples, we have -- you start to see bulges, even herniations in the third decade of life, and then they -- progressively more of them as we get into the fourth and fifth and sixth

decades of life; correct?

A. Radiographically, that is what -- that is something that is seen in a certain percentage of people.

Q. So -- and it's your opinion that this -- it's your opinion that this motor vehicle accident caused an aggravation of a preexisting asymptomatic condition; correct?

A. As a very general description of what happened, yes. But then I gave you a specific explanation of what -- what occurred.

Q. And -- and if this motor vehicle accident caused an aggravation of a preexisting condition, meaning an aggravation of a preexisting spondylolytic spondylolisthesis, that -- that the best-case scenario for the plaintiff would be an apportionment of this injury, of this condition to the subject accident; correct?

MR. ROBERTS: Objection. Calls for legal conclusion.

THE COURT: I'm going to let him answer.

MR. MAZZEO: Thank you, Judge.

THE COURT: I don't know that -- the term may imply a legal issue, but I don't know that the jury understands the legal issue as -- so I'm going to let

him answer.

THE WITNESS: Anytime -- I'm sorry. May I?

THE COURT: Go ahead.

THE WITNESS: Anytime there is a preexisting condition, issue, there's always the potential for apportionment. When it becomes an issue is when that preexisting condition would likely have resulted in the need for treatment for that individual had the accident not occurred.

So in the case of -- of Ms. Garcia, I considered her preexisting condition of having this offset at L5-S1, but there is nothing that tells me the offset at L5-S1 would likely have become symptomatic in the future or would likely have resulted in her needing treatment in the future.

So for that reason, there -- even though she had it before, there isn't an indication to give a percentage of her need for care to this preexisting condition, simply because she would not have likely required treatment for it in the future.

BY MR. MAZZEO:

Q. Okay. Now, also, Doctor, on direct examination earlier, you were using your anatomical figure up there to show the jurors. You pulled a disk out, and it showed a herniation; right?

A. Yes.
Q. For the nucleus pulposus to escape from the an annulus fibrosis?
A. Yes.
Q. And -- but based on the review of the films, there was no indication that -- and that's all -- strike that.
That's -- also refers to an annular fissure; right?
A. That would be one reason that a person may have ultimately a disk herniation.
Q. Okay. Because an annular fissure is a general term that refers to a disruption or tear in the annulus fibrosis?
A. Correct.
Q. And -- and the annulus fibrosis are these concentric circles of fiber and tissue, and it doesn't necessarily have to mean a tear in the entire wall of the disk; correct?
A. Correct.
Q. Okay. Because a herniation is just one form of an annular fissure that results in the -- that gel -- gel material escaping from within; correct?
A. Because of a through-and-through tear.
Q. Okay. And there was no indication on any

MRI -- well, on the MRI from January 26th of 2011 that there was a breach in the entire wall of the annulus fibrosis; correct?

A. Correct.

Q. And there was no indication from the MRI, from the report and from your review of the film later on, that there was any of this gel coming in contact with any nerves in the neural -- in the foramen, in the openings of the -- of the facet joints; correct?

A. Agreed.

Q. Okay. I -- you also talked about the -- the surgical procedures performed by Dr. Gross in your direct examination; correct?

A. Briefly.

Q. And -- now, a laminotomy -- let's just talk about some of these terms for the jury. They've heard some of these terms as well.

A laminectomy is a procedure which removes the entire lamina from the vertebral bone; correct?

A. Yes.

Q. And a laminotomy is a procedure that just removes a portion of the lamina; correct?

A. Yes.

Q. Okay. I believe you stated that you've treated hundreds of patients postoperatively; correct?

A. Yes.
Q. And would you agree that laminectomies are typically an outpatient procedure with a high recovery rate?
A. Yes. If it's -- if you're talking about just that procedure alone.
Q. Correct.
A. Yes.
Q. Okay. Generally with an laminectomy, recovery time is within a few days?
A. Before they become functional and are moving around, yes.
Q. Okay. And is it -- it's correct to say that, when a laminectomy is performed, typically it's -- or generally it's performed to treat compression or foraminal narrowing of -- foraminal narrowing of a -- of the -- of the -- of the spine?
A. Of the -- either the spine or an exiting nerve root.
Q. Okay. And -- and in addition to that, I kind of got stuck with -- on a question.
It's generally performed -- performed to treat either some type of spinal stenosis compression or narrowing?
A. Agreed.

Q. Okay. Thank you. And in this case -- in this case, the laminectomy that was performed by Dr. Gross was performed to treat the foraminal narrowing in Ms. Garcia's spine, correct, in the nerve root?

A. I think he'd have to answer that question.

Q. Okay. But if it was -- if his treatment was -- if the laminectomy that he performed was -- was done to treat the -- the foraminal narrowing in Ms. Garcia's spine, then that would have been related to a preexisting condition; correct?

A. No. This is complicated because Ms. Garcia would never be having surgery for a preexisting condition that was not causing her symptoms.

So she was having surgery because she had injury to this segment. She was having lower back pain, and Dr. Gross was performing a surgery directed at that segment and the segment above. What he had to do to accomplish that is a combination of things that involved his area of expertise to answer those questions.

But she wouldn't be having the surgery just based on an X ray or an MRI scan that is not causing her symptoms.

Q. So -- okay. So essentially your answer boils

down to the fact that Ms. Garcia had surgery -- Dr. Gross performed the surgery because Ms. Garcia had symptoms in her lower back?

A. She had symptoms following the accident. Those symptoms correlated with a number of factors that included imaging studies and injection results. And the problem did not resolve after an appropriate amount of treatment time and an appropriate amount of conservative care.

Q. And you understand from reading the expert reports of the -- of the defense experts that it's disputed -- there's a dispute as to what the pain generator was in Ms. Garcia's back; right?

A. I have seen those -- I've seen their reports, yes.

Q. Okay. And there's a dispute as to whether -- by the defense as to whether Ms. Garcia needed this fusion surgery performed by Dr. Gross to treat her low back complaints.

A. Yes, I do -- I'm aware of that, yes.

Q. Okay. And this reference that you referred to in your report of motion segment injury, would you agree that there's no findings on any diagnostic imaging studies showing a symptomatic motion segment injury?

A. I guess I need to clarify your question. I want to make sure -- you're asking me if I can put up an MRI scan and -- and point to a particular finding that shows my diagnosis?

Q. Correct.

A. No, I cannot do that.

Q. Okay. And would you agree that there are no findings on any diagnostic studies, MRIs and X rays, showing any acute changes to the spondylolisthesis or the spondylolysis?

A. Agreed.

Q. Would you agree that there is no objective medical evidence that the previously "asymptomatic" spondylolytic spondylolisthesis ever became symptomatic from the motor vehicle accident?

A. Could you repeat that, please?

Q. Would you agree that there's no objective medical evidence that the preexisting asymptomatic spondylolytic spondylolisthesis ever became symptomatic as a result of the motor vehicle accident?

A. I think that the injection results provide some objective information. But I would agree -- I think the intent of your question is objective in terms of an imaging study, and I would agree there's not an imaging study that shows that.

Q. Okay. You referred to -- okay. I mean, this is -- I was going to get to this later, but we'll talk about it now.

The radio-frequency ablations -- Dr. Kidwell had performed a radio-frequency ablation on Ms. Garcia in September. I believe it was September of 2015.

A. Yes.

Q. And -- and this radio-frequency ablation is -- essentially, effectively it burns the nerves. The objective of the technician or the pain management interventionalist is to burn the nerves to stop the signal of pain stemming from that location.

A. From that structure, correct.

Q. From that structure. Okay.

And do you agree that, once those nerves are burned, that they're not going to regenerate within a month?

A. For sure. Agreed.

Q. Okay. And -- and as you testified, typically you -- you see, I guess, in the literature and from your own experience, typically after a radio-frequency ablation, you're going to see a -- the pain to recur within 8 to -- 8 to 16 months. I'll have to look at your --

A. 6 to 18.

Q. Oh, 6 to 18 months?
A. Yes.
Q. Okay. Certainly not within three months after the procedure; correct?
A. Agreed.
Q. Not within two or one month after the procedure; correct?
A. Agreed.
Q. Okay. And -- and it's your opinion that this radio-frequency ablation performed by Dr. Kidwell was successful?
A. Yes.
Q. Now, would you agree that if -- after this procedure was performed, that if Ms. Garcia had a flare-up of the usual pain within a month after this procedure, that the -- that Dr. Kidwell probably didn't target the pain generator?
A. No, I wouldn't agree with that.
I'm aware that she had a flare-up of pain the following month and -- but I don't believe that that is an indicator that he -- that the procedure was unsuccessful.
Q. Well, his goal -- Dr. Kidwell's goal, when he performed this radio-frequency ablation, was to do two things.

One was to -- was to eliminate the pain that Ms. Garcia was complaining about at or around the time that she had the procedure done; correct?

A. I don't know that the goal at -- with pain management is to eliminate. I'm sure it is to significantly decrease.

Q. But you would agree, though, that if -- if the nerves are burned by way of this rhizotomy, that once they're burned, she's certainly not going to feel pain coming from where the nerves were burned; right?

A. Right.

Q. Okay. And we know that he did a radio-frequency bilateral at L3 -- L3-4 and L4-5 facets as well as the right sacroiliac joint?

A. Correct.

Q. Okay. Notwithstanding that, she returned -- and you're familiar with the fact -- you testified that she had a flare-up in the usual pain; right?

A. She had a flare-up of pain.

Q. Well, she actually testified -- she actually reported that she -- and I'm referring to Plaintiff's 26, page 712. And it's on the screen for you. So here it is.

We had the procedure done September -- it was September -- I believe around September 15th of 2015;

correct?

A. September 24th.

Q. I'm sorry. September 24th.

A. I think.

Q. Okay. So -- and -- and then she had a -- after that, she had a -- an office visit on September -- with -- with Dr. -- with Dr. Kidwell, her next office visit was September 30th, a week -- a week after the procedure, September 30th. Here we go.

Right?

A. Yes.

Q. "She returns today for reevaluation. She is one week status post radio-frequency rhizotomy," et cetera, et cetera; right?

A. Yes.

Q. Okay. And then the very next office visit -- here we have -- this is Plaintiff's 26712.

It's -- the date of service is November 11th, 2012; right?

A. Yes.

Q. And -- and she said she was "experiencing flare-up in usual pain at last office visit."

Did I -- did I quote that correctly?

A. Yes.

Q. Okay. So she's not saying that she's

experiencing flare-up in usual -- she's identifying when she had the flare-up in usual pain and that she had it at the last office visit of September 30th of 2015.

A. Okay. I'm getting a little dizzy here. If you could put the September 30 back --

Q. Sure.

A. -- please.

Q. There it is. That's Plaintiff's 26694.

This was the very next -- Doctor, this was the very next treatment date that she had -- or consult date, not treatment date, consultation date after the rhizotomy on 9/24; correct?

A. Yes. But I think -- if I could, this is dated September 30th. The next note you showed me was November. And --

Q. Here it is.

A. -- they're referencing at the last office visit she had a flare. The note you showed me on September 30th doesn't talk about the flare.

There's a note that's missing in this sequence that talks about the flare-up of pain, and it was after September 30th.

Q. Oh. But before November 11th?

A. Yes. That's my recollection.

Q. Okay. Okay. Here we go. I think I had them out of order. Sorry.

Here we have October 14th of 2015. That's Plaintiff's 26702.

So this would have been -- this actually would have been the next office visit after September 30th of 2015.

A. Okay.

Q. Okay. So -- so then -- so then it's your understanding that the November 11th, 2015, report would be when it says she was experiencing flare and the usual pain at last office visit.

She's talking about October 14th?

A. That's my understanding.

Q. Okay.

A. That makes sense.

Q. Fair enough. And so October 14th would be -- that would be 20 days from when she had the radio-frequency ablation.

A. Yes.

Q. Okay. All right. So let's just go to this -- this page, then.

When she's referring to usual pain, that would be the pain that she was -- she would have had -- that preexisted the radio-frequency ablation and the --

which would have been the reason why she had the RFA in the first place; correct?

MR. ROBERTS: Objection. Foundation. Mischaracterizes the record.

THE COURT: He can answer with his understanding.

THE WITNESS: I think that it could be interpreted that way. It's not totally clear, and it's inconsistent with what is described in the prior note from October.

BY MR. MAZZEO:

Q. Now, we know that when she had -- on -- on October 14th, when she had a reevaluation, if the procedure was September 24th, it wasn't a month status post radio-frequency; correct?

A. Right.

Q. Less than a month?

A. Yes.

Q. Okay. And also in this report, October 14th, Dr. Kidwell notes, "She's really deconditioned."

Do you see that?

A. Yes.

Q. Now, you -- you contend that all of the medical treatment -- basically your direct examination with Mr. Roberts today was -- you went through the

board where he showed you all of the -- all of the medical providers that Ms. Garcia saw after this accident. And -- and you attributed and you contend that all of the treatment that is indicated -- all those providers that are indicated on that board was reasonable, necessary, and related to the accident; correct?

A. Right.

Q. Okay. And -- now, you agree that you would have no opinion whether -- with regard to the back brace, we know that she was given a back brace by Dr. Cash and then another by Dr. Lemper; right?

A. Yes.

Q. And you have no opinion whether she would need this back brace to -- for normal activities of daily living; correct?

A. I'm not sure I understand.

Q. Well, you have no opinion as to whether she would need this back brace to engage in daily activities and basic functioning, do you?

In other words, simply -- just because she was given a back brace doesn't mean that it was -- she needed it to -- to engage in her daily activities; correct?

A. I would agree.