No. 71348

IN THE SUPREME COURT OF THE STATE OF NEVADA

EMILIA GARCIA,
Appellant,

v.

ANDREA AWERBACH,
Respondent.

APPELLANT'S APPENDIX
VOLUME XVII, BATES NUMBERS 4001 TO 4250

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nonunion of a spinal fusion, is micromotion?

A. I don't know that micromotion is the cause. But micromotion and pseudoarthrosis happen at the same time. They usually go together. I don't know which is the chicken and which is the egg always, but ...

Q. Well, again, I want to be fair to you. Do you acknowledge that micromotion can cause nonunion? Or do you think that nonunion happens first and then micromotion follows?

A. And, again, either can occur.

Q. All right. Well, let's talk about the chicken. If micromotion causes nonunion, can you explain -- is there a recognized medical mechanism that accounts for that finding?

A. Well, the -- the biology behind it is if there isn't stability in the fusion construct, meaning it there's motion in it, it won't fuse.

Q. But why?

A. I wasn't quite finished with my answer.

Q. Sorry.

A. Except to the degree that there should be some axial stress, fusion actually occurs when there is some shared stress. And that's why those spacers and the -- between the bones are important. Stress being weight across the fusion.

I'm sorry. Your next question was?
Q. Now, before you did the surgery, you had a meeting with your patient; right?
A. Yes.
Q. And the purpose of the meeting was to get her informed consent to your surgical procedure. True?
A. In part, yes.
Q. And in that meeting, you described the risks and benefits of the surgery; right?
A. Yes.
Q. You didn't beat around the bush; right?
A. I don't.
Q. You didn't sugarcoat this one at all; right?
A. I don't.
Q. And all of the risks that you listed to her, the last one is always death; right?
A. It is.
Q. Okay. And she asked you questions, yes?
A. Yes.
Q. And you answered her questions, yes?
A. I did.
Q. Okay. You didn't give her any guarantees this was going to work?
A. Correct.
Q. You discussed with her the likelihood of

incomplete pain reduction based upon outcome statistics; right?

A. Yes.

Q. And based on what you told her, you were of the view that she understood that this might not work; right?

A. I don't think that's true.

Q. She understood that you might not be able to fully reduce the slippage; true?

A. That's true.

Q. And the slippage was the motion that was causing the pain. True?

A. Yes, in part. There were other reasons for her pain.

Q. Now, the outcome statistics that you shared with her to -- to get this informed consent, do you have those memorized or do you have to look them up on some document or some database and read those to the patient?

A. I don't normally read them to the patient. But I do have them in my files, and they are not memorized except the general consensus on these papers is patients, 70 to 80 percent have a good or excellent outcome with this type of surgery.

Q. So this kind of rule of thumb that we have

heard that -- that some spinal surgeons say about one third, one third, one third, you don't subscribe to that; right?

A. It doesn't appear in the medical literature.

Q. Now, after the accident but before your surgery, were there any other subsequent incidents that Ms. Garcia's spine was subjected to that were medically relevant to you in coming to the opinion you have expressed here today on causation?

A. No.

Q. Now, you recollect that on September 14th, 2011, Ms. Garcia had an emergent appointment with Dr. Lemper; right?

A. Yes.

Q. And she came in and related to him that something happened in the shower the previous night; correct?

A. Yes.

Q. And he immediately injected her -- her facets at L3-L4, L4-L5, and L5-S1 bilaterally. True?

A. He did.

Q. Okay. And you weren't involved in the decision to undertake that procedure; right?

A. Correct.

Q. And that's because it was an emergency

situation and she needed it now, and so Dr. Lemper handled it; right?

A. I suppose.

Q. And the history provided has been the subject of other -- of depositions. And do you recollect ever speaking to Ms. Garcia about what happened in the shower on September 13th, 2011?

A. No.

Q. And, you know, I think what you're looking for is -- try page GJL201. Do you have that in your book there?

A. Well, I brought my book. You just tell me what that is. Maybe I have it in front of me.

Q. Why don't I just show it to you. It is from Exhibit 24. And it's from one of your neurosurgical consultation follow-ups, November 1st, 2011. Do you remember that?

A. Thank you. I don't. But I will pull it up.

Q. Second paragraph.

A. Oh, indeed. I apologize. I did talk to her.

Q. I'm here for you, Doctor.

A. Finally.

Q. So what she said was three weeks later, she felt a shocking pain in her low back while in the shower. She crawled into bed and could not move for

over a day. Do you see that?

A. I do.

Q. Did Ms. Garcia ever told you -- tell you that she also crawled out of the shower that day?

MR. ROBERTS: Objection. Misconstrues evidence.

THE COURT: Overruled. The way he asked it, he's just asking if he was told that.

THE WITNESS: I don't know.

BY MR. STRASSBURG:

Q. Okay. Now, is it possible, is it even conceivable that a slip and fall in a shower can cause pain or injury to a spine in the condition of Ms. Garcia's?

MR. ROBERTS: Objection. Hypothetical not based on the facts in this case.

THE COURT: Overruled. He can answer.

THE WITNESS: Given that this is a complete hypothetical, since there's no evidence of any slip or fall, it's simply pain while in the shower, anything's possible.

BY MR. STRASSBURG:

Q. So it is possible that a slip and fall in the shower can cause the kind of condition that you've been treating for four years; right?

A. Well, possibly, but unlikely, given that we were already treating her for these symptoms and she described to Dr. Lemper an increase in the symptoms while in the shower and not describe any slip and fall.

Q. Is it possible that merely bending over in the shower to wash your legs, you know, could produce forces in the back that would further injure Ms. Garcia's spine?

A. Well, it's extremely highly unlikely given, I expect, she had been showering for the better part of over 30 years prior to that day; but as a reasonable man, anything is possible.

Q. And so that's why the fact that she hadn't had any pain before this accident was so important to you; right?

Right?

A. It's an important factor.

Q. Yes, because it showed you that all of her activities of daily living that her spine had gotten used to for 30 years had not caused her any pain; right?

A. I'm not aware of any prior pain, correct.

Q. Okay. And that -- but the importance of that fact to you was that everything she was doing with her spine for those 30 years -- walking, running, whatever;

right? -- did not subject her spine to forces great enough to injure it. True?

A. I don't know that I could speak to the daily forces on her spine --

Q. Well, she didn't have any pain, Doctor.

A. I didn't finish my answer. I don't think I can speak to those forces. What I can speak to is the clinical picture. No pain before, a traumatic event, and then pain after from that event very close in proximity to that event with the reasonable mechanism. So I have to look at all that information.

Q. And the clinical picture is important because it showed you that all of the forces her spine had been subjected to for years and years before the accident did not cause her pain in her back or legs. True?

A. Correct. I'm not aware of any such preinjury back or leg symptoms of any import.

Q. All right. Now, you have charged for your services for the care and treatment of Ms. Garcia. True?

A. I have.

Q. And you have -- you decided from the get-go to accept her as a patient to be treated on a lien; right?

A. Yes.

Q. And you understand how medical liens work in Nevada; true?
A. What do you mean?
Q. You understand how medical liens work; right?
A. I don't know what you mean. If you can be specific, I will be happy to answer.
Q. Sure. You know what a lien is; right?
A. I do.
Q. And you know what working is; right?
MR. ROBERTS: Objection. Vague.
THE COURT: Sustained.
BY MR. STRASSBURG:
Q. All right. Let me try again. You know what to expect with a lien; right?
A. Again --
Q. Still too vague?
A. -- I don't know what you mean.
Q. Okay. So you know that when you treat on a lien for a patient who has a case in litigation that the only way you get paid is if she gets money; right?
A. No. I think I have testified earlier in this courtroom, and again today, the outcome of the trial has nothing to do with the payment for services.
Q. Nothing whatsoever?
A. Correct.

Q. You could care less how this case comes out; right?
A. I hope justice is served, but I'm not contingent --
Q. Don't we all.
A. I didn't finish my answer. Would you like the rest of it?
Q. Sure.
A. There's nothing contingent about my services, and she and I discussed that well prior to any litigation I was aware of.
Q. Now, do you still own that lien?
A. I do.
MR. ROBERTS: Objection. Irrelevant.
THE COURT: Sustained. I don't know that it matters.
BY MR. STRASSBURG:
Q. Okay. Now, have you entered into any agreements, contracts with any of the providers of medical services to Ms. Garcia other than yourself to serve as a collection agent for any of those parties?
A. Just one other.
Q. And that was Pacific Hospital of Long Beach; right?
A. No.

Q. Who was it?
A. The assistant surgeon, Ron Fillmore, RN-FA.
Q. Okay.
THE COURT: You know, I'm going to go back. I sustained a -- an objection to whether or not he still owned the lien. I think that is relevant, so I'm going to overrule that objection.
MR. STRASSBURG: Okay.
MR. ROBERTS: He answered anyway, Judge.
MR. TINDALL: May we approach?
THE COURT: Come on up.
(A discussion was held at the bench, not reported.)
BY MR. STRASSBURG:
Q. Do you know whether the bill from Pacific Hospital has been guaranteed for payment by anybody?
A. I don't know.
Q. Now, you indicated that all the charges of Pacific Hospital were reasonable except hardware; right?
A. Correct.
Q. And if I could just show you from the -- this would be Exhibit 24338. Oh, there's pages missing. Hmm.
MR. ROBERTS: Objection. Move to strike.

THE COURT: Yes, sustained. I don't know if that was a statement or question.
BY MR. STRASSBURG:
Q. Do you recollect what -- exactly what Pacific Hospital charged for the International Implants that you used in your surgery?
A. I think it was between 115,000 and 124,000. They might have been conflicting bills.
Q. Now, if I told you it was $115,108, would that ring a bell?
A. I suppose.
Q. Now, the bills of Pacific Hospital, there's a line item -- and you reviewed those bills; right?
A. Yes, I did.
Q. There's a line item for International Implants. That's the 115; right? And then there's a line item for other implants, 129,694. Do you know what those are?
A. I think the other implants is the International Implants plus the bone putty.
Q. Okay. So they're duplicate charges. They both have the implants in them; it's just the other one has the bone putty?
A. That's my belief. Otherwise, the hospital bill -- 90-some percent of the hospital bill would be

those two charges, which doesn't make sense, looking at the rest the bill.

Q. Yeah, it didn't to me either. So 14,000 for bone putty?

A. I suppose. I did say those were a little high.

Q. What did each one of those screws cost?

A. I would have to look at the bill.

Q. Well, it's not by the screw. It's -- it's just like a lump. Do you know what each screw cost?

A. I don't have that knowledge in front of me. But it is by the part. It's not by the lump. You're seeing the lump amount on the bill, but I'm sure there's a breakdown in the distributor sales log or what have you.

Q. But the International Implant, those were the implants that you used; right?

A. International Implants is a distributor. The actual implants are listed on the op report from which company.

Q. Okay. So that's the U.S. Spine Titanium Alloy --

A. Yes.

Q. -- is the manufacturer?

A. Correct.

Q. Okay. I see. So International Implants is just like the Home Depot, and U.S. Spine is -- is like the Makita tools?

A. Yes.

Q. Okay. Got it. Now, when was the last time you saw Ms. Garcia?

A. A couple of weeks ago.

Q. And did you have occasion to assess her physical condition a couple weeks ago?

A. Yes.

Q. Anything about her physical condition that would prevent her from coming to court?

A. I mean, she has days where she has to rest due to some symptoms. I don't know that she could sit here every day all day.

Q. But generally she's -- has the physical capability to come to court?

A. Generally, yes.

Q. And have you issued her any instructions limiting her activities?

A. She and I discussed common sense, and she limits herself, avoiding a lot of lifting and bending, if possible.

Q. So you didn't put her under any restrictions that would have prevented her from coming to court for

this trial; right?

MR. ROBERTS: Objection. Irrelevant.

THE COURT: Overruled.

THE WITNESS: I didn't personally, but I wasn't asked by her either way to evaluate that.

MR. STRASSBURG: I'm going to stop, Judge. Thank you.

MR. ROBERTS: Yes, thank you.

THE COURT: Mr. Roberts.

MR. ROBERTS: Losing my voice. Yes, Your Honor.

REDIRECT EXAMINATION

BY MR. ROBERTS:

Q. And -- and, Doctor, from my redirect and follow-up questions, I'm not only going to be following up on some things that you have said on cross-examination by Mr. Strassburg, but I'm also going to take you way back when to when you first came and were cross-examined by Mr. Mazzeo. And there are a couple of things I just want to clarify from that cross-examination.

A. Okay. Thank you.

Q. First of all -- and -- and all of these things I am about to ask you, give me your opinion to a

reasonable degree of medical probability more likely than not. If you can't do that, just let me know. Okay?

A. Understood.

Q. All right. More likely than not, would losing weight have caused Ms. Garcia's pain to go away without need for your surgery?

A. No.

Q. More likely than not, would quitting smoking have caused her pain to go away without the need for your surgery?

A. No.

Q. More likely than not, if she lost weight, would she have still needed the rhizotomy?

MR. MAZZEO: Objection. Foundation. Speculation.

THE COURT: I'm going to allow him to answer based on what he understands. Overruled.

THE WITNESS: Yes. Thank you. Yes.

BY MR. ROBERTS:

Q. Okay. Clarify -- I've forgotten the way I phrased the question. Clarify your "yes." Say it in a complete sentence for me.

A. Even if she had lost more weight, she would have still needed the rhizotomies that she has

benefited from and still needs ongoing.

Q. Very good. Thank you for that, Doctor.

The shower incident which Mr. Strassburg just discussed with you, was your initial recommendation to Ms. Garcia that she needed surgery, the spinal fusion, before or after the shower incident?

A. Before the shower incident.

Q. And Dr. Cash's recommendation for surgery, was that before or after the shower incident?

A. Also before the shower incident.

Q. To a reasonable degree of medical probability, did the shower incident cause her need for the surgery you performed?

A. No.

Q. Okay. You were shown a small snippet of Dr. Cash's testimony here before the jury which related to micromotion. I just wanted to go back and show you a little bit more of that and then ask you a follow-up question. Okay?

A. Okay.

Q. That line of questioning began -- and this is back on February the 16th, and the line of questioning which led to Dr. Cash's testimony began at page 181:

"And, now, you mentioned surgery. Can you specify the treatment that you recommend for

Ms. Garcia?"

So Dr. Cash was not talking about any actual physical condition. He was talking about the reason you have the screws, to eliminate motion. So putting that in context, let me ask you: Have you seen any medical evidence that Ms. Garcia has micromotion in her fusion post surgery?

A. No.

Q. Have you seen any medical evidence that the bones that you put in did not properly fuse?

A. No.

MR. ROBERTS: Audra, can you put up surgery part two? You can just blow up any one of those pictures. They've all got the hardware.

BY MR. ROBERTS:

Q. Okay. Now, we -- you had a discussion with Mr. Strassburg, and you spent some time talking about the screws and the rods. Tell the jury what the main purpose of those screws and rods is.

A. To assist in stabilizing the spine while the bone fusion is healing.

Q. Once you have a successful fusion, are the screws and rods still needed?

A. Technically, no. They're obsolete at that point. The bone fusion becomes stronger than the

actual screws and rods.

Q. And -- and if the hardware's causing significant pain, do you sometimes have surgery to remove it?

A. Sometimes. Yes.

Q. Did the lack of the one screw in the -- in the associated rod, L4, cause a failure to fuse?

A. No.

Q. Did it cause any damage or pain to Ms. Garcia?

A. Well, I asked her to wear the brace after surgery a little longer than usual just to make sure, because we didn't have a screw at that one segment. But other than having to wear the brace a little longer, it did not cause any damage to her not to have a screw there.

Q. To a reasonable degree of medical probability, is any of Ms. Garcia's current pain caused by the fact that you were unable or made a decision not to place the one L4 screw?

A. No. And we know that by virtue of her response to the pain management after the rhizotomies and what have you.

Q. Okay. You were asked a few questions about pain from the hardware. And -- and let me just ask you

a couple of follow-up questions with regard to that.

You previously told the jury, in your medical opinion, the need for the fusion was caused by the automobile collision?

A. Correct.

Q. If she had not had the fusion, could she be having hardware pain?

A. She would be having spondylolisthesis pain, not hardware pain, if she didn't have the surgery.

Q. Okay.

MR. ROBERTS: Almost done, Your Honor.

BY MR. ROBERTS:

Q. Okay. Did you review the records of Dr. Gulitz, the chiropractor?

A. Yes.

Q. And those complete records are marked as Exhibit 15 in this litigation.

Did Dr. Gulitz perform any adjustments to Ms. Garcia's lumbar spine which could have caused or contributed to the spondylolisthesis?

A. I need to take a quick peek.

Q. Thank you.

A. (Witness reviewing document.)

I'm looking for my summary of those records. Here we go. Well, I don't see a description of the

actual treatments in front of me, although I have looked at them before. However, it would be highly unlikely that an adjustment to the lower back would be something that would lead to a spondylolisthesis or cause one.

Q. And as you sit here today, you don't recall whether or not the chiropractor even did an adjustment to her lower back?

A. I apologize. I would have to go back through, and I didn't memorize my own file, as you all know.

Q. And I am sorry. Thank you, Doctor.

You were asked by Mr. Strassburg about whether you had done a flexion-extension X ray prior to the surgery.

A. Yes.

Q. Let me ask you this question: Did you need a flexion-extension X ray in order to determine if Ms. Garcia's surgery was medically necessary?

A. No.

Q. And I -- correct me if I'm wrong, but I believe you testified, when you were here with us last week, that you believe more likely than not the spondylolisthesis was preexisting the collision?

A. I believe the spondylolysis was, and I think

we either determined she would have had a spondylolisthesis without symptoms or was in good alignment without symptoms. I don't think we can know that where there's no reason to do a film before the injury.

Q. Thank you, Doctor.

Assume for me that the collision did not actually cause an instability in the spondylolisthesis, and that it was preexisting. Does that -- would that change any of the opinions given to the jury?

MR. MAZZEO: Objection. Vague. Speculation. Foundation.

THE COURT: I'm going to allow him to answer. Overruled.

THE WITNESS: In your hypothetical, if there was a spondylolisthesis that preexisted --

BY MR. ROBERTS:

Q. Yes.

A. -- the injury, and the facts remain that Ms. Garcia was asymptomatic before the accident but became symptomatic as a result of the injury, those symptoms and the treatment are still because of the injury. So even if there was -- because I did make that one of the possibilities -- even if there was some instability prior to the accident, if there were no

symptoms, the treatment she had is still related to the injury.

MR. ROBERTS: Thank you, Doctor.

BY MR. ROBERTS:

Q. And, finally, you actually opened up Ms. Garcia and you were able to look inside, like anyone else. Could you tell the jury what you saw as far as any conditions that you believe could have been contributing to Ms. Garcia's pain.

A. Sure. It was clear to me and documented in my operative report that she had --

MR. MAZZEO: Objection, Your Honor. Beyond the scope of cross-examination.

THE COURT: I don't think it is. Overruled.

THE WITNESS: I saw the actual spondylolisthesis, the slippage. And when I put the screws and rods in, I was able to leverage it back into position. In fact, earlier this afternoon, counsel showed the X ray in the operating room, and you can see the bones were in alignment, which is why she felt better after surgery.

I also saw the disk herniations, both at the L4-5 and L5-S1 level, and I cleaned those up when I freed the nerves, as counsel asked me about earlier. And then, lastly, I saw the nerves particularly on the

right side narrowed, their path was narrowed by a combination of the disk pushing up toward it from my view and the slip narrowing the foramen where the nerve passes. So I cleaned all that up. And by removing the bone, I made more room for the nerve; by realigning, I made more room for the nerve; and by cleaning up the disk, I made more room for the nerve so I could take care of the decompression goal of the surgery.

MR. ROBERTS: Thank you so much. We appreciate you coming back again a second time, Doctor.

THE WITNESS: Thank you.

THE COURT: Anybody else?

MR. MAZZEO: No, Your Honor.

THE COURT: Mr. Strassburg.

RECROSS-EXAMINATION

BY MR. STRASSBURG:

Q. Excuse me. True or false, the L5 vertebra had to move to cause the injury from the collision that you treated?

MR. ROBERTS: Objection. Vague as to time.

MR. STRASSBURG: Fair. Let me clear that up.

THE COURT: I think that might be --

BY MR. STRASSBURG:

Q. Let me clear that up. I want to get this

right.

So as a result of the forces on the spine from the collision, in your opinion, the L5 vertebra had to slip to cause the injuries that you treated? True or false?

A. One of the injuries, but not all of the injuries.

Q. Which one?

A. The spondylolisthesis. Not the protrusion at L4-5 or L5-S1.

Q. You -- you indicated that you saw no evidence of micromotion, no evidence of improper fusion; right? Remember that?

A. Yes.

Q. But you never took a CAT scan. True?

A. I just did X rays and an MRI.

Q. You've indicated the bone fusion is stronger than the screws and rod, but that's only if there's actual union of the particular bone grafts; right?

A. Correct.

Q. And about how many separate individual bone grafts do you put in that area that has to fuse?

A. Technically four.

Q. And those you cut away from the rest of the spine?

A. From the bone we removed, we recycle it, and then the bone putty are crunched and mixed together to make a graft.

Q. So it's four pieces of bone that you have cut away from the rest of the spine. True?

A. It's a Play-Doh. It's not a piece. But otherwise true.

Q. Well, I'm trying to understand. You said that for the graft you use the patient's own bone?

A. In part, we do.

Q. Okay. And those are the actual pieces of bone that you have cut away; right?

A. They start as pieces and then we crunch them into a fine mill, mix them with the putty, and regraft them.

Q. And about how big are the pieces in the fine mill?

A. I would say like a grain of rice, give or take, maybe a little smaller.

Q. So there's hundreds of these pieces after you grind them up; right?

A. Sure.

Q. And you put them in the putty; right?

A. Right.

Q. And all those hundreds of pieces of bone

graft in the putty, they all have to fuse together; right?

A. Yes.

Q. And if they don't all fuse together, then you have this condition we were talking about, nonunion; right?

A. We could have that possibly.

Q. And nonunion can cause a complication in the form of pain. True?

A. It can.

MR. ROBERTS: Objection. Hypothetical not based on the record.

THE COURT: Overruled.

THE WITNESS: It can possibly.

BY MR. STRASSBURG:

Q. Now, regarding the pain from the hardware, I heard your testimony, and I -- it seems like you would also agree that if the need for the surgery is not related to the accident, then the hardware pain and any other complication from the surgery would also not be related to the accident. True or false?

A. Could I trouble you to read that back so I make sure I answer that correctly?

Q. Yes, sure. Why don't I try a better question. Let me try again.

A. Thank you.
Q. So if the condition -- the medical condition that you addressed in your surgery was not caused hypothetically -- I know you don't agree, but hypothetically, that was not caused by the collision, then complications from that surgery would also not be caused by the collision? True?
A. That would be possibly true, based on your hypothetical.
MR. STRASSBURG: Thank you, sir.
MR. ROBERTS: One more time, Your Honor?
THE COURT: Sure.
MR. ROBERTS: Thank you.

FURTHER REDIRECT EXAMINATION

BY MR. ROBERTS:
Q. Doctor, in your opinion, did all of the bone grafts fuse that you placed in Ms. Garcia?
A. Yes.
Q. Have you seen any evidence of nonunion?
A. I have not seen any evidence of nonunion.
Q. And you've also been provided medical records from other treatment providers of Ms. Garcia; right?
A. I have.
Q. Have you seen any of her treatment providers that have suggested there was nonunion?

A. No.
Q. And you've seen all of the reports of the doctors hired by the defendants; right?
A. Yes.
Q. Did any of their experts opine in any of their reports that there was nonunion?
A. No.
Q. Thank you, Doctor.
THE COURT: Any more?
MR. MAZZEO: Nothing further, Your Honor.
THE COURT: Ladies and gentlemen, any questions for Dr. Gross? Yep. We have at least one. Now we have a couple. Come on up, Counsel.
(A discussion was held at the bench, not reported.)
THE COURT: All right. Doctor, couple of questions. First one: Is it unusual not to be able to install a screw as in L4? Does it mean anything not to be able to install the screw?
THE WITNESS: It happens from time to time. I don't know that I would say it's particularly unusual, but it's not the norm. I had expected to place a screw at L4, and when it had come out through the bone, then there wasn't enough bone to try again.
And does it mean anything? No. There are

some surgeries where we just put screws on one side, and it's adequate. Some doctors do surgery from the front of the spine by itself and don't put any screws, and that can work too. In fact, 30 years ago, we didn't have those screws, patients just had the bone graft and they were in body casts, and it still worked. So does it mean anything in the long run? No, it worked just fine.

THE COURT: Okay. Thank you. Mark that next in order.

This one has several different parts. So would someone experience pain as a pars defect fails?

You know what I'm going to do? I'm going to read several of these together.

Would someone experience pain as a pars defect fails? Would the spine become unstable after? If so, how soon could it become unstable, and why, pertaining to the pars defect?

THE WITNESS: Okay. I think I can -- I can do it all. There are two kinds of pars defects. There are the kind you're born with and there are the kind that can happen from a fracture.

This was not a case where there was a fracture. If a fracture occurs, those usually become rapidly unstable right away. The kind you're born with

generally don't become unstable by themselves. They require help with some type of injury. Because there's a very tough fibrous tissue, the gristle that's holding that together. And that gristle's weaker than bone and more susceptible to injury.

When it's injured, it doesn't heal back like a bone might. And the slippage then can occur at varying rates. There's no rule. Sometimes it's within days it becomes quite manifest and is just overtly unstable immediately or early.

Sometimes it's a slow, progressive, or what my favorite spine professor would call a glacial process where it takes time for this to be fully manifest because there are other muscles and things trying to hold the spine in check, and the instability is a slow thing, fighting against the muscles trying to hold it.

I think I got all the parts.

THE COURT: The next question, you may have already answered it: Is this a factor with the plaintiff?

THE WITNESS: The -- the plaintiff or the patient falls into the category of a preexisting defect that was stable. Then that gristle got disconnected, and I saw that at surgery. It was that loose fibrous

tissue. And she slowly slipped. We saw that in the sequential films going from -- I think it was 4 to about 8 then about 10.2 millimeters over -- over months.

THE COURT: Okay. Next question: Could an adjustment to the lower back affect the back pertaining to the pars defect?

THE WITNESS: Possibly. I suppose I would be unreasonable to say that a very rough chiropractor who forces someone with a pars defect in the lower back could bring forth an instability related with that defect in place. I have never seen that in my practice. And I do work with a lot of chiropractors, but I suppose it's possible.

THE COURT: Okay. Next question: Was there an adjustment to the lower back on her first or follow-up visit?

THE WITNESS: Well, that is a question I was asked a little bit earlier also, and would I be allowed to look at that as Exhibit 15 for just a moment? Would that be fair to answer the question?

THE COURT: Sure.

THE WITNESS: That was Dr. Gulitz's?

MR. ROBERTS: Yes. I've got a copy of it right here, Your Honor. May I provide it? If I may

approach.

THE COURT: That's fine.

MR. ROBERTS: And for the record, I'm providing the witness a complete copy of Exhibit 15.

THE WITNESS: Thank you. Just take a quick look. In the first few visits after the injury, I -- I don't see chiropractic manipulation or adjustments as any part of the treatment. And I think the question was restricted to the -- was it the first few visits after the injury?

THE COURT: Was there an adjustment to the lower back on her first or follow-up visits?

THE WITNESS: Well, as I march through the records, I don't see adjustments. It looks like therapeutic exercise, electrical stimulation, heat therapy was the initial treatment. I'm now a month after the injury, and I have yet to see chiropractic treatment as part of the treatment at all in terms of adjustments. Would that -- would that suffice?

THE COURT: I think that's good. Thank you, Doctor.

Mark that next in order.

Mr. Roberts, any follow-ups based on those?

MR. ROBERTS: Yes.

FURTHER REDIRECT EXAMINATION

BY MR. ROBERTS:

Q. The treatments from the chiropractor that you just listed for the jury --

A. Yes.

Q. -- could any of those things have caused a spondylolisthesis? Electrical stimulation? Heat therapy?

A. Not to heat or electrical stimulation. I suppose therapeutic exercise could have. There's just no documentation showing that she was doing an exercise and, boom, it got worse.

MR. ROBERTS: That's all, Your Honor. Thank you.

MR. MAZZEO: Nothing, Your Honor.

THE COURT: Defense table?

FURTHER RECROSS-EXAMINATION

BY MR. STRASSBURG:

Q. So if I understand your answer to the juror's question correctly, you believe that the slippage didn't just stop shortly after the accident; it continued progressively, and it was shown in the -- in the August 19th, 2011, imaging studies, it was shown on the November 19th, 2012, imaging studies, that the

slippage continued to -- to progress, to widen; right?
A. Yes.
Q. And the widening -- the continued widening of that slippage enabled the -- the nerve roots to become evermore impinged upon by the actual bone of the vertebra; right?
A. In part, yes.
Q. And the -- and the bone -- as the vertebra move forward, the bone that makes up the foramen, that hole that the nerve comes out, it gets smaller and smaller and squeezes and squeezes on those nerves, and that's what created the pain; right?
A. That's not what created the pain, but there was progressive narrowing where the nerve passes.
Q. And did the narrowing go so far as to mechanically impinge upon the nerve root itself?
A. Somewhat. As I showed on the MRI films last week, there was a little pressure against the nerve. But I wouldn't -- I wouldn't dramatize it to say it was squeezed and squeezed.
Pain from the back isn't just from irritation of those nerves. It's from the slippage mechanical pain and the disk herniation discogenic pain.
MR. STRASSBURG: Thank you, sir.
THE COURT: Any more?

MR. ROBERTS: No follow-up, Your Honor. Thank you.

THE COURT: Thank you, Doctor. Appreciate your time.

THE WITNESS: Thank you. Thank you, everyone.

THE COURT: All right, folks, tomorrow is Wednesday, we can start early. So we're going to start at 9:00 o'clock.

During our break this evening, you're instructed not to talk with each other or with anyone else about any subject or issue connected with this trial. You are not to read, watch, or listen to any report of or commentary on the trial by any person connected with the 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 perform 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 tomorrow at 9:00. Have a good night.

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

MR. STRASSBURG: So, Lee, tomorrow is Kidwell.

THE COURT: Is there anything we need to do on the record before we go off?

MR. MAZZEO: No, Your Honor.

MR. ROBERTS: No, Your Honor.

MR. STRASSBURG: No.

THE COURT: All right. Off the record.

(Thereupon, the proceedings concluded at 5:06 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 Tuesday, February 23, 2016, at 9:59 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 23rd day of February, 2016.

Kristy Clark

KRISTY L. CLARK, CCR #708

CASE NO. A-11-637772-C

DEPT. NO. 30

DOCKET U

DISTRICT COURT

CLARK COUNTY, NEVADA

* * * * *

EMILIA GARCIA, individually,

Plaintiff,

vs.

JARED AWERBACH, individually; ANDREA AWERBACH, individually; DOES I-X, and ROE CORPORATIONS I-X, inclusive,

Defendants.

REPORTER'S TRANSCRIPT

OF

JURY TRIAL

BEFORE THE HONORABLE JERRY A. WIESE, II

DEPARTMENT XXX

DATED WEDNESDAY, FEBRUARY 24, 2016

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

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I N D E X

LAS VEGAS, NEVADA, WEDNESDAY, FEBRUARY 24, 2016;
9:06 A.M.

P R O C E E D I N G S

* * * * * * *

THE COURT: All right. We're back on the record, Case No. A637772.

Do the parties stipulate to the presence of the jury?

MR. ROBERTS: Yes, Your Honor.

MR. MAZZEO: Yes, Your Honor.

THE COURT: All right. We are back with Dr. Kidwell.

Since it's been a while, I'm going to have you resworn again. If you would stand and raise your right hand.

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

THE WITNESS: I do.

THE CLERK: Please be seated. Please state and spell your full name.

THE WITNESS: Walter Morris Kidwell.

K-i-d-w-e-l-l.

THE COURT: Thanks for coming back, Doctor.

Go ahead, Mr. Roberts.

MR. ROBERTS: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. ROBERTS:

Q. Good morning, Dr. Kidwell.

A. Good morning, sir.

Q. When we last broke, you had just told the jury that you expected Ms. Garcia's visits to you to reduce in the future.

Could you explain how much?

A. Certainly. My normal practice is, once someone becomes into a stable routine and I have established care with them quite some time, I'll liberalize the time between their visits.

My intention with Ms. Garcia would be to get her through the next radiofrequency rhizotomy and then, once stable, probably liberalize her to four visits a year. Obviously, if something happens that she needs to come in early, I'll be happy to see her. But assuming that she's in a stable routine, that would be all that's necessary.

Q. Thank you, Doctor. And just to wrap up,

thinking back to when you were with us last time and the opinion you just gave, are all of your opinions stated to a reasonable degree of medical probability?

A. Yes.

MR. MAZZEO: Objection. Speculation.

THE COURT: Overruled.

MR. ROBERTS: Thank you, Doctor.

That's all I have, Your Honor.

THE COURT: Cross, Mr. Mazzeo?

MR. MAZZEO: Yes, Your Honor. Thank you.

CROSS-EXAMINATION

BY MR. MAZZEO:

Q. Good morning, Dr. Kidwell.

A. Good morning.

Q. Now, Dr. Kidwell, it's correct that Glen Lerner's office had referred Ms. Garcia to you as a patient?

A. No. My records indicate that she came from Dr. Gulitz on a referral, I think, in 2011.

Q. Okay. And, now, you have worked with Glen Lerner's office on other cases; correct?

A. Yes.

Q. And at one point I believe you had testified -- not -- not here but previously at a

deposition -- testified that you may have worked on more than 50 cases of -- of clients from Glen Lerner's office; is that correct?

A. Sure. I've been in town almost 16 years. So in that time, yeah, I'm certain it exceeds 50 patients.

Q. Probably more than 100, 150?

A. I don't know. I actually don't track that. But I would say, just by feel, it's well in excess of 50.

Q. Sure. And you've also had a number of cases referred in addition -- other than this case -- well, let me rephrase that.

You've also had a number of cases and patients referred by Dr. Gross to you for treatment as well; correct?

A. Yes.

Q. Okay. And would you say that -- the -- you've had an ongoing professional relationship between you, your facility, and Glen Lerner's office for a number of years now?

A. A professional -- what do you mean by "professional relationship"?

Q. Whereby you will work on and treat clients of Glen Lerner's office.

A. Yes. I -- I treat patients from lots of

attorneys, including Glen Lerner's office.

Q. Sure. And -- and your relationship with Glen Lerner's office, as well as other plaintiffs law firms in town, is mutually -- it's a mutually -- mutually profitable relationship. Would you agree?

A. Well, I can't speak to the profitability of their practice. I have no knowledge of that. I do treat patients. And I profit from that absolutely, just like any physician profits from treating physicians [sic]. That's why you go to school.

Q. And -- okay. Moving on, would you agree that a person's recollection regarding an event is better closer to the event being described and diminishes over time?

A. Possibly. I don't say you can -- I don't think you can make that blanket statement 100 percent because there are certain events in our life that stick out pretty well and you remember.

Q. Sure.

A. What I had for coffee last week, I have no idea. But there are certain life events that are indelibly etched in my mind. So I don't think that's a total accurate blanket statement.

Q. And I wasn't saying 100 percent -- to 100 percent.

What I was asking you was that the actual memory of an event --

A. Yeah.

Q. -- the details of the event are better closer to the event being described than they -- than a memory is, let's say, five years from the event.

A. I'd say, general speaking, probably true. Although, again, it depends on the nature of the event and the significance it has on that individual.

Q. And in attributing -- in attributing injuries to a specific traumatic event, some things that you would consider would be preexisting conditions, onset of symptoms, diagnostic studies, and mechanism of injury; is that correct?

A. I'll take that. Yes, sir.

Q. Okay. And would you agree that the onset of pain following a traumatic event is a significant factor impacting causation?

A. You mean the proximity of onset of pain to the collision?

Q. Yes.

A. It's a factor.

Q. Okay. And would you agree that a patient's reporting of symptoms at the time of the event or contemporaneous with an event is more accurate than

recalling the onset of symptoms later on?

A. Again, that goes back -- speaking in specifics in this case, I think it depends on the significance of the actual event. There are life events that people can recall with absolute clarity and certainty, and there are nonimportant events that you don't recall.

And as for proximity, it's normal in our practice to have people develop symptoms within a few days or even a week or so after an event. I think -- even develop symptoms six or eight months after an event. That certainly diminishes the proximity.

Q. So -- and what you're focusing on in your answer is the severity of the events.

So if -- there are some events in our lives that can be very significant which are indelibly imprinted on our mind, as you said; right?

A. Correct.

Q. And there's other events that are less significant that we may not -- may not be as imprinted on our mind; correct?

A. Correct.

Q. So -- and -- and so for -- by way of example, an accident which results in -- let's say a small-impact accident that results in no injuries at

the time of the accident, that would probably be less significant in terms of one's memory than an accident that resulted in death --

A. Right.

Q. -- or paralysis?

A. And you know it's all so individualized, but I think it comes down to the significance of the event to the individual.

Q. Okay.

A. Something that's important to you may not be important to me.

Q. Now, is it -- generally speaking, is it -- is it fair to say that you want to ascertain from -- from a patient's early medical records when and what symptoms were reported following an accident?

A. Correct.

Q. Would you agree that the accuracy of a patient's self-report is based on, to some extent, the consistency of statements that have been made in various medical records?

A. I think you need to repeat that.

Q. Yeah. The accuracy of a patient's self-report -- so in this case we have Ms. Garcia that saw you on -- in August of 2012.

A. Correct.

Q. And -- which was 20 months after the accident; correct?

A. That's correct.

Q. Okay. So the accuracy of -- of a patient's self-report to you and to other medical providers is based on the consistency in the self-report to you and -- and to other medical providers.

Would you agree?

A. I would say that what the patient reports to me is their recollection of the events. What other physicians have documented is what they have documented of what -- of the patient reporting their events to them.

Q. Correct.

A. So that relies on the patient's reporting, but it also requires good documentation by the other physicians. So there's a lot of variables here, just to be complete.

Q. And -- and in this --

A. In my review of Ms. Garcia's complaints, what I saw was consistent with what I saw with other records.

Q. Oh, very good. Okay.

And -- and based on what you've reviewed in this case, you haven't -- you haven't made -- offered

an opinion that any doctors misreported anything that Ms. Garcia might have told them at the time of their evaluation, have you?

A. I don't think I've presented that at all.

Q. No. Okay.

A. With -- with the exception I have done some -- I do believe in expert rebuttal. I disagreed with some of the conclusions in that.

Q. Fair enough. But with regards to Ms. Garcia's reporting to them of her history of the present illness, you haven't made any determination and you certainly haven't testified that any of the treatment providers made mistakes with the entries with regard to her self-reporting?

A. I haven't addressed it one way or the other.

Q. Very good. And it didn't come across -- it didn't come to your attention that any treatment providers made any mistakes in -- in the reporting of -- or in documenting what Ms. Garcia reported to them; correct?

A. Nothing comes to my mind right now.

Q. Okay. So, again, getting back to the accuracy of a patient's self-reporting, would you -- would you agree that the accuracy of a patient's self-reporting is based on the consistency of reporting

from one physician to another?

A. No. I don't think that's correct at all. What you're saying, their accuracy, they report what they report. Accuracy is how close to the target they are.

So what you're saying is what other physicians might have recorded reflects the accuracy of her self-reporting. I have no way to validate that. All I can say is what a patient reports to me is what they report. And if I see any inconsistencies over time, then that brings in the question. But she was there.

Q. Sure.

A. I mean -- so you can't rely on anybody else more than the patient to self-report because they were the ones that were there.

Q. Exactly, Doctor. So I'm not -- I'm not focusing on what the doctors documented in the report. I'm focusing on what Ms. Garcia told the doctors, which is now reflected in -- in each of these medical providers' reports.

Do you understand?

A. Yes, I do.

Q. Okay. So that's what I'm talking about.

So the accuracy of what -- what -- of what

Ms. Garcia reported to you and to Dr. Cash and to -- at MountainView Hospital, and these other doctors, would you agree that the accuracy -- we -- we want to look at a consistency in Ms. Garcia's self-report.

Do you agree?

A. Yeah. I mean, every patient has certain amount of inconsistencies, what ends up being documented, because I see an awful lot of these. But for the most part, I'd agree with you.

Q. Okay. Doctor, now, I believe that you said that -- a few minutes ago, you had mentioned that you believe that Dr. Gulitz had referred Ms. Garcia to you as a patient; correct?

A. Correct.

Q. Okay. But, in fact, Ms. Garcia represented in her deposition testimony that she was referred to you by her attorney, Glen Lerner's office.

A. I have a referral in my record from Dr. Gulitz's office. It well predates the actual time we saw her, but her original referral was to my office.

When I saw her, she was a transfer of care from Dr. Lemper. So Dr. Lemper initially treated her, and I -- I believe the situation -- I'd indicated some administrative issues, but I believe the situation was she was looking for a doctor closer to where she lived.

Q. And that Glen Lerner had coordinated that to --

A. Probably gave her -- gave her my name off a list. I don't know.

Q. Okay.

A. I don't have documentation of that.

Q. Fair --

A. But I do know the original referral came from Dr. Gulitz.

Q. Fair enough. Okay. So we're going to look at some medical records here.

Okay. The first one I'm showing you, Doctor -- and I will -- I'll identify all of these for the record.

This is from MountainView. This is the physician clinical report, as you can see at the top. This is Plaintiff's 18, document 1 in evidence. The treatment date here is January 5th of 2011. And I just want to direct your attention to the history provided by Ms. Garcia on the day of the accident.

You've seen this report, correct, Doctor?

A. Yes, I have.

Q. Okay. So -- and what this shows is Ms. Garcia reported she felt fine after the accident --

A. Correct.

Q. -- she was pain free after the accident, and patient symptoms started today.

Do you see that?

A. Correct.

Q. Thank you. Then I'm going to go to -- the next one is Dr. Gulitz's report. It's page -- Plaintiff's Exhibit 15, page 2. This is from January 12th of 2011. And I just want to direct your attention to the bottom of the page.

"Ms. Garcia stated" -- so that's her self-reporting it -- "that, after the collision, she was feeling shaky, nervous, in pain, and upset."

Do you see that?

A. Correct.

Q. Thank you.

A. Can I see the date of the visit, please?

Q. Oh, yeah. We have to go to -- this is the -- Plaintiff's 15, 2, is actually -- it's January 12th of 2011.

A. All right.

Q. This stamp line is not the date -- the stamp line is not the date of treatment.

A. Correct.

MR. MAZZEO: Right? Did I get that correct?

MR. ROBERTS: I wasn't following you. I'm

sorry.

MR. MAZZEO: Oh, okay.

BY MR. MAZZEO:

Q. Okay. Just for -- so there's no misunderstanding, I'm going to now show you -- this is document -- Plaintiff's 15, page 1. And the date of treatment is -- date of initial exam, 1/12 of '11.

A. Thank you.

Q. Do you see that? Okay. Very good.

And now we have Dr. Andrew Cash's treatment record of 2/16 of 2011.

A. Correct.

Q. And that's where Ms. Garcia reported, "Patient fought through the pain over the next four days because she did not want to miss work."

Do you see that?

A. Correct.

Q. Okay. And -- and that statement to you and to the reasonable person would indicate that she had pain from the time of the accident for the next four days; correct?

A. Correct.

Q. Thank you. Now, moving on to Dr. Gross's record from May 31st of 2011, "Ms. Garcia states she recalls being jerked from side to side with forward

flexion of her body. She was dizzy, dazed, confused, and nauseated. She was in shock."

Do you see that?

A. Correct.

Q. Okay. And that indicates in the way that it's reported that she had pain immediately at the time of the accident. Yes?

A. Not necessarily.

Q. Okay. That's the way you read it?

A. The way I read all four of those together, if you want to --

Q. No, I don't. Stop.

A. -- me to address a composite.

Q. No. I was just showing you what -- what Ms. Garcia reported.

A. Okay.

Q. Would you agree that in the records I showed you that there is an inconsistency between the -- what Ms. Garcia reported as to the onset of symptoms?

A. I would agree that at face value there was an inconsistency, but in a sense, there's not.

Q. Thank you. Doctor, let's move on. Let's look at another report here.

So we're going back to the MountainView Hospital record, January 5th of 2011. We're going to

go to -- and that's Plaintiff's 18, page 1. We're going to move on to Plaintiff's 18, page 2, "Social history: nonsmoker, no alcohol use or drug use."

Do you see that?

A. Yes.

Q. Thank you. Now, moving back to the same record I showed you before from Dr. Gulitz from January 12th -- I'm sorry -- January 12th of 2011, "Social history: She does not smoke. She indicated she does drink alcoholic beverages socially."

Do you see that?

A. Yes.

Q. And you see that there's a -- there's an inconsistency between what she reported to MountainView Hospital and seven days later what she reported to Dr. Gulitz. Yes?

A. On that? Are you kidding me?

Q. Yes. On that, yes.

A. Okay.

Q. I'm not kidding.

A. I'll say there's an inconsistency. Okay.

Q. Thank you, Doctor.

Now -- and just let me highlight this.

And you do see that, on this record of January 12th, she said she does not smoke?

A. Correct.
Q. That means she doesn't smoke occasionally; she doesn't smoke at all. Right?
A. That means they recorded that she doesn't smoke.
Q. Okay.
A. This is an emergency room.
Q. Oh, wait. No, Doctor. That's Dr. Gulitz.
A. Gulitz? Okay.
Q. Dr. Gulitz reported that.
A. Right.
Q. Thank you.
A. Um --
Q. No, I'm not asking for an explanation. I'm showing you entries in the record.
A. Okay.
Q. You don't have to explain and justify why there might be inconsistencies. I'm pointing out inconsistencies.
Okay. Moving on to Primary Care Consultants, Plaintiff's 16, page 4. This is for January 12th, same day as Dr. Gulitz, "positive for occasional tobacco use. Positive for occasional alcohol use."
Do you see that?
A. Yes.

Q. Thank you.

Dr. Andrew Cash, Plaintiff's 23, page 3, "She smokes a pack a month."

Do you see that?

A. Yes.

Q. Thank you. Moving on to Dr. Gross's report, May 31st, 2011, second page. This is Plaintiff's 24, 16. "Social history: She smokes about six cigarettes a week, and she noted she had smoked for 27 years"; correct?

A. Correct.

Q. Moving on to Dr. Lemper's report. This is Dr. Lemper's report -- Plaintiff's Exhibit 21, page 2. And this is Dr. Lemper's report from 6/29 of 2011. And she -- this is about a month after she met with Dr. Gross. She indicates that she smokes just under a pack per day.

Do you see that?

A. No. That doesn't say "just under a pack per day." That says "less than."

Q. Less than a pack per day?

A. Zero is less than a pack per day.

Q. Well -- but if -- but we can get -- we can get funny with these words.

But if it says "less than" -- and that's a

less-than sign; correct?

A. Right. But I think you need to actually interpret what that means.

Q. And -- and, Doctor, is this a less-than sign?

A. Yes, it is.

Q. She's not saying half a pack a day; she's not saying six cigarettes a day. She's saying less than one pack per day. Yes?

A. Correct.

Q. Thank you. Now, moving on to your record. Now, your record -- this is on the screen. This is from November 7th, 2012. And that's Plaintiff's 26, page 66. And you see that -- I'll zoom in on it.

She indicates to you that she does not smoke; correct?

A. Correct.

Q. Is that an accurate statement or did you maybe make a mistake in putting this entry in here?

A. Well, the answer is well beyond that. These kind of entries are clearly --

Q. No, no, no, Doctor -- Doctor --

A. I can explain --

Q. Don't give a self-serving answer.

MR. ROBERTS: Objection, Your Honor. Let the witness answer.

MR. MAZZEO: It's nonresponsive, Judge. I'm asking about -- I asked him a specific question about this -- this entry, not a self-serving answer for the plaintiff.

THE COURT: You asked, "Is this an accurate statement or did you maybe make a mistake in putting this entry in here?" He gave you two choices. If there's a different choice, you just have to let him know.

THE WITNESS: There's a different choice.

BY MR. MAZZEO:

Q. Okay.

A. Um --

Q. No, no, no. I'm not asking you about a third choice --

A. Okay.

Q. -- to explain it.

Did you -- did you -- is this an inaccurate statement in this report?

A. I don't know. There's a third choice that you won't let me explain.

Q. I'm ask -- I'm asking you about this one sentence.

Do you see it? "The patient" --

A. Correct.

Q. -- "does not smoke."
A. I do not personally collect that data. So there is an alternative explanation.
Q. Does someone else from your office collect that data?
A. Yes.
Q. And is it your contention that someone else from your office may have made a mistake? Yes or no.
A. That's certainly possible.
Q. Okay. Thank you. And by the way, that date again was November 6th of 2012. And then we have -- we go to Dr. Gross's report of November 13th, seven days later, of 2012. And she tells Dr. Gross, who she's gearing up for surgery at the end of December, "She agreed to fully quit smoking to enhance the fusion rate, and I explained that to her." Do you see that?
A. Yes.
Q. I read that correctly?
A. Yes.
Q. Thank you. Do you agree that, based on the records that I showed you, that there are inconsistencies in Ms. Garcia's reporting of the onset of symptoms and smoking?
A. Well, there certainly appears to be inconsistencies on whether she smoked or how much she

smoked, absolutely. Inconsistencies in the reporting of it anyway.

Q. And in the reporting --

A. Or the collection the data.

Q. And in the reporting of the onset of symptoms; correct?

A. Actually, like I said, at face value, it appears so.

Q. Thank you.

A. But if you dissect the words that are there, actually, I believe it's consistent.

Q. Okay. Oh, okay.

A. I can explain that.

Q. Would you agree that the inconsistencies in the records that I have just pointed out to you impacts Ms. Garcia's overall credibility in her reporting of not just items regarding onset of symptoms and smoking but other items as well? Yes or no.

A. I don't think you can make that statement in the context of what you presented.

Q. Do you agree, Doctor, that some patients may attribute a preexisting condition to a subsequent -- subsequent traumatic event where a third party might be responsible?

A. I would say yes, that's happened.

Q. Okay. And -- and that's because -- especially in a situation where a -- a party patient litigant has a financial interest in the claim?

A. I think there's literature to support that, particularly in the workmen's comp community.

Q. Now, you've testified that all your treatment is related to the subject accident; correct?

A. Correct.

Q. Yep. And that's your opinion; right?

A. Yes.

Q. And you understand that your opinion here is -- is in dispute with regard to this litigation?

A. Seems like every time I'm up here, my opinion is in dispute.

Q. Okay. That's -- that's probably a fair assessment. Okay. So --

A. Nature of the beast.

Q. So just because, Dr. Kidwell, you say that all treatment is related to the motor vehicle accident, it doesn't necessarily mean that it is; you are just offering your opinion?

A. Within a reasonable degree of medical probability, yes, sir.

Q. Well, I know that you've testified with that catchall phrase that was asked and prompted to you

by -- by Mr. Roberts, but nonetheless, it doesn't mean -- this reasonable degree of medical probability, it still doesn't mean that all your treatment is necessarily related to the subject accident just because you say it is.

MR. ROBERTS: Objection. Is there a question?

THE WITNESS: Well, actually, I think it does. I have treated her longer, more than anybody else. I have had the opportunity to see her over time. You take out the specter of litigation, we wouldn't even be here, but still her treatment plan would have been exactly the same.

BY MR. MAZZEO:

Q. Generally, you would expect -- is this fair to say? -- about an 88 to 92 percent success rate for a two-level fusion?

A. 88 to 89?

Q. No, 88 to 92 percent success rate.

A. Shoot, I can't quote you the numbers on that on a fusion. You'd have to ask my surgical colleagues.

Q. Fair enough. Now -- but you did testify that you believed -- in your estimation and your opinion, you believe that the fusion was successful?

A. Oh, yes, it appears to be very successful.

Q. Okay. Now, in your report --
A. She had a Grade II spondylolisthesis that was now stabilized.
Q. Doctor, you answered the question. You don't have to go on. Thank you.
Now, in your report -- here we go. In your report, and I think you testified on direct examination last week, you had said -- and I was looking at my notes, so I was trying to figure out which day you had said in -- in 2013 when Ms. Garcia reported to you that she started to develop some pain in her right thigh.
And -- and I believe I have located a record. August 7th of 2013, I believe, is the -- is the record date. And that would be -- that would be Plaintiff's 26. Let's see. That would be Plaintiff's 26, page 43. Okay. So that's August 7th. She reports she developed some pain -- some pain in her right thigh. Do you see that?
A. Yes.
Q. Okay. Would that be the first time that she -- she reported to you that she developed pain following her surgery? That she developed pain in the right thigh.
A. She's a month out from surgery. I expect her to have a lot of pain in a lot of places. I don't

think that's significant.

Q. Well, no, this is August. We're -- we're eight months out from surgery. This is the August 7th. What I was --

A. My mistake. Sorry.

Q. No, that's fine. That's fine. But what I was asking you about -- because I remember you testified the other day -- and I had something in November, but I found this record as -- as the first date following her surgery, which was about eight months later, that she reported to you that she had developed some pain in the right thigh?

A. Correct.

Q. And so my question was -- and we can -- we can look at some of your records. My question was, was that the first time, in 2013, that she reported that to you?

A. I think so.

Q. Okay. And just -- just for accuracy, we're going to look at some of your records. So we're going to go to January 30th, 2013, and this is Plaintiff's 26, page 27. And -- and the chief complaint's neck and low back pain -- well, that's --

A. January 30th. Let me --

Q. Right.

A. -- look at something.
Q. But in any event, she did not report -- what I'm showing you is -- I just want to be clear that she didn't report right anterior thigh pain or right thigh pain when she saw you on January 30th. Correct?
A. We can look at her pain diagram and make sure, if you'd like.
Q. Well, do you have a copy of the -- you have a copy of the full report with you?
A. I can pull up on my computer her pain diagram, if you wish.
Q. Well, let me ask you this. You don't have to pull it up. So if she did in the pain diagram -- you look at the pain diagram when a patient fills it out; right?
A. Yes.
Q. And you use the -- you look at the pain diagram and, from that, you extract information which you then put into your report; correct?
A. Correct.
Q. Okay. So if she had indicated that she had pain in her thigh or leg, you would have indicated that. Yes?
A. Possibly.
Q. Okay.

A. It depends the significance of it.
Q. Okay. All right. Well, in any event, it wasn't anything that you deemed to be significant -- if she did report it to you, it wasn't anything that you deemed to be significant to put it into your report?
A. Correct.
Q. Okay. Let's move on to your next record. I believe the next treatment date you have is April -- April 10 of 2013. And you note she's doing fairly well; her pain scores are down, 5 over 10. You see that?
A. Correct.
Q. Otherwise, under this Chief Complaint section, there's no indication of her reporting any pain in her thigh or leg; correct?
A. Correct.
Q. Okay. Then moving on to -- moving on to the next record, May 8th of 2013, again, under Chief Complaint, that paragraph, that's where you would indicate if she was reporting any -- any -- any indication of pain in her -- in her low back or thigh, that would be indicated there; correct?
A. Correct.
Q. Okay. And she didn't indicate anything there?

A. No, she was pretty much on track.
Q. She's on track. All right. Good. Good. Good.
And we're going to move on to then the next record, Plaintiff's 26, page 39. And so this is June. I know the words are small. Can everybody see that? June 11th, 2013. Again, we're six months out from the surgery. She's on track still?
A. Yes.
Q. She's not reporting any pain in her thigh or down the leg?
A. Well, she's still having some pain. I don't note specifically in the thigh, but we reduced her medications, got her off the narcotic and put her on Ultram, which is significant, so she's on track.
Q. Very good. Very, very good.
And then we -- and then -- all right. So -- so you're thinking at this point she's doing fairly well with her recovery, with -- this is some indication that the surgery's a success; correct?
A. Correct. She's on track.
Q. Okay. All right. Now, what I'm going to show you is Dr. -- this is Dr. Gross's record. It's in evidence. January 7th. So we're about 7, 11, 12, 13 days out after the surgery?

A. Correct.

Q. This is Dr. Gross's record, Exhibit 24, page 44. And, now, she's reporting she's having some right anterior thigh numbness and rare, brief, temporary shock-like pain since the surgery. Do you see that?

A. Correct.

Q. Thank you. Now we're going to go to the February 2013 record, and this is Plaintiff's Exhibit 24, page 50. And so now this is two -- this is -- this is a little over a month after the accident -- after the surgery, and she's reporting to Dr. Gross that she has intermittent right leg pain with some numbness in the anterior thigh and posterior thigh. You see that?

A. Yes.

Q. Thank you. And then we go on to Dr. Gross's April 3rd, 2013, report. Plaintiff's Exhibit 24, page 56. And she's reporting to Dr. Gross she still has some intermittent right leg pain where it had been numb. Do you see that?

A. Correct.

Q. And -- and Dr. Gross also noted she had missed some appointments. This is the April 3rd, 2013, report. She missed some appointments while visiting

her sick mother in Texas. Do you see that entry?

A. Correct.

Q. Okay. Okay. So is it correct, true or false, Doctor, she's reporting to Dr. Gross that she's having pain in her right anterior thigh and numbness within a -- two weeks after the surgery, a month after the surgery, two months after the surgery, but she's not reporting those same symptoms to you when you're seeing her in February, April, May. Is that correct?

A. Incorrect.

Q. Okay. Well, we are going to move on because we went over your medical records, didn't we?

A. I've got pain diagrams that show she documented everything.

Q. Doctor, we went over your medical records, though, didn't we? The records where you have the -- you made entries about --

A. Sure.

Q. -- Ms. Garcia's --

A. But that's an incorrect statement.

Q. Are you saying that your records are incorrect?

A. No. I'm saying -- you're saying that she didn't report it, and indeed she did. We just didn't include it as part of the pain complex. But I have

pain diagrams that demonstrate it with her own hand.

Q. Thank you, Doctor.

Now, on April 2nd of 2014, Doctor, you used the diagnosis of failed back surgery syndrome. Yes?

A. That's correct.

Q. And you also used that diagnosis -- that wasn't only time you used that diagnosis; correct?

A. Correct.

Q. You also used that diagnosis August 25th of 2014, a failed low back surgery syndrome. Yes?

A. I don't know. I don't have that in front of me, but I'll take your word for it.

Q. Okay. Do you have -- do you have that record in front of you on your computer?

A. Which date again, sir?

Q. Yeah, that would be -- I believe I said August 25th, 2014.

A. August 25, 2014, is when I performed the spinal cord stimulator trial.

Q. Correct.

A. One of the diagnoses was failed low back surgery syndrome.

Q. Okay.

A. I did have a diagnosis for that.

Q. Now, that term -- and I know you talked about

it on direct examination, but that term -- one second, please. That term refers to chronic back and/or leg pain that occurs after a back surgery?

A. Correct.

Q. And is it correct to say that when pain persists after a back surgery, that it's true that the cause of the pain need to be reevaluated?

A. I would say generally true. Yes.

Q. And is it -- is it also correct to say that it may be the case that the surgery was performed to -- to address an issue that was not the true pain generator? Not saying in this case, but in general.

A. Well, that's a pretty big speculative term, but I would say possible.

Q. Okay. And -- and it may -- when we use the term and reference failed back surgery syndrome, it may also reference damage from a spinal procedure itself that is causing the pain?

A. I think I stated in my prior testimony that failed back surgery syndrome really is a nonspecific diagnosis. That's why we don't like it. We're forced to use it because of coding; however, it doesn't tell you anything about what really is going on.

Q. Thank you.

A. So the questions you ask are generally

correct, but I think the take-home message with failed back surgery syndrome, it's a terrible diagnosis. It's something that's forced on us by a coding industry that tells you nothing about the nature of the problem.

Q. Exactly. Because you -- when -- when -- when there's pain that persists after a surgery, that -- after a surgery that you deem to be successful, if pain continues to persist, you may not know the source of that pain. Correct? You have -- you want to ascertain what it is; right?

A. Correct.

Q. Okay. And -- and it's possible that -- it's possible that the pain may be due to -- due to a -- the -- the results or effects of a spinal procedure that could have caused the additional pain after surgery. Yes or no?

A. In some cases -- and there's a lot of different reasons for pain. The list is long and distinguished. But you can develop something as simple as epidural fibrosis. That means scarring on a nerve that occurs after a surgery. And that usually occurs later on in the course of recovery.

Q. So --

A. So that's -- that's just one of many possibilities.

Q. One of many possibilities; right?
A. Correct.
Q. And, hence, the reason why you're going to use this garbage-bag diagnosis of failed back surgery syndrome; right?
A. Well, I'm kind of forced into using it. Like I said, it's a coding standard. There are a lot of diagnoses that don't make sense. As I previously testified, the word "spondylosis" for facet pain. Well, "spondylosis" doesn't mean facet pain, but we're forced to use that code in order to do the procedures, so we're stuck with that.
Q. And if there's pain that arises after surgery and you don't know what the cause is, then if you don't want to use failed back surgery syndrome, you can use another word ending in "syndrome," right, until you find out what the cause is?
A. I don't follow you on that one.
Q. Well --
A. Ending in syndrome? What do you mean?
THE REPORTER: I'm sorry, pending and syndrome?
THE WITNESS: I'm sorry?
THE REPORTER: I didn't get what you said.
THE WITNESS: I said I don't know what you

mean by blank syndrome.
BY MR. MAZZEO:
Q. You can use any term. If you don't like the word or the phrase "failed back surgery syndrome," you can use any term that -- there could be another garbage-bag term that you can use to say there could -- this pain could be from a multitude of different -- it could arise from a multitude of different reasons --
A. No.
Q. -- and we have to figure out what it is; right?
A. Well, the other name is post laminectomy syndrome. But, yes, I mean, that's unsatisfying to all of us. We want to determine what's going on.
Q. For a lack of a better term, you guys use "post laminectomy -- laminectomy syndrome" or "failed back surgery syndrome"; right?
A. Correct.
Q. Okay. And you do agree that Ms. Garcia reported new complaints after the surgery that she hadn't previously reported prior to the surgery?
A. Are you referring to the thigh pain?
Q. Yes.
A. Certainly I will give you that.
Q. Okay. You'll give that to me because

we're -- we are --

A. Well, actually -- actually, let me check one thing just to be totally accurate. Give me one second.

Q. Sure. Just let us know what you're looking at.

A. I'm pulling out my archive records that has pain diagrams in it. It's the same thing that's on my disks that I submit. It's a rather large file, so it takes a second.

Q. That's fine. And -- and what you're focusing on, just so we're clear, you're focusing on the -- my last question, which referred to Ms. Garcia reporting new pain complaints after the surgery; right?

A. That's what I am focusing on.

Q. Thank you.

A. Okay. On her initial visit -- I have the patient registration form. We're looking at --

Q. You don't have to -- oh, go ahead.

A. On her initial visit -- I'm looking at her pain diagram to where she illustrates pain in both thighs. So there was something there to begin with. I can show it to you, if you'd like.

Q. Pain and numbness in both thighs from August of 2012?

A. This is my initial consultation -- what's the

date on that?
Q. August 15th of 2012.
A. Yes, sir.
Q. It's not something that you had -- was that something that you had noted in your initial consultation report?
A. Yeah, down both legs. But if you look at the pain diagram, you can clearly see where she's drawing it on her thighs as well.
Q. Indicating anterior thigh numbness and pain?
A. It's indicating pain scores, I will give you that. You're welcome to look at it.
Q. But not indicating anterior thigh pain, thigh numbness and pain. Just pain scores?
A. I just see sevens and eights all drawn on here right across her anterior thigh. So she did have that before.
Q. Do you agree that if the surgery was successful -- and you have -- strike that.
You have worked on and you have treated a lot of patients who have had surgery; right?
A. Yes.
Q. Okay. And would you agree that there are a good number of -- of patients who have this two-level fusion surgery who do not need additional diagnostic

injections -- procedures after the surgery to ascertain what the pain generator is?

A. I think what you're saying is, are there people that go on to become pain free and I never see them again? That's correct.

Q. Yeah. And actually, with -- there's probably a good -- there's probably a fairly large number of patients who have fusion surgery who go on afterwards that you won't see again. They won't need additional diagnostic procedures to ascertain the source of additional pains.

A. Correct. And I don't know the current numbers. Several years ago, the numbers they threw out in the surgical community for innerbody fusion, single level, was that 50 percent get better, 30 percent no change, and 20 percent get worse.

Again, this -- I don't have any actual study on those numbers that the community threw out several years ago. That was all surgeons, all patients across the board.

Q. So as you sit here today, you are not standing by those figures, then?

A. No, because the success rate, to my understanding, was higher when you're treating actually a spondylolisthesis.

Q. Okay. Good. Thank you. And would you agree that most patients that -- that have had a surgery for treating a spondylolisthesis generally do not need a lifetime of pain meds after the surgery?

A. "Generally" is a big word.

Q. Most of the time?

A. I would say more than 50 percent of the patients go on to recover completely.

Q. Yeah. And I'm not saying recover -- okay.

And would you say that more than 80 percent of the patients recover sufficiently enough that they don't need a lifetime of pain meds after the surgery?

A. No, no, I can't agree or quote that number. I don't know.

Q. Okay. Would you agree that most patients that have had a two-level fusion to correct a spondylolisthesis would not need a trial spinal cord stimulator to attempt to reduce the increased continual pain following the surgery?

A. Well, if you have already stated that 50 percent or more will go on to a full recovery, then -- then that obviates a spinal cord stimulator in that population just by numbers.

Q. So that's a yes?

A. No. Those who fail to recover --

Q. Not asking about those that failed to recover. I'm asking you that most of those that have a two-level fusion surgery to correct a spondylolisthesis do not need -- go on to need a -- a trial spinal cord stimulator.

A. Well, your question is deceiving. That's the same question worded differently.

When you say 50 percent or so go on to full recovery, that infers no pain meds, no additional therapies.

Q. It's a simple -- simple question, Doctor.

A. But it's not that simple. You're leaving out the rest of the population who didn't recover.

Q. I'm not -- I'm not asking you about the small percentage that don't recover.

A. Well, it's not that small. Okay?

Q. Percentage-wise, most -- from your own words on the witness stand under oath --

A. Most.

Q. -- you said that most patients that have had a spinal fusion to the -- to correct the spondylolisthesis, it's successful. Yes?

A. Correct. "Most" means greater than 50 percent.

Q. Yes. And you don't know the statistics; it

could be as high as 80, 90 percent?
A. I don't think so.
Q. Okay. But you don't know?
A. Well, I treat patients a lot. So I --
Q. Statistically you don't know the answer?
A. Not to that degree of --
Q. Fair enough.
A. -- certainty, I don't.
Q. But you do know the answer to a degree of certainty that most that receive a two-level spinal fusion surgery to correct a spondylolisthesis go on to -- for -- for complete recovery; right?
A. Yeah. I believe it's a little greater than 50 percent.
Q. Thank you. And that's -- and we're talking complete recovery?
A. Then again, if you throw out those innerbody fusions on a single level, that actually would suggest less. So I'd have to -- to be accurate, refer to my surgical colleagues for the recent numbers on that.
Q. Fair enough. But based on the testimony you -- and I'm not asking you for numbers. We're just -- from your testimony, you're just saying greater than 50 percent?
I'm not pinning you down to 51 percent, 60,

or 80 percent; but we know it's greater than 50 percent.

A. We know that I believe it's greater than 50 percent.

Q. Okay. And -- and that's all I'm asking you.

A. Okay.

Q. I'm asking you your opinion, as you sit here today.

A. Okay.

Q. Not asking you to give an opinion of what Dr. Gross believes but what you believe, Dr. Kidwell; right?

A. Correct.

Q. Okay. So, now, moving on to that question again, would you agree that most patients who have a two-level spinal fusion to correct a spondylolisthesis would not need a trial spinal cord stimulator after the surgery? Yes or no.

A. Yeah, I think I answered that. Because it's the same population that went on to full recovery.

Q. Thank you.

Would you agree that most patients -- another question, and I anticipate the same answer.

A. Okay.

Q. Most patients who have a two-level fusion

surgery to treat a spondylolisthesis would not need a lifetime of radiofrequency ablations costing $1,440,000?

A. Well, the cost got me by surprise because I don't know that number.

Q. Okay.

A. So let's just say I have no knowledge of that.

But the same population, if 50 percent got better to full recovery, that infers that no other treatment was necessary.

Q. Thank you.

And -- and -- and to continue with that, you wouldn't need typically -- and most patients who have this type of fusion surgery wouldn't need an option of having a permanent spinal cord stimulator to reduce pain levels after a surgery like this. Yes?

A. Correct. Same answer, same population.

Q. Correct. Thank you.

Now, the other day you testified that you had spoken with -- you sat down with Plaintiff's counsel for three hours and 40 minutes to discuss your trial testimony; correct?

A. Correct.

Q. And when you sat down with Mr. -- you sat

down with Mr. Roberts; correct?
A. Yes.
Q. As well as other attorneys?
A. Correct.
Q. Okay. That would be Mr. Smith?
A. Yes.
Q. And Mr. Mott?
A. Correct.
Q. Anyone else?
A. I don't believe so. A court reporter -- no, there wasn't a reporter there.
Q. No?
A. I think that was it.
Q. Okay. And -- now, before you sat down with them, you felt reasonably certain that all your treatment was related to the subject accident; right?
A. Correct.
Q. However, during your meeting with Plaintiff's counsel, they expressed to you concerns about you being able to tie in all your treatment to the motor vehicle accident, and that's why they sat down with you for 3 hours and 40 minutes; right?
A. I didn't get a sense there were any concerns. Where did you get that?
Q. They -- they discussed with you your trial

testimony, which included treatment that you provided to Ms. Garcia; right?

A. Correct. It was a very nice, helpful review going through all of my medical records. I thought it was very helpful.

Q. Very helpful. And they -- and what you needed to do was justify why certain diagnostic tests fell short of diagnosing a pain generator; isn't that correct?

A. No. I don't understand what you mean by something fell short.

Q. Didn't you have to -- I know I wasn't there.

I wasn't there, right, when you met with Plaintiff's counsel?

A. No, sir, you weren't there.

Q. No.

A. I would have remembered that.

Q. Yeah. And isn't it a fact that, when you sat down with them, you needed to justify why the surgery was not successful, because she still had -- Ms. Garcia was still having pain complaints after the surgery; right?

A. Are you --

Q. You needed to justify --

A. Are you -- no, not "justify." That's not the

right word.
Q. Okay. Withdrawn. I'll move on --
A. Okay.
Q. -- Doctor.
Now, as you testified, Dr. Gross focused on -- his surgery focused on Ms. Garcia's spondylolytic spondylolisthesis at L5-S1?
A. Well, she had two-level fusion. So that would include L4-5.
Q. Correct.
A. Correct.
Q. Right. Okay. It focused on those two levels, and specifically it was to address the spondylolytic -- the pars defect with the spondylolisthesis?
A. Again, Dr. Gross could probably speak much more eloquently than I could on this.
However, the surgery was to fuse L4-5 and L5-S1. There's a large slippage spondylolisthesis at the L5-S1 level. However, had she not had pain, she never would have come to anybody's attention and, therefore, wouldn't have had surgery.
So what we're treating is her pain complaints.
Q. Sure.

A. Obviously, she had a structural defect that became symptomatic from -- I mean, it's obvious it became symptomatic from the collision.

Q. Well, that's your opinion that it became symptomatic from the collision. That's in dispute.

A. Well, to me, it's obvious.

Q. From -- for you, it's obvious. Okay.

A. So --

Q. But do you --

A. -- had she not had symptoms, she would have not sought treatment, nor would she have had surgery or an injection.

Q. That's a -- that's a great point. Because patients come to you and they -- they come to you and to other doctors because they have symptoms; right?

A. Correct.

Q. And they -- and these symptoms are in the form of pain generally and other symptoms; right?

A. Correct.

Q. And pain is a subjective component of the evaluation, of the reporting by a patient; correct?

A. All pain complaints are subjective, and most medical complaints are subjective. If you come to me with shortness of breath, chest pain going down your arm --

Q. Sure.
A. -- that's totally subjective, but it is what you tell me it is.
Q. Exactly. So -- and, now, the spondylolytic spondylolisthesis was a condition that preexisted the motor vehicle accident. Yes?
A. Most likely. I don't think we have any data to show that it was preexisting, but most of the time you consider that slippage a chronic thing.
Q. And we've established that postsurgery Ms. Garcia continued to complain of pain. Yes?
A. Well, we have established that she was on track for recovery. You know it takes two years to recover from a fusion. That -- it takes two years to get as good as you're going to get.
She was on track, improving. And then, it looks like, about eight months out she started to develop some pain. Further on, it became worse and worse. So that's really what happened.
Q. That's what I was asking you.
Postsurgery, did it continue --
A. Well, "postsurgery" is a big word. Is it a month postsurgery? Two months postsurgery? Ten months postsurgery?
Q. Oh. Fair enough.

A. The chronology is important.
Q. No, you're right. You're right.
So when I say "postsurgery," within a year, not your two-year time for when she would have optimal recovery from a fusion.
So within a year after the surgery, she continued to complain of pain in her low back and legs. Yes?
A. Well, there was a point in time it started getting worse.
Q. Okay.
A. Fair enough?
Q. So she continued to complain. Yes?
A. Correct.
Q. Okay. Thanks. And given that you have been treating Ms. Garcia -- and in each of your records, you said --
By the way, when Ms. Garcia came to see you in August of 2012, you knew that she had a medical-legal claim; she was -- already commenced litigation?
A. Correct.
Q. Okay. And -- and so typically you take -- when Ms. Garcia came to you -- you were retained in this case as a treating physician. Yes?

A. Yes.
Q. Not as a forensic expert?
A. No.
Q. Right?
And so -- and you agree that your primary function is to diagnose and treat a patient. Yes?
A. Yes.
Q. Okay. And you were not retained to determine causation?
A. When I first see a patient in treatment, I'm not being retained to see that patient. I am treating that patient.
I get retained when I'm asked to provide a report. Up to that time, there's no retention. It's not -- I don't work for Glen Lerner's office. I don't work for --
Q. Sure.
A. -- Ed Bernstein's office. I don't work for Bob Vannah's office. I work for my patient. I treat my patient.
Q. And you're not an advocate on behalf of the patient with respect to her medical-legal claim; right?
A. No, I'm an advocate for accuracy. That's -- that's my goal, to treat a patient appropriately and be as accurate as I can.

Q. When you say "accurate," accurate in your treatment, accurate in documenting your treatment records; correct?

A. Sure.

Q. Okay.

A. Absolutely.

Q. So now -- so getting back to my question, you weren't retained to determine causation -- I'm not saying you didn't, but your -- if your primary focus is to diagnose and treat a patient, then your primary focus is not to determine causation. Yes?

A. Yes and no. I've been doing this a long time. So when I see a case is in litigation for whatever source, I always include a statement of causation on the initial visit. But I have not been retained to do that.

Q. No, no, no. I -- and I understand that. No. Fair enough.

But -- but knowing that -- that at the time that Ms. Garcia came to see you in August of 2012, you knew when she spoke to you -- and I guess when she was referred by Glen Lerner's office. But when she spoke to you at the initial consultation, you learned, certainly at that point if not earlier, that she already had litigation ongoing with respect to the

complaints for which she was seeing you for.

A. That's completely obvious. Sure. I know she's in litigation.

Q. Yeah.

A. That's all I know. But, again, I render causation statements based on a temporal relationship between relative onset of symptoms and the collision. And I do that because I've done enough depositions to know it always comes up. They're going to want to know, so I include it automatically so I don't have to go back and do it again.

Q. Exactly, Doctor. Very -- I'm glad you made that point, because you typically include that when you know that patients -- you include a causation -- causation section when you know that patients are --

A. Correct.

Q. -- involved in a medical-legal claim; right?

A. And you've reviewed some of my records in the past. And you know very well, if there's a -- an issue of preexisting, I'll include that and I'll try to differentiate what's new, what's old. Yes, you've seen my records before.

Q. I have seen your records before, and I've deposed you before, and I've cross-examined you at trial before. Yes?

A. Yes, sir.
Q. Okay. So -- so typically -- and -- and I think you made a very good point. When you -- you'll -- you'll include a causation reference in your treatment records when you know that the patient has a medical-legal claim; right? You just said that?
A. Yes. I'll go out of my way on medical-legal claims and workmen's comp to define it a little better.
In a nonlitigation-type case, I will still try to include in my statement when something happened or what caused it. Example, "Guy fell off a ladder at home, hurt his back." Simple statement like that.
Q. Sure. Because --
A. I include that in all records.
Q. I'm sorry.
A. But since it comes up so often and I've done a lot of depositions, I automatically include it as a specific section in things where I know litigation is pending.
Q. Sure.
A. Workmen's comp, personal injury.
Q. Absolutely. So and -- and you still make a reference -- you'll -- you'll make a reference in almost every one of your treatment records of this patient, Ms. Garcia, as to the causation; right?

A. You mean further-on records -- I mean, later records throughout the course of the treatment?

Q. During the course of treatment, in your --

A. No. Actually, I don't include that every visit. It's already been established on the first visit. I don't need to say -- repeat stuff over and over again. I pay for transcriptionists at a rate, so I tend not to be too wordy.

Q. Right. And your understanding, though, as you're treating Ms. Garcia from August of 2012 up until, I believe you said -- I'm not sure if you said a few weeks ago.

A. Last week.

Q. Last week. Okay.

So from August of 2012 up until -- we're going on three and a half years, I guess, at this point.

So for three and a half years, the treatment that you've given her, in your mind, has been all related to the subject accident. Yes?

A. Oh, yes. I think that's totally obvious.

Q. Okay. So after meeting with Plaintiff's counsel for 3 hours and 40 minutes prior to your direct examination where essentially, Doctor, you basically just went through, from what I saw -- I'm sitting over

here and I'm seeing Mr. Roberts just going through one record after another and what did she say and what was your finding.

So, basically, you went through your medical records on direct examination, and then you were asked opinions about the accident-related treatment; correct?

A. What's the question?

Q. So I know -- I know it was a little -- that was a little preamble.

A. You got me a little confused. Go ahead.

Q. That's -- fair enough. So you're not going to come in here now today and say that "Ladies and gentlemen, my opinions are wrong. She probably had issues that were not related to this accident."

You're not going to say that because you've already made a determination, because she's a -- she's a litigant, that all her treatment is related to the accident based on Ms. Garcia's self-report to you; right?

A. You have three questions wrapped into that.

Q. You want me to --

A. I guess the short version is, are you saying I'm going to change my opinion? The answer is no.

Q. Correct. You're not. Okay.

Now, let's -- give me a second, Doctor. I'm

going to take a look at something. We're actually going to back up. We're going to back up to her very first treatment visit.

And this is Plaintiff's 18, page 1. Physician clinical report, again, January 5th of 2011. Couple of questions for you.

And, by the way, Doctor, did you review this at some point, if not with your initial consultation but at some point during your treatment of Ms. Garcia?

A. I probably did.

Q. Okay. We're going to go on to the second page, and I want to focus on -- by the way, January 5th of 2011 was three days after the accident. Yes?

A. Yes, sir.

Q. Okay. So we're going to go on to Plaintiff's 18, page 2. We're going to focus on the physical examination that was -- that was done at the hospital there.

Now, at the -- at the hospital, Ms. Garcia complained of neck pain; right?

A. Correct.

Q. And -- and then a physical examination was performed on Ms. Garcia on January 5th of 2011; correct?

A. Correct.

Q. And -- and what the record shows is that -- so it shows, with regard to her head, "Head was nontender. No swelling of the head."

You see that?

A. Correct.

Q. And then going on to the neck, "No muscle spasm in the neck. Painless range of motion. Nontender. No vertebral tenderness."

Do you see that?

A. Yes, I do.

Q. And then back, "No back tenderness. No vertebral point tenderness or muscle spasm."

Do you see that?

A. Correct.

Q. Extremities -- now, when we talk about extremities, what are we talking about?

A. Arms and legs.

Q. Right. Okay.

So "Normal inspection. Pelvis is stable. Extremities atraumatic."

What does that mean?

A. No bone sticking out, no bruising.

Q. Okay. And "no lower extremity edema."

A. Correct.

Q. Edema is accumulation of fluid?

A. Correct.
Q. So -- and typically, when you're in a -- when you have a traumatic -- if -- if part of the body suffers a -- a traumatic assault or injury, you might see some swelling and edema; right?
A. What they're actually looking for is probably DVTs, clots, or compartment syndrome or something like that. I think that's what that statement is really looking for.
Q. Okay. "Neuro exam: No motor deficit. No sensory deficit."
Do you see that?
A. That's correct. That's what it says.
Q. Okay. And the clinical impression is low back strain; right?
A. Low back strain.
Q. Right. Now, that -- that term, "low back strain," refers to stretching or tearing of a muscle or tendon?
A. Basically, yes.
Q. Okay. And when they -- when you refer -- when a reference is made to low back strain, we're talking about musculoligamentous injuries; right?
A. Correct.
Q. And would you agree, Doctor, that -- would

you agree that some well-known factors that contribute to low back pain include the conditioning that a person is in, whether they're in good condition -- physical condition or in poor physical condition; right?

A. Are you talking about chronic low back, or are you talking about a simple strain?

Q. Well, it could be chronic low back pain and even a simple strain.

A. Well, a strain is usually a result of some precipitating event --

Q. Okay.

A. -- which obviates -- which is probably not related to being overweight or smoking or whatever. It's -- it's an acute event.

Q. Okay. And if it's a chronic condition, then we're -- then that's something that poor physical conditioning could have a -- that could be a factor that could contribute to that; right?

A. That could be a contributing factor to chronic low back pain --

Q. And --

A. -- without any other etiology that you could find.

Q. Sure. Would you agree that smoking could also be a factor that could contribute to low back

pain?

A. Smoking, as you know, is bad for a lot of different reasons. It causes bodies to degenerate a little bit, in addition to cancers, lung disease, all that other bad stuff that happens. It can accelerate the aging process a little bit.

Now, directly causing pain? I don't know that. It's pretty well documented that most smokers don't do well after a fusion if they continue to smoke.

Q. Sure.

A. I think you can say that. I would say that's pretty well-documented literature.

Q. And -- and the reason for -- just for the jury's edification, when we talk about smoking and -- and the -- the implication of smoking on -- on a patient's recovery, smoking -- and you can correct me if I'm wrong here -- doesn't that constrict or restrict the blood vessels and capillaries and it reduces the blood flow?

A. Well, depends on the structure. You know, in a simple sprain-strain, I don't think it would do much to inhibit healing.

Q. Sure.

A. The disks, you know, they're blood supply from the end plates above and below the vertebral body.

So the nutrients that go to a disk to keep it healthy basically happen by passive diffusion.

So nicotine is a vasoconstrictor. And I think that's why people don't heal after a fusion, because the blood supply is just not there in a space that already has a lousy blood supply.

Q. Okay. Thank you. Would you agree that a person's weight might be a factor that can contribute to chronic low back pain?

A. Well, if you have chronic low back pain to begin with. There are people who lose a lot of weight, and the pain gets a little bit better. Absolutely correct.

Q. Do you agree that a person who has a preexisting spondylolytic spondylolisthesis, that weight -- if a person is carrying excess weight, that that could actually be a factor that causes the progression of --

A. I don't know that specifically. There's lots of skinny guys with spondylolisthesis too. So I don't know if you can make that statement. And there's a lot of people who are overweight that have absolutely no back pain. So I don't know if you can make that correlation either.

Q. And -- okay. And -- and would you agree that

a person who's working and standing during an eight-hour shift could cause that -- could -- could experience low back pain from the continuous loading upon the disks?

A. I don't know. The human being is made to stand up. I mean, a lot of people work eight-hour shifts and they get a little stiffness. We all do. I know when I'm doing procedures wearing lead all day long, my upper back starts hurting. But we're made to stand erect. We're Homo sapiens. So the body is built for that. So I don't think that's a huge factor either.

Q. Okay.

A. Otherwise, we would all be crawling on our knees.

Q. I am sorry. I didn't hear that.

A. I said, otherwise, we would be crawling on our knees preferentially.

Q. And then we'd end up with four legs instead of --

A. And a tail.

Q. Okay. So I'm going to show you Dr. Gross's -- his report from April 3rd of 2013. Kind of looked at this earlier, but this is the first page of it. April 3rd, it's Plaintiff's 24, page 83. I'm

going to take us to the -- the fourth page of this report.

Okay. Now, Dr. Gross made some references with regard to summary of treatment for this injury. And he noted in this report Dr. Lemper's -- the transforaminal epidural steroid injection plus the bilateral hip injections on 8/30 of 2011?

A. Yes.

Q. Do you see that?

Also he noted the L -- L3 to S1, and that's three levels, bilateral facet and joint injections on 9/14 of 2011. Do you see that?

A. Yes.

Q. Now, according -- and then also he referred to your bilateral L5 and S1 selective nerve root block on 9/27 of '12; right?

A. Correct.

Q. Now, what he noted was that with regard to Dr. Lemper's initial injection, notwithstanding -- notwithstanding any testimony from Dr. Lemper or from you that that might have been a successful injection, what Dr. Gross reports here is "no response from the patient." And then in parenthesis "temporary response per Dr. Lemper's notes."

Would you agree that the temporary response

and temporary relief that she relieve -- that she experienced -- she reported following this procedure was -- and because it was only temporary, that -- let me see, that was -- I'm sorry -- that that would not be a -- in terms of a diagnostic tool, we can't rely on this -- this -- this epidural steroid injection by Dr. Lemper to have affirmed a pain generator at the levels that Dr. Lemper injected? Correct?

A. Are you aware -- epidural injections are not a diagnostic tool for anybody, no matter who's doing it, Dr. Lemper or anybody. They're not a diagnostic tool. The object of the procedure is to deliver a corticosteroid near the target. But if you put it in a sufficient volume, it will spread up and down two, three segments.

If something good happens -- in other words, pain is relieved over time -- all you can say is they had a positive response to the steroid. It gives you no diagnostic information except maybe there's a pain generator close to where you put it, but it's not considered a diagnostic tool.

Q. Fair enough. So -- and it's done for therapeutic purposes?

A. That's correct.

Q. Okay. Now, in this case, because it was --

she had a only temporary response, we can't say that this was therapeutic for her because we expect the steroid that's injected to last much longer than one day; right?

A. "Expect" is a strong word. You never know what you're going to get until you try it. An adequate or a significant improvement would be significant improvement over time.

Q. She didn't have that.

A. No. She had a temporary response. My read of that is that it was very short-lived.

Q. Very short-lived. Okay.

Moving on to the L3 to S1 three-level bilateral facet joint injections. Dr. Gross noted "return to baseline post injury pain and improved motion with worsening since."

So -- and we've already talked to Dr. Lemper about whether -- whether this was beneficial or not. Now, this is both -- when we talk about a facet joint injection, kind of look at that as both diagnostic and therapeutic; right?

A. If you keep the volumes low enough, it certainly can be diagnostic.

Q. Sure. Okay. But we know that Dr. Lemper wasn't able to identify any pain generator following

this procedure.

A. I don't have enough information from that statement to draw a conclusion.

Q. Fair enough. Okay. And then going -- going down to 9/27 of 2012, you performed a bilateral L5 and S1 selective nerve root block; correct?

A. Correct.

Q. Now, selective nerve root block, different than an epidural steroid injection, that is diagnostic, right, and potentially therapeutic?

A. Yes. When I do those, I specifically want to anesthetize the target segment. So I keep the volumes very low, less -- less than -- probably 1 cc or less. I concentrate the steroid to a higher concentration. There's a higher concentration of local anesthetic because I really want to numb the segment up.

What -- that note from Dr. Gross doesn't indicate that when I saw the patient immediately post-op, 20 minutes later, got her up and moving around, she had complete relief of her pain. That's the diagnostic part?

What happened days later is not the diagnostic part. That's the steroid help. And in this case, I don't think it provided any long-term substantial relief.

Q. And -- and when you're -- when you're asking the patient to identify her response to this procedure, after the procedure, she's still -- she's in the recovery room?

A. Correct.

Q. She's lying on a gurney?

A. Yeah. We get them up, though.

Q. Well, you get them up because they have to get up at some point and leave; right?

A. No, no, it's part of an exam. We get them up and move them around, have them flex and extend. You know, it's a diagnostic tool. So I don't want to just sit there, are you comfortable lying there in no pain. We get them up, move them around, find out.

Q. And you understand that there's -- there's to a certain extent -- because you have been in this business for a long time -- that a patient who has -- coming in to you with chronic pain, complaining of that, there's a certain placebo effect when -- after these procedures, because there's the anticipatory -- an expectation by the patient that finally I'm going to get relief because I'm getting an injection, I'm getting a procedure.

A. Well, like you said, I do an awful lot of these, and I get all kinds of reporting. I have some

patients say, well, 50 percent's gone, 20 percent is gone, 30 percent is gone, all of it's gone, 80 percent. And, I mean, I get all kind of numbers. So I don't -- I don't think there's a huge placebo response on this. Patients generally tell me, when we move them around -- you know, if you're lying there, it's one thing. You get them up, move them around, it's another. That's why we do it. It's called provocation. We're trying to provoke their pain after I have anesthetized a segment.

So I think what you can glean from this is that something's symptomatic at the L5-S1 level in that area. That's the area I targeted.

Q. Okay.

A. And I anesthetized the nerves, and the nerves are numb, pain goes away. You got to think, hmm, might be where the pain is coming from.

Q. Then -- and -- and then she -- I think, per your October 10th, 2012 report, it shows that she had about one to two days of relief from the symptoms and then they returned?

A. That's absolutely correct.

Q. Okay. Now -- and then you also had performed -- and on 12/1 of 2014 and March 16 of 2015, you performed both facet injections and a sacroiliac

joint injection?

A. Correct.

Q. And on 6/10 -- and give me a second. I am going to direct your attention to your record of June 10th of 2014 -- or 2015. I'm sorry.

And Ms. Garcia -- and this is just for the record. So this is the June 10th of 2015. And what Ms. Garcia reports to you is that she had two sets of these combined injections that included the right SIJ plus facet joint injections bilateral at L3-4 plus hardware blocks --

A. Correct.

Q. -- right?

And she said she had reported significant -- significant sustained improvement on the few occasions -- on both occasions for a few weeks only; right?

A. Correct. That's when she had pretty remarkable improvement from them.

Q. Okay. And -- and then on 9/24, Doctor, 9/24 of 2015, you had performed the radiofrequency ablation?

A. That's correct.

Q. That's correct. Okay. So you performed a radiofrequency ablation at the sacroiliac joint?

A. Correct.
Q. And also radiofrequency ablation bilateral at L3-4 and L4-L5?
A. Correct.
Q. Okay. And I know that you testified that was successful, in your estimation. I believe you testified, though, you really want to -- your determination as to whether a radiofrequency ablation is successful is, you told us last week, you really want to see -- its success or failure depends on -- you want to look eight weeks out.
A. When I do a procedure like that, it's painful. It's -- it's a -- the nerves really get unhappy about being burned. So some patients feel better within a week or two. Sometimes they have a lot of muscle pain and spasm afterward. So I don't really evaluate, say this thing didn't work, until we're eight weeks out. And in her case, we're five months out, and she's doing really well.
Q. Okay. So -- so then we look at your report, Plaintiff's 26, page 694. This is the first visit after the radiofrequency ablation, September 30th of 2015. Yes?
A. Yes, sir.
Q. Okay. She talks about how well she's doing.

She's -- low back pain decreased. Yes?

A. Correct.

Q. Okay. And then her very next visit after that was on October 14th, and that's where you had -- you had testified that there's a belief that the pain is really above and below the radiofrequency sites. She -- oh, here it is. Until about -- she developed -- she was doing well until about four days ago. She developed some pain. Do you see that?

A. Correct. That wasn't my belief. I actually examined her.

Q. Okay. Okay.

Now, going to November 11th, so we're just under eight weeks out from the -- from the procedure that you gave -- that you performed on -- on 9/24 of '15. This is Plaintiff's 26, page 712. And you note that she's experiencing flare-up -- it says "flare." I imagine you meant flare-up.

A. Well, actually, my PA saw her that day. And she was relating to the prior visit, the flare of symptoms.

Q. Okay. Okay.

Is it flare-up? I know the word "up" is missing. Is that what was meant?

A. You can just say there was a flare.

Q. Flare?
A. Flare-up, same thing.
Q. Same thing. Okay. So if I use "flare-up," it's the same thing as "flare"?
A. That works for me.
Q. Okay. So it says, "She was experiencing flare" -- or flare-up -- "in the usual pain at the last office visit -- visit." You see that?
A. Correct.
Q. Okay. Now, last office visit we looked at was October 14th of 2015; right? That was the one prior to November 11th.
A. Okay.
Q. Well, on -- on October 14th, it's no one's contention that she was experiencing usual pain; right?
A. Oh, I think you're misreading the whole thing.
Q. My question -- it's not whether I'm misreading it. I'm asking you a question. On October 14th, 2015 --
A. Correct.
Q. -- is it fair to say that when we talk about usual pain, we're talking about something that is constant, continuous, ongoing?
A. No, I think Gina meant the following visit,

she was referring to the flare of pain. I specifically -- specifically went out of my way to indicate that it wasn't at the procedure sites. And there's a reason for doing that.

What -- I'm really looking to make sure there's not an infection or something after the procedure. So she had no pain at the procedure sites nor is she having swelling or redness. That's what I'm worried about is infection.

And I noted that her pain was really above and below. So I have to explain that. And then after some discussion, she had been a little more active because she felt better. I mean, this is normal human behavior.

Q. I understand that, Doctor, and that's -- that's what you said. What I'm looking at here is the November 11th, 2015, report, where Gina, your PA --

A. Yes.

Q. -- where she indicated several -- couple words here. She was experiencing a flare-up in usual pain at last office visit.

So my question then: When we talk about usual pain, we're talking something that is constant, ongoing; right?

A. Right. I think she got it wrong. She didn't

read my note.

Q. I understand that's your opinion as you're explaining this. But --

A. Well, I have to explain it. I'm responsible for her.

Q. Got it. Okay. And when we say "flare-up" -- when we say "flare-up," generally that term -- so -- so she is not just saying usual pain, but when we refer to the term "flare-up," we're referring to something that has happened previously. Yes?

A. Right.

Q. Okay.

A. What are you getting at? I'm kind of getting lost here.

Q. You're getting lost? Okay. Look at the screen.

A. I get that.

Q. Okay. And so what Gina reported was that Ms. Garcia was experiencing flare-up in usual pain at last office visit?

A. Correct.

Q. Okay. Thank you.

By the way, your -- your -- the sacroiliac joint injections and the facet joint injections that you performed on 12/1 of 2014 and 3/16 of '15 never --

you never actually identified the pain generator from those injections, did you?

A. You know, actually I think we did.

Q. You're -- you're saying -- because I didn't see it on any report. You're saying that you identified whether it was right side or left side and you identified the specific location?

A. No. As I testified last week, after my discussion with Dr. Gross, I did not realize -- and Dr. Gross educated me on this because I'm not a spine surgeon -- that when they do a fusion, they do electrocautery of the facet nerves, the medial branches, the place I do the radiofrequency.

Q. Right. I'm not asking you to repeat your testimony that you gave on direct from last week.

A. Well, that's how I explain it. I mean --

Q. Okay. Well, you know, let's move on to something here, Doctor. So you believe that your -- this -- this radiofrequency -- or strike that.

It's your contention as you sit here today that you believe that Ms. Garcia's -- all the treatment you gave to Ms. Garcia was appropriate, it was reasonable, and it was related to her pain complaints; right?

A. Correct.

Q. And -- and you believe that your -- your procedures actually was appropriate in identifying pain generators for Ms. Garcia; correct?

A. Yes, I do.

Q. And -- and that's from -- and we're talking about from when you first saw Ms. Garcia in August of 2012 up to the present. Yes?

A. Correct.

Q. Okay.

THE COURT: You at a good break point, Mr. Mazzeo?

MR. MAZZEO: Yes, Your Honor.

THE COURT: Let's go ahead and take a break for a few minutes, folks. I want to make sure everybody stays alert and awake.

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 perform any other kind of book or computer research with regard to any issue, party, witness, or attorney involved in this case.

You're not to form or express any opinion on any subject connected with this trial until the case is finally submitted to you.

See you in ten minutes.

(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?

MR. ROBERTS: No.

MR. MAZZEO: No, Your Honor.

THE COURT: You did make an objection earlier that I didn't get a chance to rule on. It would have been overruled anyway.

MR. MAZZEO: Thank you, Judge.

THE COURT: You guys -- you do -- you have a hard time giving him a chance to answer, back and forth. It's hard on her.

MR. MAZZEO: I will keep that in mind.

THE COURT: So relax.

MR. MAZZEO: I will keep that in mind, Judge.

THE COURT: 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. We're back on the record, Case No. A637772. Do the parties stipulate to the presence of the jury?

MR. ROBERTS: Yes, Your Honor.

MR. MAZZEO: Yes, Your Honor.

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

THE WITNESS: Yes, sir.

THE COURT: Mr. Mazzeo, go ahead.

MR. MAZZEO: Yes, thank you, Judge.

BY MR. MAZZEO:

Q. Okay. Dr. Kidwell, I believe the other day when you were on direct examination, you -- when you were referencing the -- your -- I believe it was the 9/27/12 selective nerve root block, you had indicated at that time -- and I'm just looking for my place here -- that you don't believe that -- that Ms. Garcia received -- received the -- the relief that you had anticipated or expected?

A. Post procedurally, she had complete relief of pain, so that's the diagnostic part. And, you know, that's not anticipated or not. It is what it is. It's just a data point. As far as sustained improvement, she did not enjoy it. That's correct.

Q. Okay. Thank you.

And, now, also in -- in conjunction with your review of records in this case, you had reviewed radiodiagnostic imaging studies; correct?

A. I reviewed reports.

Q. Reports?

A. Yes, sir.

Q. And I believe I remembered, from your prior testimony that you have given on other cases, you typically don't review the diagnostic imaging studies; you'll rely on the radiologist's findings that are contained in his or her report. Correct?

A. Correct. Generally the patients don't bring them. If they do, I review them. If they don't, I don't. Unless there's a reason for me to pull them. Then sometimes I send for them.

Q. Okay. Now -- and you reviewed those reports during the course of the treatment as well as in preparation for your trial testimony today; correct?

A. That's correct.

Q. And is it correct to say that from the reports that you reviewed -- and let's be specific. I believe you reviewed the X ray report of 2/8 of 2011.

A. I believe so. Let me see what I have on my notes.

Q. Sure.

A. I reviewed those, the initial X ray reports as well as a couple of MRIs.

Q. And an MRI report from 1/26 of 2011?

A. Yes, sir.

Q. Okay. And -- and I'll focus on those two. With regard to the X ray report, I know there were --

A. Hang on. What was that date again?

Q. 1/26 of 2011.

A. Yeah, probably reviewed that report. Also have August 19th, 2011.

Q. And 2011. Okay. So initially the -- the X ray report from -- I know there were two lumbar X rays that were done in -- one in January of 2011, one in February of 2011. And --

A. I will take your word for it. I don't have that in front of me.

Q. Just so we're clear, the one that you reviewed -- the report that you reviewed was the 2/8/2011?

A. I believe so. It's in my notes. I went through them all. I just don't have the dates committed to memory.

Q. Fair enough. And, now, after your review of that report, is it correct that the radiologist did not indicate any findings of acute or traumatic injury?

A. On the X rays?

Q. Yes.

A. Yeah. What they're looking for, fractures. And there weren't any.

Q. Well, whatever he was looking for.

He did not indicate any -- any findings of acute or traumatic injury in that report?

A. Well, actually, that's really all that shows is an acute injury as a fracture. So ...

Q. Okay. Well, let's move on to the lumbar spine -- the MRI of the lumbar spine on 1/26 of 2011.

You reviewed that report drafted by the radiologist?

A. Yes, sir.

Q. Okay. And --

A. 1/26/2011. Let me find that.

Q. Sure.

A. Okay.

Q. And what the radiologist noted were a number

of findings.

One in particular was a bilateral pars interarticularis defects and the spondylolisthesis?

A. Correct.

Q. And that was a preexisting condition I believe you've testified to?

A. Probably.

Q. Okay. Also the radiologist noted facet joint hypertrophic changes as well?

A. Correct.

Q. And would you agree that those would have been preexisting conditions?

A. Probably.

Q. Okay.

A. Without actual imaging before, you can't say with absolute certainty. That's why I say "probably."

Q. Certainly. And is it fair to say that the radiologist did not identify any findings of any acute or traumatic injury in his report?

A. Well, again, you have to understand what -- what would be an acute finding or a traumatic finding.

Generally, on an MRI, that comes down to a fracture or a bone contusion. Those are really the only things that show up as acute findings.

Q. Well, in addition to that, you -- you can

actually -- I'm sure you've seen imaging reports where the radiologist noted the presence of edema.

A. Well, that's what I'm suggesting. Edema is how you know -- when you see a bone contusion, you see acute edema. That's how they know it's acute. Other than that, it's a fracture, which is associated with edema as well.

Q. Is it correct to say that the radiologist with respect to this MRI --

A. I can say that --

Q. -- didn't -- hold on -- did not identify any presence of edema?

A. Correct. Did not identify -- well, did not identify a fracture or a bone contusion.

Q. Okay.

A. I can say that.

Q. Okay. Now, also with respect to Ms. Garcia, is it correct to say that you never placed any work restrictions on her during her course of treatment?

A. I don't know. I haven't reviewed it to that degree, so I can't tell you. I don't think I have.

Q. Okay. Well, based on your best recollection, as you sit -- strike that.

You -- you did review your treatment records in preparation for your trial testimony; correct?

A. I will say, as far as I know, I did not. But if you pull something up later that I missed --

Q. Oh, no. I just --

A. -- I stand corrected.

Q. No. I think that's -- I didn't see anything on your treatment records.

A. I didn't either.

Q. Okay. And is it correct that you never imposed any restrictions on Ms. Garcia with respect to her activities of daily living?

A. Correct.

Q. And is it correct to say that you're not aware of any physical restrictions or limitations that Ms. Garcia had at any time during your treatment of her?

A. Did she have physical limitations? Oh, absolutely.

Q. Well, not -- not -- I'm talking about physical restrictions, things that she's unable to do with respect to activities of daily living and work.

A. Oh, you mean did somebody put her on work restrictions? Is that what you're asking? Or are you asking my opinion of what she should be doing?

Q. Okay. Let me rephrase it. Fair enough. Okay.

From reviewing your medical records, I did not see anywhere in your medical records where you may have identified that Ms. Garcia had certain limited -- physical limitations which would impede her ability to engage in activities of daily living and -- and accomplishing her work requirements.

A. Actually, she had a big limitation. She was in severe pain. I did not put work restrictions on her because she indicated that she really had to work. So that's typical of my practice. I will not impose work restrictions because most of my patients have to work. They have to eat, so they work for a living.

Q. And you know that at the time -- during the time that Ms. Garcia was treating with you, with the exception of four months after the surgery, that she was working 40 hours a week at the Aliante Casino?

A. Correct.

Q. And is it correct to say that, during the course of your treatment with Ms. Garcia, that she did not discuss with you any limitations that she may have had in her activities of daily living?

And I'm not talking about pain. I'm talking about physical limitations in her activities of daily living.

A. I -- I actually spoke to that indirectly in

one of my notes where -- indicating she continues to work. "Quite frankly, I don't know how she does it." That's a direct quote. I forget which note it is.

But, no, we discussed that. But, again, the vast majority of my patients indicate they have to continue working. And -- and so I don't give them work limitation because it'll harm them as far as their job.

Q. Okay. And -- and do you know -- do you know that Ms. Garcia continued working at Aliante until April of 2014?

A. Yeah. I know she's -- she worked up to some point in time. I thought it was 2014 --

Q. Okay.

A. -- or 2015. I'm not sure. But I know at some point she was no longer working.

Q. Okay. Now, is it correct to say that you did not direct -- or you did not advise Ms. Garcia that she's unable to come in -- to come to court and sit during this trial because of any physical limitations, did you?

A. You know, I don't know if we gave her a note or not. I can't tell you.

Q. Okay.

MR. MAZZEO: Thank you. I'll pass the witness.

THE COURT: Mr. Strassburg or Mr. Tindall?

MR. STRASSBURG: Thank you, Judge.

CROSS-EXAMINATION

BY MR. STRASSBURG:

Q. Dr. Kidwell, why wouldn't you know if you didn't give her a note to come to trial?

A. Well, I've got 8,600 pages of records in front of me. So I don't have committed to memory every little detail, to be honest.

We might have -- my staff might have provided me that; they might not have. So I can't say with any reasonable degree that I have knowledge of that.

Q. But, I mean, you saw her a week ago.

A. She was seen in my office a week ago by my PA.

Q. Not you?

A. No, sir. I'm due to see her next month.

Q. These office visits that we've seen in the medical records, how many of those are -- is she seeing you personally compared to how many she's seeing somebody else?

A. I haven't added it up, but it's probably a three-to-one ratio.

Q. Three-to-one how?

A. Two visits -- or two to three visits with my PA versus one with me.
Q. Okay. Bear with me a second, Doctor.
A. Don't get tangled up. Man, that looks dangerous.
Q. There's a hookup here somewhere. Oh, I see. Okay. I left it up here.
MR. STRASSBURG: Judge, could I have the television, please?
THE COURT: You're up and running. You're up and running.
BY MR. STRASSBURG:
Q. All right. Dr. Kidwell, good morning.
A. Good morning.
Q. I'm Roger Strassburg. We met out in the hall. I represent the other defendant, Jared Awerbach, the driver of the car.
A. Okay.
Q. As I said to other witnesses, I want to be entirely fair to you. So if I ask a question that's not clear or that you don't think's fair, just let me know and we'll clear it up on the spot. Okay?
A. Fair enough.
Q. I also wanted to acknowledge and thank you for your service to this country as a flight surgeon in

the military.

A. Well, quite frankly, I should have paid them I had such a good time.

Q. Good to know. Okay. I take it back.

A. My only regret is retiring. Anyway ...

Q. Now, you know one of the issues in the case is causation of her pain; right?

A. Correct.

Q. Now, are you here as a testifying expert as well as a treating physician or just as a treating physician or don't you know? I mean, maybe you --

A. Well, you know, I'm not a lawyer nor do I pretend to be one, and I know the rules of what an expert is has changed over the last year so.

So, to the best of my knowledge, I'm a treating expert.

Q. Okay. And in that line, you've had occasion to review other medical records in her case file; right?

A. Yes.

Q. And you've had occasion to familiarize yourself with the work by Dr. Gross, the surgeon. Yes?

A. Yes.

Q. And you needed to do that as part of your treatment because you were -- you needed to have some

general understanding of what Dr. Gross did and what he thought to assist you in performing your treatment; right?

A. Well, I think it made it pretty clear at one point we did coordinate care, because Dr. Gross asked me to do something and I clarified it with him. And like I previously stated, he actually taught me something very good.

Q. He took you to school?

A. No, I wouldn't use those words. He had a rationale for a procedure he wanted to be performed, and the rationale was perfectly appropriate and it worked. The proof's in the pudding.

Q. And that rationale was -- is that he, I think you said, cauterized certain nerves --

A. Right.

Q. -- in the spine when he removed the bone and put in the rods and screws and bone grafts; right?

A. Correct -- well, I don't know about bone grafts.

But to perform a fusion -- and you've seen the pictures I have that actually demonstrates the hardware he put in, the screws and the plates. Like I say, I've never seen a fusion except doing anesthesia for him. But I've never operated doing a fusion, so I

did not know that he would cauterize the nerves that go to the facet joints at time of fusion. It's just like me doing a rhizotomy, even better, because he's got the perfect exposure and he can cauterize the heck out of those things. So that was -- that was new to me.

Q. And -- and the -- the source of your knowledge of his cauterizing of these nerves during surgery was himself; right?

A. Yes.

Q. He -- he told you orally over the phone?

A. Correct.

Q. And did you have occasion to consult his operative notes for any further information about that activity?

A. Oh, no, I didn't need to. I mean, why would I want to?

Q. Oh, I don't know. Just to learn some more about a matter that you didn't know anything about before.

A. Well, it's not that I don't know anything about it. I didn't know that he cauterized the nerves and facet joints as part of his procedure, but I've read plenty of op notes. I don't need to read another one.

Q. And based on what he told you --

A. And I have seen his op notes. Don't get me wrong; I have read them. But I -- what you're inferring is, after my conversation with Dr. Gross, I should have gone back and reread his op notes. That's not the case.

Q. No, no, no. Really, don't get defensive. I'm not implying anything. I'm just asking.

A. I'm just trying to be accurate.

Q. I'm fine with that too, and I'm fine with you being on your guard. This is a very important case, and we need to be accurate.

Now, did Dr. Gross tell you or did you know what piece of medical equipment he utilized to perform this cauterization of the nerves?

A. The device may come under different names, but basically it's an electrocautery device. In general, we call it a Bovie.

Q. B-o-v-i-e?

A. Correct. Now, there -- there's different manufacturers. Electrocautery is what it's called. When I do surgery, I use electrocautery too, so I'm familiar with it.

Q. And how many volts does the Bovie that Dr. Gross utilized on Ms. Garcia employ?

A. Oh, I have no idea. I wasn't there.

Q. And what is the zone of influence of the cauterization of the Bovie that Dr. Gross utilized on Ms. Garcia?

A. Again, I wasn't there. I'm speculating. I have used electrocautery --

Q. No --

A. -- in the course of my --

Q. -- you can't speculate. I mean, you can estimate, you can approximate, but you can't speculate. Okay?

A. Okay.

Q. So try again.

A. In my experience utilizing electrocautery for surgery, it creates a -- a burn, not just a little light skin-turning-white burn; it actually chars tissue when it's on cut and coagulate.

Q. That's a setting on the machine?

A. Correct.

Q. And did you ask Dr. Gross what setting he used on the cauterization Bovie when he did it on Ms. Garcia?

A. No. No. There would be no reason to do that.

Q. Well, are there other settings besides, you know, the one you just mentioned?

A. There's cut and coagulate.
Q. There's only two?
A. On the ones I've utilized.
Q. Do you know if Dr. Gross's Bovie had more than two settings?
A. No idea. Wasn't there, sir.
Q. Okay. And what's the difference between cut and cauterize?
A. I can't tell you the exact voltage. One is for dissecting tissue. One is -- creates a bigger bubble for cauterizing blood vessels, let's say.

In the course of surgery, when I'm doing a dissection -- I do these things when I put in spinal cord stimulators -- you dissect the tissue. You sure as heck don't want to make a big burn across the skin. As you open the skin, you will cauterize just below the skin where there are bleeders. And then you can use the different setting to actually cut the tissue.

Q. All right. And did Dr. Gross tell you -- well -- and let me ask you this.

It sounds like you assumed that he set the Bovie on "cauterize" when he used it on Ms. Garcia; true?
A. No. I --
Q. So it could have been "cut"?

A. I didn't give it any thought for -- the very reason is Dr. Gross is a suburb, experienced neurosurgeon. So I take it at face value he cauterized the nerves.

What setting he used is absolutely irrelevant to the conversation. I wasn't there nor am I going to scrutinize it.

Q. So you don't presume to second-guess a surgeon like Dr. Gross; right?

A. That's a large statement.

In the good course of medical care, I had a question and we had a discussion, which is normal.

Q. All right. And can you tell us exactly which nerves at which levels Dr. Gross told you that he used this Bovie on?

A. I know which joints enervated by which nerves. Each facet joint has two nerves that supply enervation to them. They overlap.

So in the course of his fusion -- my computer is messing up. In the course of his fusion, in order to fuse the levels he fused -- and he was going to cauterize the nerves -- I would expect it would be L3, L4, L5, and S1.

I'd have to have a skeleton to show you what the nomenclature corresponds to. But in the course of

the fusion, that would be expected.
Q. And the cauterization would not be of the nerve roots; it would be of the medial branch?
A. Correct. The nerves that exit the spine at each segmental level is the -- the dorsal root is what it's called.
MR. STRASSBURG: Randy, can I have the model? I'm sorry.
THE WITNESS: I can demonstrate this.
BY MR. STRASSBURG:
Q. Yeah. Do you mind?
A. Not at all.
Q. It might be clearer.
A. It's actually kind of a complicated subject, so this will be good. If I can stand up.
Q. Give us the clear version.
A. Okay.
Q. Yeah, can you come down here?
THE WITNESS: Judge?
THE COURT: That's fine.
BY MR. STRASSBURG:
Q. Let's stand right in the middle. We get close.
A. All right. This -- these are the nerves that do the important things. These are the ones that go to

your legs. They provide sensory and motor.

These are the dorsal roots or the nerves that go down to the legs. If you cut one of these, you won't walk so well.

These little cracks here are the facet joints. There's a branch that comes off this nerve -- off this big nerve and runs right along here that goes into the joint. That's called the medial branch of the dorsal ramus. Actually, down here it's a lateral branch, but that's not important.

Each joint has two nerves. So this joint here would be enervated by this nerve and this nerve. This nerve wraps around; this one comes down.

So to denervate -- in other words, make this joint insensitive to pain -- you'd have to cut both of these nerves.

Q. And can you see this medial branch without a microscope?

A. If you're dissecting? Oddly enough -- this is an important point. You can cauterize a sensory nerve anywhere in the body as a treatment. Trouble is, you can't find them.

But for these you can because they always sit in the same location, which is right here (witness indicating). So when I do radiofrequency rhizotomies

on people, I put the electrical needle right here. And Dr. Gross is --

Q. And just for the record, you're indicating the notch, the foraminal -- this notch --

A. Right.

Q. -- here between the -- what is this? The --

A. The transverse process and the superior articulating process.

Q. Which are these two points here?

A. Which is this thing sticking up right here. The nerves are always there.

Therefore, when you're doing a surgery, it would be quite easy just to Bovie the entire notch then. And you'd probably get a better burn doing it -- an open surgical procedure than I do with a needle because I have to get a needle to lay parallel with the nerve. Except with my new technology, I would have a bifurcated needle that makes a bigger burn, about --

Q. That's the Venom?

A. Yes.

THE COURT: Hold on a second.

Tom, can you get the microphone for the doctor, please?

You're -- you're -- it's fine. You're talking to the jury. Kristy's just having a hard time

hearing you. I can't hear you.

Just put that right up close to your mouth.

THE WITNESS: Where were we?

BY MR. STRASSBURG:

Q. We were talking about the nerve in the valley between these two bones and the zone of influence of the cauterizing heat bubble, I think you called it.

A. Correct.

Q. How big is that zone of influence of that bubble? Does it fill up the whole valley?

A. It's not that big. It depends on what he's doing with it.

With electrocautery in surgery, you could cauterize here, cauterize here, cauterize here. And so you'll go right down the gutter, a little bit lateral, a little bit medial. It would be very simple and easy to denervate that whole area, much easier than the way I do it with a -- with a conventional radiofrequency rhizotomy.

So I anticipate he would be able to even make a bigger burn than I could.

Q. About how big could he make that burn?

A. As big as he wanted.

Q. Can you give me a range? Quarter inch? Eighth of an inch?

A. It could. I mean, there's no reason to go beyond the gutter, and so I would assume that he would Bovie inside the entire gutter. And that's an assumption. I wasn't there. But it makes perfect logical sense.

Q. Why don't you take your seat again. I don't know that you'll need the mike.

THE COURT: Thank you, Doctor.

BY MR. STRASSBURG:

Q. All right. Do you have an opinion as to the medical process that caused Ms. Garcia's pain?

A. Pain is not anatomic. It is physiologic. What that means, if you look at an MRI, an X ray, a CT scan, you can't see pain. You can only see anatomy.

Like I previously testified, it's like looking at a car, a picture of a car with a broken windshield, flat tire, bent fender. From that picture, you cannot derive any information into how the engine runs. It's only a snapshot in time of anatomy.

Pain is physiologic. It's a chemical reaction basically, stimulation of certain receptors that receive pain.

So putting it all together, my medical opinion was that she was injured in the collision. She's probably initially stunned, most people are, and

developed pain over the subsequent few days, which is normal for many patients. Everything she was reporting is not out of the normal scope of what I see with patients.

Now, if she came back six months later and said, "Well, I got hurt six months ago, and now I'm having pain all of a sudden," that's not within the normal scope of what we see with acute injuries. But to be initially stunned and shocked, your adrenaline is up, and then over the next few days to develop pain, that's perfectly normal.

Q. So it sounds like -- you correct me if I'm wrong -- that, in your judgment, that all of the pain symptoms that she's experienced during the time you have seen her were caused by the collision; true?

A. Correct. That's what I was treating her for.

Q. Okay. And the -- can you explain to us the medical mechanism that you believe resulted in the forces of the collision resulting in the pain?

A. It's my understanding that, as a part of the collision, she was traveling approximately 35 miles an hour, struck by another vehicle, causing her vehicle to spin at least 180 degrees. It's pretty high velocity, probably hyperextended or laterally flexed her spine. She already had a spondylolisthesis there. The

sequence of events caused that to become damaged with progressive pain. That's it in a nutshell.

Q. All right. So when you say the forces of the collision resulted in lateral movement of her spine, which way do you believe her spine moved?

A. I don't know. I mean, she spun 180 degrees. If you ever watch a video of people -- of crash test dummies, they get flopped all over the place. I mean, nobody is really there to videotape it, but I dare say if you took one of the crash test dummies and put it in an 180-degree spin when traveling 35 miles an hour, it would result in some shaking up, for lack of a better word.

I'm not a biomechanic engineer. I have done some airline -- airplane crash reconstructions in my job as a flight surgeon in the Navy, but no, I don't hold myself out to be a biomechanic engineer.

But then again, it really doesn't take a rocket scientist to know that, if you get hit by a car and your car spins 180 degrees, that's a substantial impact. Period.

Q. All right. Now, do you have an opinion as to how the physical forces of this collision and the spinning affected her spinal vertebra?

A. Adversely?

Q. Yeah. Can you describe the nature of the adversity.

A. Again, I wasn't there. I can't reconstruct it. But I think if you took anybody, put them in a car traveling 35 miles an hour, hit them, cause their vehicle to spin, that they're that going to be moving about the cabin a little bit and have some energy imparted to them.

Q. Well, just to enable us to better understand where you're coming from, is it your belief that the forces of the accident caused the -- this L5 vertebra to slip forward over the disk between it and the S1?

A. Well, absence edema on an MRI, you would have to expect that the pars defect was preexisting and was a spondylolisthesis to some degree. Could the injury have exacerbated that shearing? Sure. I would go that far.

But what most of my testimony -- most of my causation is based on a temporal relationship between the onset of symptoms and this traumatic event. And I know of no other preexisting pain, I know of no other traumatic event or any other rational cause to suggest that something else caused this lady's pain.

It started at this point in time; that's when her symptoms started. Did she have some spinal

pathology before that? I would say more likely than not. But I -- there's no documentation that I know of out there to suggest that she was symptomatic.

Q. So if -- if I understand you correctly, then -- you tell me if I don't -- it sounds like you can't really be specific as to the exact kind of medical mechanism that accounts for her pain symptoms; true?

A. No. Again, I can be absolutely certain with the information I have -- and this is my opinion -- that there is a temporal relationship between the onset of her symptoms and the subject collision.

Obviously, nobody was there except her. There's no GoPro in the car to watch how she flopped around. I know that's a very scientific word, "flopped around," but for lack of a better description. Think about it.

You're traveling along at a moderate rate of speed, you get hit, and your vehicle spins violently. I mean, getting hit and spinning is not a nonviolent act. It's a violent act. Your car is not supposed to do that. And it's not smooth.

MR. MAZZEO: Objection, Your Honor. Foundation. Speculation. Beyond the scope of this expert's expertise.

THE COURT: You've talked about it for a little while now. I'm going to let him -- I'm going to let him testify what his general understanding is. You can't talk about forces and vectors and that type of thing like that.

THE WITNESS: Okay. Well, I have ridden in F4s, F14s, and various other planes, and I'm well familiar with G forces. I pulled 9 Gs in an F16 one time.

MR. MAZZEO: Move to strike. There's no question pending.

BY MR. STRASSBURG:

Q. And those 9 Gs --

THE COURT: I'm going to allow it.

BY MR. STRASSBURG:

Q. -- injured your back, did they?

A. Played a little havoc with my neck.

Q. But your spine was okay?

A. Well, I don't know. I haven't imaged it before and after.

Q. But you don't have --

A. Actually, I can relate to that, if you want a personal experience --

Q. No.

A. -- if you will allow me.

Q. No, I won't. I want you to answer the questions I ask you. I have let you take the bit in your mouth and run with them, but let's answer the questions I ask you. All right?

A. Okay.

Q. All right. So -- bless you.

It sounds as though your opinion is based most firmly on your reasoning that she's pain free before; she hurts afterwards; the only thing between those two is this accident; and, therefore, it has to be the collision. Right? Stands to reason, doesn't it?

A. It absolutely stands to reason. I agree with you.

Q. All right. So what it doesn't stand is that you're not able -- because you weren't there, because it's outside the scope, you're not able to offer a medical mechanism that actually explains how the forces in the accident resulted in these pain symptoms; true?

A. Well, having not been there, I cannot tell you exactly how she, quote, flopped around the compartment of her car from that impact. So all I can say is that she sustained a violent act.

MR. MAZZEO: Objection, Your Honor. That's -- he can't say that. Approach, please.

THE COURT: Come on up.

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

THE COURT: Objection is overruled.

BY MR. STRASSBURG:

Q. I forgot where I was. Let's go on to something else. Let's do a bit of an overview here. And let me get this chart up here, because it occurs to me that you are one of the physicians who has seen her the longest and the most often; right?

A. Correct.

Q. And you've had an opportunity to observe her, you know, maybe it's once a month, once a quarter, whatever, but you have -- over years, you had a chance to observe her; right?

A. Correct.

Q. All right. And when Ms. Garcia came in to see you, you or your assistants asked her to characterize her pain symptoms; right?

A. Correct.

Q. All right. And you had her write them down. Didn't you?

A. We had her fill out pain diagrams, yes, sir.

Q. Okay. And a pain diagram is -- it's like a picture of a silhouette of a human body, front and

back, and the patient indicates on the diagram where it hurts and how much; right?

A. Yes, sir.

Q. Okay. Because that gives you over time, then, kind of a record of her self-reporting of her pain symptoms; right?

A. Yes.

Q. And that's useful to you as a conscientious physician because you ascribe credibility to the self-report of the patient for purposes of treatment; right?

A. Are you saying do I believe my patients?

Q. Yeah.

A. Pretty much. Unless I am presented with something to make me think otherwise.

Q. And she did not?

A. No.

Q. I -- that's true, she did not; right?

A. That's correct. She did not.

Q. Just so -- you can't always --

A. I understand.

Q. All right. So on -- on the pain -- I'm sorry. On the chronology -- and it should be right in front of you on your screen too, Doctor. Your line shows you started seeing her -- you first saw her on

August 15th, 2012; right? And you saw her, or your office did, regularly thereafter; right?

A. Can I come up and look at your screen? This one is pretty small.

Q. Yeah, sure. Whatever you need to do.

THE COURT: Go ahead.

THE WITNESS: That's still pretty small. Okay. Let me get a microphone. Okay.

BY MR. STRASSBURG:

Q. So that looks about right, like the -- that is an accurate depiction of basically the time you saw her or your office did?

A. Kind of looks so, yes, sir.

Q. Okay. I mean, these are the easy ones.

A. Right. I just don't have the days committed to memory, so I will take your word for it.

Q. Fair enough. Fair enough.

And not all of these indications on the chart are actual times that you performed a therapeutic procedure; right?

A. Correct. This is pretty nice.

Q. Why don't you stand over there so everybody can see. And -- and you -- your -- okay. And you -- okay.

And so the therapeutic procedures that you

performed were here. On 9/27 of 2012, you did the nerve roots; right?

A. Correct.

Q. And then on 9/16/2014, that was the trial of the spinal cord stim?

A. Correct.

Q. And that's something you put in, see if it works, and then take out; right?

A. It's a test run, yes, sir.

Q. Okay. And then on -- you also did -- you injected the facet joints on 12/1; right?

A. I'm assuming your dates are correct. Again, I don't have it committed to memory.

Q. No, and -- and I'm not suggesting you should or that you're less credible for not doing so. I'm just trying to explain to everybody where we are.

A. Yes.

Q. Okay. And there is a difference between epidural injections and the selective nerve root block injections; right?

A. In my hands, there's a difference because -- it's the same injections as far as where the needle goes. It's just selective nerve block is more specific to a level because of higher concentration and lower volume.

Q. Exactly right. And what I'm getting at here is typically, when there's an epidural that everybody's familiar with, you're going into the thecal sac area here; right? Your -- I mean, your needle is actually going into kind of the main channel; right?

A. No. That requires a little explanation.

Q. Well, let me ask the second part of it, and then you can clarify it. Right? Because I'm sure you'll be better at that than I will.

The selective nerve root and the facet injections, those are different because they actually go to a particular facet capsule, which is a -- kind of a structure that surrounds the facet and encapsulates it. The nerve root blocks, they go a particular nerve root area.

And so the facet injections and the selective nerve root blocks, those are more specific to individual body structures than an epidural, which may affect many levels at once; is that true?

A. Partially. It requires explanation.

Q. Have at it.

A. There are three mechanisms of how to perform an epidural injection in the lumbar spine. The first is an intralaminar, then there is translaminar. That means the needle is directed between the spinous

processes into the epidural space. That is the old garden-variety epidural injection. When women have babies, that's where you put a catheter to anesthetize the nerve roots to help with the pain of labor.

Q. So one injection can affect several levels; right?

A. Right. It's a shotgun, puts medication all over the place.

The second way of doing it is a caudal epidural. Right here, at the bottom of the sacrum, there's a little hole which you can put a needle in through, and it's like a translaminar. Medication goes everywhere. It's a little bit lower.

The third mechanism is a transforaminal injection, and transforaminal means through the foramen. The foramen is the hole that the nerves come out. So a transforaminal injection is conducted by putting a needle right here, medication follows the nerve root track and then goes into the epidural space. That is identical to the location that they use for a selective nerve root block.

So any difference between a transforaminal injection and a selective nerve root block is concentration and volume. The needle placement is exactly the same.

The reason for doing it this way -- and most practitioners in my field do it this way now because there's a very low incidence of getting into the spinal fluid and causing spinal headache. This is little more specific to a level, but one of the risks of the translaminar going through the middle is going too deep, puncturing the dura, getting into the spinal fluid, and that can cause a miserable headache. If anybody has never had a spinal headache, that's what a spinal headache is.

So with the transforaminal method, it's a matter of concentration and volume. If I want to spread it around, I put a high volume in. It still spreads all around. If I want to be specific, I keep the volume very low, 1 ml., and I concentrate my medication to get more bang for the buck.

Q. Thank you. Now that you have explained that, which -- could you share with us which ones of your procedures -- or forget the rhizotomy because that's different. But which ones of your procedures were the targeted, small volume in a specific location?

A. Right here.

Q. And you're indicating the 9/27/2012 nerve root bilateral at L5 and S1; right?

A. Right. In fact, the therapeutic component of

that actually functions as an epidural injection.
Q. Okay. And, in that instance, you were targeting specific structures, in this case, the nerve roots at L5 and S1; right?
A. Yeah. What I'm really targeting is the L5-S1 level; to a lesser extent, L4-5.
Q. Because that's where you think the injection will do the most good; right?
A. Correct.
Q. Because that's where you think there is some condition that the injection will correct; true?
A. Well, the condition I'm trying to correct is pain.
Q. And you think --
A. All the shots on the planet are not going to correct the spondylolisthesis.
Q. Right. But you are shooting your needle in these locations because that's what you think will correct the pain. Fair?
A. Correct. My suspicion is the pain generator is at L5-S1, possibly L4-5. Those are my two candidates.
Q. In the nerve root; right?
A. No, not in the nerve root. I don't put it in the nerve. That would be really bad. Patient wouldn't

tolerate that. If I stick a needle in the nerve and inject, we're going to all have a bad --

Q. In the close vicinity of this nerve root?

A. My target is the posterior disk and the nerve root's sheath, that whole area.

Q. Because you think there's some inflammation there that the corticosteroid will correct; true?

A. Correct. The purpose of the corticosteroid is to break the chemical reaction of inflammation, thus treating the pain by reducing swelling and inflammation. Inflammation causes swelling, so ...

Q. Fair enough. And so the reason you injected these nerve root at L5-S1 bilaterally is because you believed that there was inflammation there that the corticosteroid would reduce; true?

A. Generally, pain in the spine is caused by inflammation or -- let me get more specific -- activation of what's called nociceptors, n-o-c-i-c-e-p-t-o-r-s. Nociceptors are the nerve endings that are responsible for pain. For instance --

Q. Excuse me. Excuse me. Let me just -- we're kind of pressed for time. Let me just focus the question.

The reason that on 9/27/2012 you did these injections of nerve roots at L5-S1 bilaterally is that

you believed there was some inflammation in the vicinity of those nerve roots that your corticosteroid would correct. True or false?

A. True. Vis-a-vis activation of nociceptors.

Q. Fair enough. Thank you. Now --

A. Are we done up here?

Q. No.

A. Oh, okay.

Q. No. We're almost done.

Now, with respect to the injection here on December 1st of 2014, where you inject the facet joints and you inject the hardware points at the pedicle screws, you recollect doing that?

A. Yes.

Q. And you did that on Dr. Gross's orders; right?

A. Yes.

Q. And you did the same procedure on Dr. Gross's orders on March 16th of 2015; true?

A. That's correct.

Q. And did you use the same anesthesia and the same corticosteroid for both?

A. Yes.

Q. And was your procedure on December 1st and March 16th, was -- with respect to the facet joints at

L3, your injection was targeted specifically to those joints; true?

A. Correct.

Q. Because you believed there was inflammation in those joints that the corticosteroid would correct; true?

A. Correct.

Q. And then the -- you also injected the SI joint but only on the right; true?

A. Correct.

Q. And that's because you believed that there was some sort of -- I hate that.

You believe there was some sort of condition, some inflammation in the joint that your injection would correct; true?

A. That's correct.

Q. Okay. Why don't you take your seat again.

THE COURT: You may want to move that TV screen back out of the way.

MR. STRASSBURG: Sure. Thanks, Judge.

BY MR. STRASSBURG:

Q. Can you see it on your screen? Or you're welcome to come back down here.

A. I can see this. That's fine.

Q. So with respect to your injection, the one on

September 27th, as -- as you testified to Mr. Mazzeo, your records indicate that she only received two or three days of benefit; true?

A. Correct.

Q. And with respect to your procedure on August 25th, 2014, on September 16, 2014, you also indicated once the -- the -- the equipment had been removed that she was still experiencing low back pain with radicular pain down the right lower extremity; true?

A. After the spinal cord stimulator trial?

Q. Yeah.

A. After I pulled it out?

Q. Well, this would be in September. September 16, 2014, after the stimulator trial on August 25, 2014.

A. Sure. Yes.

Q. And then the December 1st, 2014, the March 16th, 2015, those procedures, from the December 1st procedure, she had significant improvement that only lasted a month and she -- and the March 16, she had improvement that lasted a few weeks only; true?

A. Correct.

Q. All right. And then you performed a rhizotomy on September 24, 2015. And, again, was that

at the direction of Dr. Gross?

A. The rhizotomy?

Q. Yeah.

A. Not direction. After she had significant improvement from two sets of injections, it was very much his opinion and mine to proceed with that.

Q. Does cauterization allow the nerves to regenerate?

A. Well, it doesn't allow them to regenerate. They regenerate in spite of the cauterization.

Q. Well, do they grow around the part that's cauterized, or does the part that has been cauterized, like, rebud, like pruning a bush?

A. They regrow. I don't know exact path they take. I think they regrow in the channel, because when I go back to do repeat rhizotomies, I find the nerve in the same place.

Q. But you are aware that nerves that have been cauterized can bud in different directions from the original path; true?

A. Yes, that can happen.

Q. In fact, that's pretty typical the way -- when nerves are damaged by -- by heat, they kind of -- they regenerate themselves kind of wild; right? In a bramble?

A. I think you're talking about a neuroma.
Q. Yeah.
A. I don't know if anyone's ever classified these as neuroma. I do know when I do repeat rhizotomies on people, and I have done some year after year, the nerves are always right where I expect them to be.
Q. And what's the margin of --
A. So I don't have to chase them anywhere else.
Q. What's the margin of error for hitting those little medial branch nerves?
A. The variability of where the nerves are originally is usually traditionally thought to be a needle width away. That's using an 18-gauge radiofrequency needle. So the original approach is to do multiple burns. With the Venom needle, it'd make such a big lesion, that's really not necessary.
Q. And how big a lesion does the Venom needle that you used on Ms. Garcia make?
A. Probably 2 millimeters distal to the tip of the needle and then the full width of the needle plus another 2 or 3 millimeters. So I would say roughly 6 or 7 millimeters.
Q. By two?
A. No, no, that's from the distal tip. The

whole needle -- it's probably -- let me go to memory. Probably about 6 or 7 by 7 or 8 millimeters total. We actually --

Q. So if it's an oval, I mean the zone of influence is an oval. What would be the dimensions long and -- and high?

A. Probably about 6 to 7 by 7 to 8. I mean --

Q. In millimeters?

A. Millimeters. I can pull that information. We actually demoed this with chicken breasts. It's pretty remarkable.

Q. You yourself --

A. Yes.

Q. -- did it with chicken breasts?

A. Yeah. When I was first looking at the new technology, I was pretty skeptical. And we set up some chicken breasts, put the needles in there, and ran it. And it was a nice lesion. It was very impressive.

Q. And the lesion was in the chicken meat; right?

A. Correct. Or the tissue.

Q. Or the muscle?

A. Correct.

Q. And what kind of effect does the -- this Venom needle, with its large zone of influence, have on

the muscle of the chicken that you observed?

A. It cooks it.

Q. Does it -- medium rare? Medium? Well done?

A. It cooks --

Q. Charred?

A. Have you ever cooked a chicken breast? It cooks it. It cooks it thoroughly for that -- it was -- it was a very nice demo.

Q. Well, now, you just leave my cooking skills out of this.

A. I don't know anybody that eats chicken rare, but I could be wrong.

Q. So it's --

A. But it cooks it thoroughly. It doesn't char it. It turns it from the fleshy pink color to white, cooked chicken.

Q. Well, now -- and what does it do to any nerves that are in the meat? Did you happen to demo that, or did you just confine your demonstration to the meat itself?

A. Oh, just to the meat itself. I've got over two years' experience in Venom now and been very satisfied with the results, that it's equivalent to conventional radiofrequency rhizotomy doing multiple passes.

Q. Now, let me show you this image that I want to talk to you about. And -- and, again, you're welcome to join us in the well of the court if that would be more comfortable, although if Kristy shoots you afterwards, it's --

A. I'll duck.

Q. So do you see here that we have charted your -- your -- the numbers from the self-reporting that Ms. Garcia gives you when she comes in to see you? Do you see that?

A. Yes.

Q. And you can see, I think, that the -- and, again, I don't expect you to -- to memorize the dates, and I'm not going to ask you dates and say, "Ooh, well, you know, you miss" -- no.

But, generally, you can see that the numbers run from 8 out of 10 to, it looks like, 3; right?

A. Yes.

Q. And --

A. Or --

Q. -- there are ups and downs; right?

A. Correct.

Q. And the -- do you have a recollection of what her pain number was when she was discharged from the ER on January 5th, 2011?

A. No, I don't have that.
Q. If I told you it was 6 of 10, would that sound right to you?
A. Yeah, I'd be fine with that.
Q. Well, I would show this to you, but I know -- let me show you this document and see if I can refresh your recollection. And it is GJL Bates No. 80. Hold on.
Let me do it, bearing in mind your rulings, Judge.
MR. ROBERTS: Exhibit 26, page 233.
MR. STRASSBURG: Oh, great. Hey, thanks. Mr. Roberts, I appreciate your -- I will take help from whatever corner. Thank you.
BY MR. STRASSBURG:
Q. And let me show you -- show us all this document. I'll represent to you this is a document in evidence, came from the ER at the hospital. And she was -- the hospital records indicate that she reported her pain level on departure as 6 of 10 --
A. Yes, I will acknowledge that.
Q. Sound right to you? Thank you, sir.
So if we use this information, then, and we overlay it on our chart -- because, again, to be fair to you, I thought it would be fair to -- I mean, you --

you've been examined on individual treatments, visits, that kind of thing. I want to try to look at the whole course of treatment from an overview.

And here, would you not agree, that we can see that, if you lay it off at 6 -- okay. It's a little bit low, but general -- this is the 6-out-of-10 line, and it goes across here. And you can see that, on a number of occasions after the surgery, her pain that she reported to you was actually worse than it was when the ER cut her loose; right?

A. Oh, when I first saw her on initial visit, she was far worse than 6 out of 10 in the ER visit.

Q. And did you ever ask her, after you looked at the records, you know, "Emilia, I mean, you're 6 of 10 when you leave the ER. You do the chiro care. You get better, and your neck pain goes away. You do a little bit of physical therapy, and you're down to, like, 4. And now you come see me, and all of a sudden, you're worse. What happened?" Did you ever ask her?

A. No. I didn't have the ER visit when I first saw her. But in the course of treatment -- what? Did I see her a year later? -- she was definitely progressively getting worse. I think that's what you can glean from that.

Q. Well, did you ever ask her, "Hey, what --

what happened during that year before I saw you?"

A. Well, no, I did not ask her specifically other than nature of her treatment with Dr. Lemper. That's what I asked her.

Q. I mean, did you ever ask her whether she'd experienced any other, you know, accidents after the -- the motor vehicle accident or -- or had engaged in any activity that exacerbated the pain?

A. Well, certainly. I go through that with them.

Q. Sure.

A. I don't have any information anything else happened.

Q. Now, the cycles -- she went through kind of cycles of -- of pain.

Would you give me that? Would you agree with that?

A. That little V you're showing there, certainly.

Q. Yeah, that's the first cycle, the up and down. There's also, then, another cycle, the second cycle.

Then there's a third cycle of pain; right?

A. Right.

Q. And there's a fourth cycle of pain; right?

A. Correct.
Q. And after the rhizotomy, the pain's been trending downward. But based on your knowledge of how these patients go, would you not expect there to be another cycle, another increase in pain?
A. Actually not. This is a nice graph. Your last data point is December 9th of 2015. Since then we've seen her two or three more times, most recently last week. And her pain was still down around a 4.
So that's a very good trend as far as showing that the rhizotomy is working.
Q. Sure.
A. She's not cycling. Now, her pain is going to come back, I predict. And when that happens, we'll do the rhizotomy again.
Q. And how much pain does she have to report to you before you'll say, "Okay. I'll do another rhizotomy"? Is it 5 out of 10? 6? 7?
A. No. No. There's no fixed number. I leave this option to my patients because there's more than pain scores that tell the story. It's level of function, quality of life.
And she's been through a rhizotomy. She knows what it's all about. So she'll basically tell me when she's ready to do it again.

Q. All right. Now, it's no secret that we have different viewpoints.

But can we not at least agree that, based on this chart, her pain across the entire course of treatment was variable? It went up, it went down in pain cycles; true?

A. Yes.

Q. And can we also not agree that, on occasions, her pain was worse during the period of time you were treating her than it was when she left the ER?

A. Oh, absolutely. Very first time I saw her, her pain was off the charts.

I think if you look in my note, I went out of my way to remark about her level of discomfort. When I use the word "severe pain," "can't sit," that's a big deal because that's not nomenclature I generally use.

Most of my patients come in with a moderate level of pain, and I document that. When I say somebody is miserable, can't sit, pacing the room, that's a note to myself that this is really, no kidding, severe.

And, if anything, I think she underreports --

Q. Okay.

A. -- at least at that time.

Q. Are you hungry?

THE COURT: I am.

THE WITNESS: For lunch? I have clinic in about an hour and a half. So ...

MR. STRASSBURG: The judge saw right through me.

THE COURT: He says he's got a clinic in an hour and a half, so how much longer do you have? You guys want to come up for a minute?

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

THE COURT: All right. Folks, we're going to send you to lunch.

During our lunch 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.

Let's just take an hour. Go to about five after 1:00.

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

THE COURT: Hold on. Hold on. We're outside the presence, but we're still on the record.

The issue, I guess, Doctor is this: It sounds like we're going to probably have, I'm guessing, at least an hour and a half with you still. So I don't know if -- if there's a possibility of you moving your clinic.

THE WITNESS: This is, like, the fifth time I've rescheduled patients.

THE COURT: I know. And the other option is we end up bringing you back another -- a third time.

There's no way we could keep going right now and even get you out of here by 1:00 o'clock. So that's why I sent the jury to lunch.

So I'm going to let you kind of decide that, and --

MR. STRASSBURG: Doctor, I'm sorry about the

time. I really am.

THE WITNESS: Calculations are enormous.

THE COURT: All right. So is there anything else we need to put on the record right now?

MR. MAZZEO: Yes, Your Honor, just briefly.

It was regarding an objection I raised. We had a conference at the bench, and you had overruled my objection. And it was with regard to Dr. Kidwell's testimony where his understanding of the accident was that Ms. Garcia's car was broadsided, it spun 180 degrees. And from that he was able to postulate that she was involved in a violent act, and that was not something that -- that was beyond the scope of this expert witness's specialized knowledge.

He doesn't have a specialized knowledge to make that -- offer that opinion. And -- and he was suggesting to the jury that her body was involved in a violent act as a result of the simple description of her car being struck and her car spinning 180 degrees.

So I just wanted to go on the record with that, that I think that he should have been precluded and his testimony regarding that should have been stricken. Thank you.

THE COURT: And I think I told you I wasn't going to allow him to talk about delta-v's and vectors

and forces. But a layman's statement that he thought it was a violent accident, I thought was fine.

MR. MAZZEO: Okay. That's it.

MR. ROBERTS: And at the bench we also noted that this line of questioning had been going on for some amount of time without objection and that -- that this wasn't a new subject area and it had been waived.

MR. MAZZEO: And what I had noted then in response was that what I was objecting to was not Dr. Kidwell talking about the circumstance -- his knowledge of the circumstances of the accident, but I was specifically objecting to his reference to the term "violent act" where -- I believe he referenced it twice; I objected twice.

THE COURT: Okay. Anything else?

MR. MAZZEO: No, Your Honor.

THE COURT: All right. Off the record.

(Whereupon a short recess was taken.)

THE COURT: Bring them back, Tom.

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, 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.

MR. STRASSBURG: Yes.

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

THE WITNESS: Yes, sir.

THE COURT: Mr. Strassburg, go ahead.

MR. STRASSBURG: Thank you, Judge.

BY MR. STRASSBURG:

Q. Thank you, Doctor, for making yourself available.

Directing your attention to the screen here, this is an analysis and maybe -- why don't you come down here, and we'll just talk about it together so you -- you can all see.

This is an analysis of the clinical neurological tests that were performed by Dr. Gross as part of his clinical assessments of Emilia Garcia.

Are you familiar with straight leg raise, those kind of clinical neurological assessments?

A. Correct.

Q. And would you tell us what is a -- why don't

you stand to the side so everybody can see.

What -- what is a straight leg raise, and what does it measure?

A. If you -- if you recall, sciatica basically is pain that goes down the leg and emanates from the back. That's the general term we're talking about is -- we call it radicular pain. The common term is sciatica.

One of the ways to possibly bring that out is doing a straight leg raise test where you stretch the nerve basically.

Q. Is your mike on?

A. I think so.

Q. Okay.

A. So you stretch the nerve by stretching the leg up, and there's a couple of different maneuvers, but that's basically what a straight leg -- straight leg raising test is.

Q. All right. So the purpose of the straight leg raise test is clinically -- so a clinician like yourself or Dr. Gross can see if, by moving the straight leg up and down, you can provoke -- you used that word -- a pain response indicative of nerve pain; right?

A. Well, indicative of a sciatica-type pain.

Nerve pain actually means nerve --

THE REPORTER: I'm sorry. "Nerve pain"?

THE WITNESS: May or not be nerve pain, pain transmitted by the nerve from nerve irritations, which you're talking about.

BY MR. STRASSBURG:

Q. Okay. And that would include impingement on a nerve; right?

A. Generally impingement causes more weakness and numbness. Irritation of nociceptors causes the pain.

Q. And Ms. Garcia manifested self-reports of weakness and numbness in her legs; right?

A. Correct.

Q. Now, the -- a negative straight leg raise would tend to indicate that there's no nerve that's being impinged upon or has been inflamed in a sciatica-type way; right?

A. Actually, if it's negative, it really doesn't mean much. If it's positive, it means something.

Q. All right. And the -- if I'm showing you -- these are the individual times that Dr. Gross performed an assessment on Ms. Garcia by performing this straight leg raise test, left and right, did a lateral hip test, the FABER test.

Do you know what that is?

A. Yeah. It stands for flexion, extension, external rotation. Another name for it is Patrick's test.

Q. And what is a clinician trying to measure or detect with the FABER test?

A. Usually, that brings out hip pain.

Q. All right. And then there is the abduction test -- I'm sorry. Excuse me.

Why don't you tell us what that test signifies.

A. Again, these are all maneuvers to look at pressure on SIJ, sacroiliac joint.

Q. All right. So, I mean, do you see how the patient -- I mean, since she got over the surgery in oh, you know, the beginning of, say, 2013, she is -- clinically, she's negative, right, but she is still coming to you and reporting substantial levels of pain; true?

A. True.

Q. And then also the chart indicates the findings of the clinician from palpitating various muscles in her back.

Are you familiar with clinical assessments of back muscles through palpitations?

A. Yes.
Q. And could you describe that for us?
A. It's quite simple. You feel -- you look for tight muscles. A really bad spasm in the spine will stick out pretty good. I mean, you can palpate it. A minor one, not so much. And then it's all about degree. Some muscles, particularly in your neck, you can play like a guitar string. It's really taut.
Q. All right. And is that an objective finding or a subjective one?
A. Well, I know with lower back, before the objective-subjective, most physicians will tell you that their examination is objective. As far as the patient being able to reproduce that or embellish it, that's not the case. I mean, they can't do that. It's totally objective.
Q. Well, if I'm palpitating the nerve -- what do you do that? Do you do that with your thumbs and you run them up the nerve?
A. No. No. You don't run up the nerve at all. You run up and down the spine.
Q. I'm sorry. The muscle. My fault.
Yeah, you rub up the muscle?
A. You can feel it. You can feel the tension. You actually palpate each segment.

Q. And the clinician can actually feel the tension of the muscle?
A. Yes, sir.
Q. And you can feel if there's a spasm?
A. Well, the tension is a spasm.
Q. And you can feel if the muscle's tender, unusually?
A. No. No, you can't feel tenderness. That's what a patient reports.
Q. All right. But spasm and those other things you mentioned would be something that the clinician can get his hand on --
A. Correct.
Q. -- literally?
All right. So you see from the charting here that Dr. Gross is charting in his records that, when he palpates -- or palpitates her back muscles, he scores her as mildly tender literally for years after the surgical procedure; true?
A. That's what you're saying. I don't have these records to independently verify that, but I will take your word for it.
Q. So if this information is -- is accurate, then, this would indicate that, for years after the surgical procedure, although Dr. Gross could not find a

clinical indication of nerve inflammation or impairment, he was finding, through her reports of tenderness, that she was symptomatic during that same time period; true?

A. Oh, she remained symptomatic throughout that period. The main graphs illustrate that clearly.

Q. But symptomatic in the sense her muscles were tender throughout that period; right?

A. Again, I don't -- if you want to show me the records to independently verify that. But taking that on face value, I'd say that, if this is correct, it would indicate there was tenderness.

Q. All right. All right. And you can take the stand again.

And is that indicative to you of any particular -- well, let me withdraw that and ask it this way.

Let's just include a little bit more information from his records. All right. And you may want to -- you can come back down or you can look at it on your screen. But we've added some indications from -- some quotations from information that's contained in Dr. Gross's records.

And do you see that on -- for example, on here, in April of 2013, Dr. Gross's records are showing

"low back pain, well managed, happy with how doing." But at that same time, then, she -- she is indicating on your records that she's a 5 out of 10 painwise; right?

A. Correct.

Q. And when she left the ER in January of 2011, she was only 6 out of 10; right? We established that; true?

A. Correct.

Q. And then here, in -- in May of 2013, she's telling Dr. Gross she's happy, she's back to work, can stand all day; and she's telling you that her pain is, like, 4 out of 10.

A. Right. That's -- that's not at all inconsistent.

Q. And here, she's -- in October of 2013, she's telling Dr. Gross that she still has low back pain but she's getting along well; and, at the same time, she's telling you that, well, she has this episode of 7 out of 10, which then drops down to a 4 out of 10 -- 7 out of 10 in September and then 4 out of 10 in October.

Do you see that?

A. Yes, I see it.

What was the date -- when was the surgery on this graph?

Q. You see this dotted line here?

And that's an excellent question. I'm glad you brought up that. The surgery -- the surgical procedure is this dotted line here, and you see it's labeled up here.

So everything this way is postsurgery, and everything this way is before surgery.

A. Okay.

Q. And do you see here where in January of 2014 she says she has low back pain and she has some numbness, but she's denying leg pain, and her pain level is 4 out of 10 when she comes to see you; right?

A. Correct.

Q. And then she has this flare-up that Dr. Gross charts in April of 2014, and you see her pain now is going up. She's on an upswing.

She's at 5 out of 10; right?

A. Correct.

Q. Okay. And then after the -- what's the right term? Is it rhizotomy or ablation or -- what do you call it?

A. All of the above. You can call it ablation. You can call it rhizotomy.

Q. All right. What do you call it?

A. I usually call it a rhizotomy, but that's a

big word. So I say "nerve burning."

Q. Nerve burning. Oh, that sounds so destructive.

A. It is destructive. It is destructive.

Q. All right.

A. That's the whole idea.

Q. And in his -- in Dr. Gross's records and in yours, she still had leg pain and low back pain after the nerve burning. It was just on a downward slope; right?

A. Right. Look at this. This is a good graph. So she had surgery here; she's on track. Has a bump in the road, but you can see even past this bump in the road, her pain's progressing, and that's why we did a spinal cord stimulator.

Q. No, the spinal cord stimulator is over here.

A. That's right, over here.

Q. Uh-huh. Here, why don't you stand over here so they can see what you're pointing at.

A. So we're talking about stimulation in here. Pain scores vary from week to week. Nobody is absolutely consistent in my practice. We know better.

You can see the trend is here that her pain is getting worse and worse and worse. We did those two interventions and brought her pain down when we do the

rhizotomy. And now her pain as of here is about this level. So she's tapered off here from the rhizotomy and is consistent.

Q. So --

A. Over the next two or three months, we can tell for sure, but, you know, I anticipate more than five or six months, seven months, she's going to need another rhizotomy.

Q. Because the pain is going to go back up?

A. The nerves are going to regenerate, so predictably, the pain will go back up. Maybe not. It might take 14 months. It may be as long or two or three months from now. Who knows.

Q. But we can agree that her pain profile since the surgery has been up and down, highly variable; right?

A. Right. That's perfectly normal for somebody in this situation.

Q. Okay. Thank you, sir. You can ...

Now, let me show you this chart. Now, when you do your charting, or your assistant does your charting, you have a section in your chart that is called Review of Symptoms; right?

A. Correct.

Q. And the -- the -- you select from various

bodily systems and you comment upon symptoms related to those particular body systems; right?

A. Review of systems is something you capture as far as other symptoms they're having.

Q. Fair enough.

A. Most of the time, it's not something I am treating; sometimes it is.

Q. All right. Now, it --

A. If somebody's having bleeding problems, I want to know about that before I do a procedure, things like that.

Q. All right. Now, in your review of systems, you have a category called musculoskeletal.

A. Yes, I believe so. Yes.

Q. And in that category, you -- you mean the system that involves both the muscles, right, and the skeleton; true?

A. Correct.

Q. So if somebody has a sore muscle, that's where you would make your notation in that category; right?

A. It's not that specific.

Q. If somebody has a bruise in the muscle, you would make your note in that category; right?

A. Well, actually, my staff collects that. And

what happens is they say -- musculoskeletal basically means spine -- are you having spine problems?

Q. And then the neurological category means are you having a problem that's neurological in source; true?

A. Correct. Do you have --

Q. A pinched nerve?

A. -- numbness in your legs? Are you passing out? That could be neurological logic.

Q. So radicular leg pain, that would be neurological; right?

A. If the patient knows it's neurological, yes.

Q. And then, like a bruise in the muscle, tissue, that would be musculoskeletal; true?

A. Well, again, if they're sophisticated enough to know the categories.

Q. And you --

A. They might report -- and I'm using general terms in my patients. You know, we don't ask them are you having any neurologic problems. Most of my patients really don't know what that means to the degree we know what that means. They'll say, what are you talking about? Well, are you having any symptoms of anything? Well, my leg gets numb. I get headaches. Headaches could be a head category; it could be

neurologic category. So the categories are kind of fluid from my patients. So my staff does the best to -- to capture any other symptoms they might be having.

Q. And then you review these records; right?

A. Yes.

Q. You don't let your staff run amuck unsupervised; right?

A. I hope not.

Q. And you review the records for accuracy; true?

A. To the best of my ability. Sometimes I don't review every line.

Q. Right. But if they screw something up, then you make them change it so it's accurate; true?

A. Correct. If I catch it.

Q. Now, in your records, we have charted the period of time during which your review of systems in the musculoskeletal category mention back pain. And that is shown on this yellow line right here.

A. Correct.

Q. And do you see it?

A. Correct.

Q. And would you agree that throughout the tenure of your treatment of Ms. Garcia, you -- your --

you and your staff, under your supervision, you categorized her back pain as musculoskeletal; true?

A. Okay.

Q. And then above it, leg pain. Your staff and you on a number of occasions, see, for periods of time, you categorized her leg pain as musculoskeletal; true?

A. I don't understand. You mean categorize leg pain as musculoskeletal?

Q. No. In -- in your Review of Systems category, you noted leg pain; true?

A. Okay.

Q. And then for neurological, on a number of occasions, during these time periods shown in blue, you categorized for neurological conditions both leg numbness and leg weakness; true?

A. I'll take your word for it. I'd have to go through all my records to acknowledge that degree of accuracy. Would you like me to do that?

Q. No. You're not aware of any specific instance that would prompt you to dispute that; right?

A. No. My -- my point is the relevance of where you're going with this.

Q. And then in the category of Neurological in your Review of Systems, nobody in your office or you ever charted leg pain for Ms. Garcia as a neurological

matter; true?

A. Again, I will have to go through every record to know that. But if, in fact, that's the case, I will take your word for it.

Q. Now, you also charted weight; true?

A. Yes.

Q. And you -- you kept track of Ms. Garcia's weight throughout her -- I'm sorry -- throughout the tenure of her -- your seeing her. And based on the records, her weight when you first saw her was 175 pounds. Does that sound right to you?

A. I'm going to look it up. Yes, 175, correct.

Q. All right. And her weight generally fluctuated between 175 and 185 pounds; right?

A. Let me see. I know it was 165 to 175. Let me see if I got a 185 in there.

Q. Yeah, 185. You might look at April 6th of 2015.

A. That's correct.

Q. All right. Now, let me show you this chart. And this one I put on a board. Can I -- can I impose upon you to come on down, and we'll keep the blood moving in your --

A. Any day with a pulse is a good one.

Q. And I will put this --

MR. STRASSBURG: Lee, I will put this on the screen for you. Do you have it?

MR. ROBERTS: I do.

BY MR. STRASSBURG:

Q. Now, what we have here is the chart of your patient's pain assessments, her self-reporting of that up here. And it runs from the time you first saw her before the surgery in August here until the last day we got records in the case, which was December 9th of 2016. And it shows up here the categories that you and your staff were assigning to these various complaints.

And it shows Dr. Lemper's period of treatment, some quotations from his -- his records. And this is Dr. Gross down here, which shows -- with some quotations there from the records.

Here is the chiropractic. When she sees the lawyer. Here is the physical therapy session and another physical therapy. There was one assessment by Matt Smith, a physical therapist. And then there was another assessment by Matt Smith over here in November 2016 [sic] before she commenced a period of treatment, nine visits up until the end of December when the record production stopped.

THE COURT: Mr. Strassburg, let me interrupt you for just a second. I can tell Mr. Blurton can't

see this. Do you have this in a bigger format?

MR. STRASSBURG: Well, no. This is as big as I -- wait.

JUROR NO. 1: Judge, may I? I can see it on the monitor here. It's okay, but I'm watching him because he's pointing things out.

THE COURT: All right.

JUROR NO. 1: I'm okay.

THE COURT: Okay. I appreciate it. It looked like you were struggling to see it, looking back and forth. So if you can see it on the monitor, that's great.

JUROR NO. 1: Yep.

MR. STRASSBURG: Can everybody see it? Okay.

THE WITNESS: It's a struggle for me, but ...

BY MR. STRASSBURG:

Q. Doctor, why don't we switch sides here. I'll be on -- I'll look at this from your side. And -- and I want to point out some things to you and ask you a couple of questions about them. Now, in -- in your profession, you use a term called "conservative therapy"; right?

A. Correct.

Q. And conservative therapy is chiropractic, massage, electro -- whatever they do, that kind of

stuff. And then there's physical therapy; right?
A. Physical therapy is considered part of conservative therapy.
Q. And physical therapy is specifically targeted exercises supervised by a trained professional to exercise particular muscle groups; true?
A. It can include the other modalities you mentioned as well: electrical stimulation; ultrasound; range of motion; diathermy, which is heat and cold treatments; anything along those lines.
Q. And would you agree with me that sometimes those PT people can just work wonders with patients; right?
A. Yeah, most -- most patients who get injured, whether they fall off a ladder or whatever, they get better with conservative treatment, we never see them.
Q. And you can -- you've observed in your professional experience that even patients that come to you with low back pain that radiates to other parts of the body can be helped by physical therapy; right?
A. Sure. Physical therapy and chiropractic we kind of use as synonymous.
Q. But it's not the same thing; right? Physical therapy is a specific brand of therapeutic treatment that involves -- you okay?

JUROR NO. 10: Yeah, the stem cracked.

MR. STRASSBURG: Hold on. Hold on. Let me just regroup here and get another question.

BY MR. STRASSBURG:

Q. Physical therapy involves using kinetics -- motion and exercise and resistance -- to strengthen particular muscles. And it can be in the back; right?

A. Generally speaking, I would say yes. There's some caveats.

Q. Sure. I understand. And the muscle groups that you can strengthen are in the core of the body; right?

A. Correct.

Q. And there's special exercises that are -- have been devised and validated especially for the core muscle groups that involve the lower back; true?

A. Sure.

Q. And you send your patients to those kind of physical therapists from time to time; right?

A. Yes, I do.

Q. Because you've seen that that works; true?

A. Most of the time, it does.

Q. And, now, physical therapy is the kind of thing that takes effort over a period of time; right?

A. By "effort," what do you mean?

Q. Well, you got to go to the physical therapist, you have to do the exercises. They stay on you. They're -- some are like drill sergeants. Trust me, I know. Right?

A. You know what? It's -- it's not all equal. I mean, I like to say that, you know, I like to think that, but there are some therapy places where they stick them on a bicycle and they run them for an hour or half hour.

Q. But you don't send your people to those; right?

A. Try not to.

Q. You send your patients to good physical therapy shops; right?

A. Ooh, that is -- that -- that assumes that I know the inner workings of all the physical therapy places, which I don't. I do know when patients come back complaining to me that they're not getting any better because they are not doing any exercises. So I endeavor to send patients to good physical therapy places. What they do when they get there, I don't control or know.

Q. Well, let me ask you this: Now, we see here that in this time period from January to, like, through May, the first five months post accident, Ms. Garcia

saw a chiropractor?

A. Correct.

Q. And then for ten visits over a period of a month in 2012, she went to Select PT; right?

A. Correct. This is interesting. This is really good. So we're going from January, March, April, so we're looking at 15, 16 months here.

Q. No, you're looking at nine months. January 2011 through September --

A. Oh.

Q. -- of 2011.

A. I missed the -- this is August. Okay, nine months. So what you're showing here is very instructive. She didn't get better. A strain should be better. All of our experts, defense experts testify to that. Allow 6 to 12 weeks of visits. Okay. That's appropriate for a strain. And a strain should get better within three months of treatment, absolutely 100 percent correct.

And when they don't get better, something else is going on. She did not get better. She continued to have symptoms. This clearly illustrates her pain waxing and waning. It clearly shows that she got worse and the interventions that followed with this increase in symptoms. So this is very illustrative. I

like this.

Q. You're welcome, Doctor.

So it also shows and proves, does it not, that the only -- oh, by the way, are you familiar with Select Physical Therapy?

A. The group?

Q. Yeah.

A. Not specifically, no. I don't have any knowledge of anybody over there that I know of.

Q. But you've heard the --

A. I heard the name of the practice.

Q. And do they have a good reputation?

A. I don't know.

Q. Okay. But what you do know is looking at this, between the time of the accident in January of 2011 and two years later, April of 2013, the only physical therapy that Ms. Garcia subjected herself to was this one-month period here with Select Physical Therapy; true?

A. Correct. She did have a -- looks like to be two and a half months of chiropractor treatments.

Q. That's from January to May.

A. Oh, more than that.

Q. No, January to May, that's like five months.

A. Correct. But most patients will self-select

anyway. If you could do anything to -- within three or four months, most people get better, just leave them the heck alone. Give some anti-inflammatories, take some Aleve, stretch. Most people will get better on their own.

Q. Do you have an opinion as to what is the minimum length that physical therapy should be employed on a patient with Ms. Garcia's profile before declaring it to be a failure? Is one month enough?

A. Well, again, you're segregating physical therapy from chiropractic. I tend to lump them together. And the individual practitioners are different in the veracity for which they treat patients.

Q. That's not what I asked you.

A. I know.

Q. I want to you unlump them. All right?

A. Okay.

Q. Because Gulitz, he's one provider. And Select Physical Therapy, they're another separate provider; true?

A. Correct.

Q. I mean, Gulitz doesn't work for Select as an employee; right? They're separate; true?

A. Correct.

Q. All right. So let me ask you again. With respect to physical therapy alone, what, in your professional opinion, is the minimum amount of time for a patient like Ms. Garcia that physical therapy should be tried before it's declared to be a failure?

A. I will tell you what I do with my practice.

Q. No, give me a number and then you can explain.

A. Okay. From time of injury, I like to see anywhere between 8 and 12 weeks of therapy and see 50 percent improvement. There are caveats with that. If somebody has radiculopathy, that accelerates the treatment process. But when I saw her, she was over a year out, and she was in extreme pain.

Q. Now, Ms. Garcia went to Dr. Cash in February 2016, about two and a half months after, and reported to him 40 percent improvement from what she was going through with the chiropractor at that time. Do you see that?

A. Yes, I do.

Q. Now, would 40 percent improvement from simple chiropractic over the first two and a half months, would that, in your professional opinion, warrant a longer trial in physical therapy than -- than turning immediately to surgery?

A. So the timeline is she saw Cash here; correct?

Q. Yeah, that's right. February of -- February 2011.

A. And, again, you're discriminating between physical therapy and chiropractic as a utility. I am not. She went on and did therapy for, looks like, five months.

Q. All right. So for purposes of my question --

A. I mean, you discriminate. I don't. That's our disagreement.

Q. But I'm asking the questions. So would you play along with me --

A. I'll try.

Q. -- and discriminate between chiro and PT. Please. Just for purposes of the question. Okay?

A. You're -- you're basically saying physical therapy is better than chiropractic.

Q. No. Let's say I'm not. I'm just trying to establish timelines. Let's assume that you have in mind the best physical therapy guy in town; right? And would you agree with me that before we contemplate a $400,000 spine surgery, that we should subject the patient to a longer trial in physical therapy than just a month?

A. If that was done at the very beginning, I would agree with you. But to my reckoning, she satisfied that requirement.

Q. Okay.

A. I'm not going -- I'm not going to --

Q. You're indicating chiro; right?

A. Yes, I am.

Q. Okay. Because you don't want to unbundle the two. You want to view them as one; right?

A. I do view them as one, yes.

Q. I understand. I mean, I'm just trying to get the parameters of your answer out so we all know what we're talking about.

A. We're talking to a guy who was originally prejudiced against chiropractors. And with experience, including treating myself, I'd learned the utility of manipulation and the adjunctive modalities such as E-stim, heat, diathermy.

I had an osteopath in my office. Did magnificent care. I use chiropractors. I personally use a chiropractor when my neck is acting up. So I know what they can do.

Q. With manipulation?

A. Not just manipulation. It's a whole spectrum of treatment. It's --

Q. But you know that she -- she never got manipulation?

A. No. They don't have to manipulate. It's therapy. It's doing the modality --

Q. It's back rubs.

A. I wish it was back rubs.

Q. Hot towels?

A. Hot towels are good along with electrical stimulation.

Q. Do you know what Gulitz did to her?

A. I haven't reviewed -- I don't have his records committed to memory, so I don't know what modalities he employed.

Q. I'm not suggesting you should.

But can we agree that she -- she is reporting pain from 6 to 8 at the get-go with the chiropractor; and then all the way down here later, after all of this treatment, all of the money, all of the effort, Matt Smith, when he assesses her in November of 2016, it's 4 out of 10 resting and it's 7 out of 10 in pain with activity; true?

A. True. Oh, I -- I may not take your word for it. I have -- I haven't independently verified that record in the last five minutes.

Q. And after the rhizotomy, she still has the

low back pain and the leg numbness which you've indicated is an indicator for radiculopathy; true?

A. Can be, yes. It also can be part of a referral pattern of pain from the sacroiliac joint. That's why, when I did the rhizotomy, the leg pain resolved.

Q. All right. Thank you, Doctor. You can retake the stand, and let me see if there's something I can ...

In coming to your opinions you expressed here today, did you ever see a photograph of her car?

A. Yes.

Q. Bet you a lawyer showed you that; right?

A. Yeah. I didn't get it any other way.

Q. Now -- sorry. In your records which have been marked as Exhibit 26, there is a document Bates numbered GJL710 that's in evidence. And let me direct your attention to that document here.

And do you see at the top the part I've highlighted?

A. Yes.

Q. And do you recognize this form from your office?

A. Yes.

Q. And do you see -- who fills this form out?

One of your staff members or does the patient do this?

A. The patient fills that out.

Q. All right. And do you see where it says, "Who referred you to us?" And Ms. Garcia wrote in "attorney."

Do you see that?

A. Yes, I do.

Q. All right. And then also there are additional information questions, which for -- the first one is "pain No. 1," where she fills in "mid back, my legs," which she characterizes as "burning, shooting spasm, numb."

And do you see where it says "date started"?

A. Yes.

Q. And Ms. Garcia wrote in that the mid back pain started on January 6th, 2011.

Do you see that?

A. Correct.

Q. And then she has another description of pain, "lower abdomen, pelvic area, shooting spasm," and she says that started on January 6th, 2011.

Do you see that?

A. Correct.

Q. And then she says, "pain No. 3, back of the head down my neck and back, ache, sharp."

And do you see that she said that started on July 1st, 2012?

A. Yes.

Q. Okay. Now, do you know -- did she ever relate to you any incident between January 6th of 2011 and July 1st, 2012, that would account for this pain No. 3?

A. Hang on. You said July 1st, 2012?

Q. Yeah. Are you on the page?

A. Right. I'm looking at my initial consultation too.

Q. Oh, okay. That's fine. I mean, review what you need to.

A. Okay. So the question is?

Q. Did she ever indicate to you, to your recollection, anything that happened to her between January 6th of 2011 and July 1st of 2012 that would account for this new pain?

A. No. But if you look at the ER records, that was her complaint -- presenting complaint to the emergency room.

Q. Well, you know, I thought you might try that. But she doesn't -- if it was in the ER, wouldn't she have -- wouldn't you have expected her to say it incepted on January 6th, 2011, like the other two

pains; right?
A. Sure. No, I have no explanation for that.
Q. Bless you.
And when you first saw her on August 15th of 2012, she indicated to you that her pain was 8 out of 10 --
A. Correct.
Q. -- as we discussed?
And she also indicated to you at the time that she was able to work?
A. Yes.
Q. And she indicated to you that she was not currently having neck pain; true?
A. On the first visit, she was having neck pain.
Q. In her family history, for review of symptoms, she was asked to identify whether she was having neck pain, and she didn't fill that out.
Do you think that was just an oversight on her part?
A. Oh, I don't know. I don't know. When I evaluated her and saw her, if you look at her pain diagram, she was having neck pain. So go onto this form to see her pain diagram.
Q. Now, you also had her fill out, when you first saw her, a questionnaire; right?

A. That's correct.
Q. All right. And the questionnaire appears in Exhibit 26 at GJL709. And there she indicated that washing and dressing increased her pain, but she managed not to change her way of doing it.
Do you see that?
A. Yes, sir.
Q. And do you see that she also indicated at the time, in August of 2012, that the pain prevented her from -- oh, that's not good. Huh ...
She indicated that she could walk half a mile?
A. That's what she indicated.
Can we go to page 3 of this document?
Q. Hmm?
A. Can we go to page 3 of this document?
Q. Maybe. If you behave.
A. I'll try.
Q. She was asked -- let me ask you -- she was able to sit an hour; true?
A. True.
Q. And she was able to stand for two hours; true?
A. True.
Q. She was able to sleep three hours at a time;

true?
A. True.
Q. And she said that she hardly had any social life because of the pain; is that true?
A. I don't know. I can't see that.
Q. Do you see that one? Did I get it?
JUROR NO. 1: No.
THE WITNESS: Not yet.
BY MR. STRASSBURG:
Q. And she was only able to drive 30 minutes; right?
A. Yes.
Q. And the pain was gradually increasing; true?
A. Correct.
Q. Now, would you agree that treatment that is not effective to reduce the pain should not be repeated as it would be unnecessary?
A. That's a pretty broad stroke with a brush.
Q. Let me paint with a smaller brush.
Directing your attention, Exhibit 26, your office visit notes of October 10, 2012. Do you see where you were -- you were charting the status of the postbilateral L5 plus S1 selective nerve root blocks? You said, "Her symptoms have returned after a day or two." And you said, "I recommend repeating the

injection with a little more medication. If that does not help her, then further injections would not be indicated."

Do you see that?

A. Yes. That's correct.

Q. Hold on. I'm just skipping some stuff. A couple of quick questions about the rhizotomy, and then I'll call it a day.

The -- you did two procedures, right, one on the facets and then another one on the sacroiliac area of the SI joint; right?

A. Correct. On two occasions.

Q. And you only treated the right L5 medial branch; true?

A. As part of the rhizotomy?

Q. Yeah.

A. No, I treated the L3, L4, L5, bilateral 3, bilateral 4, right L5, and then all the sacral roots. I did a total of 12 lesions on the sacrum.

Q. All right. So if I show you a side view of the spine, your first procedure -- and, by the way, do you see that on your screen?

A. Yes, I do.

Q. Your first procedure was to position a needle that has -- it's got, like, a little tip that comes out

like this; right?
A. On the rhizotomy?
Q. The needle, yeah, the Venom needle.
A. Yes.
Q. And that's to make a bigger lesion, right, a bigger burn?
A. Correct.
Q. Feel the Bern?
A. Yes.
Q. And you are shooting, then, to hit the medial branch of the -- the nerve that comes out of the nerve root positioned between the L3 and L4 vertebra; true?
A. Yes, sir.
Q. And you're also shooting to hit the medial nerve that is an offshoot of the big nerve that is the nerve root; true?
A. Right. Medial branch and dorsal ramus is what it's called.
Q. All right. And the procedure that we're showing here -- the first radiofrequency procedure you performed was done bilaterally on both sides at L4 and L5; true?
A. Correct.
Q. Now, the -- the nerve of which the -- the medial branch is a part also continues to the back

muscles; right?
A. Correct. It continues to what's called the multifidus muscles.
Q. And where are the multifidus muscles?
A. They're very deep. They're basically between the joints here.
Q. All right. So they're back here?
A. Well, they're real deep. Yes, sir.
Q. Real deep. Okay.
A. They're real small too.
Q. Okay. And these nerves, what -- use that word. Innervate?
A. Innervate.
Q. Could you spell that for us?
A. I-n-n-e-r-v-a-t-e.
Q. And innervate means carry nerve signals of a sensory nature back and forth; right?
A. Correct.
Q. Okay. So when a muscle says "ouch," the way it gets that message to the brain is down that nerve passage; right?
A. Correct.
Q. And if something obstructs that nerve passage, the muscle can be shouting, "Ouch, ouch, ouch." I'm tender. Don't palpitate me. It hurts," all

it wants and the brain never finds out about it.

The brain thinks everything's hunky-dory because there's a block in the nerve; right?

A. Well, that's the theory of a rhizotomy. I mean, basically it's directed towards the facet joint and the facet joint capsule. But the structure hurts. The brain doesn't know it. The signal is not going there.

Q. Fair enough. So let's say you miss with the needle. And if instead of rhizotomizing the nerve that goes to the facet, the zone of influence also includes the nerve coming from the multifidus, right, then muscle pain would be obstructed in getting to the brain; true?

A. Well, you're using the term "muscle pain" in a larger sense. The multifidus muscle is a very small muscle. It doesn't speak for the lumbar --

Q. You might want to start that over again.

A. The multifidus muscle is a very small, tiny muscle deep in the back. In fact, we use that as an indicator to determine if we're in the right spot before we burn. We intentionally denervate that little muscle along with the joint. That does not denervate the paravertebral muscles, which are the big muscles that run up and down your spine?

So that's standard. That's -- that's the way it's done. You cannot do a rhizotomy on a medial branch without taking out a little bit of the multifidus.

Q. And the reason for that is that, not only do you do that -- that, like, pilot study in the beginning, but also when the needle gets into this location, right, the zone of influence, the radio -- it's like a microwave; isn't it?

A. Right. But your needle placement here is actually in the wrong spot. It should be a little further down to capture the entire medial branch. That's what I'm targeting.

Q. All right. So then your needle position is even closer to the nerve that services the multifidus muscle than is shown in this detail view; true?

A. Like I said, by intention, we will ablate the -- the nerve that goes to the multifidus. That's part of the procedure. It's unavoidable.

Q. All right. And why don't you tell us what the word "ablate" means.

A. Nerve burning.

Q. So that means render inoperable; right?

A. Well, just like you described, it cuts the communication from the periphery where the pain is to

the brain. That communication is that sensory nerve.

Q. All right. Now, for the second procedure you did with the RF needle, it was a little different.

First of all, it was in the sacroiliac -- the sacrum area; right?

A. Correct.

Q. Okay. And let's see. All right. So -- and what we're talking about is this area of the spine; true?

A. No, sir.

Q. Okay. You better come on down. Let's get this right.

A. These nerves here, that would be bad to burn.

Turn it over.

Q. Right.

A. This is the sacroiliac joint. This is where the pelvis hooks onto the sacrum. These holes here represent the neuroforamina for the S1, S2, S3, and S4 nerves. Burning those would also be bad. That would be a complication.

What I want to do is burn the little nerves that come out of these foramen and go to the joint. They're really variable where they sit, so I have to create almost a strip lesion, you know, a continuous burn from here to here, to get it done.

Q. All right. Showing you the picture here.

Is that generally an accurate depiction of what we're talking about?

A. No. This is too close to the foramen. I want to be out here, right along this axis here. I want to be a millimeter or two off the foramen when I do the rhizotomy. During rhizotomy, one of the major dorsal roots would be a very bad idea.

Q. Bear with me just a second.

And could you estimate for us the lesion size of the Venom needle?

A. Well, like I said, when I do this, I do -- I create what's called a strip lesion. I place the Venom needle close enough that it's almost one continuous lesion. I think we showed that last week on the fluoro pictures.

So the lesion size is going to be, I don't know, the whole length, maybe 10 centimeters or -- maybe not that long.

Yeah, that's a good picture right there on the right.

Q. All right. Why don't you come down here so we can just visit about this briefly together.

And you can share with us just -- just what we're seeing here.

A. Very good picture except these needles are not Venom. These are traditional RF needles.
Q. Venoms would be bigger?
A. No. They're bifurcated.
Q. But they would make a bigger yellow spot?
A. There's more to it than that. If you use a conventional radiofrequency needle, this will not get the job done unless you use something called bipolar.
The conventional radiofrequency needle, the energy -- the heat is distributed laterally off the needle. So in order to do a rhizotomy, you have to place the needle parallel to the nerve, not perpendicular to it, because the energy doesn't come off the tip.
One of the nice things about Venom is it's bifurcated and the energy comes off the tip so that you can place it perpendicular. And then if you get them close enough together, you can create a continuous strip lesion; lesion meaning burn, burn a continuous strip of tissue.
Q. And that's what you did on Ms. Garcia?
A. Yes. Otherwise, if you just do a conventional radiofrequency needle in this position, that will not work.
Q. And you only did this continuous strip lesion

on the right side?

A. Correct.

Q. Doctor, I have enjoyed our time together. Thank you for your patience in answering my questions I'm going to pass you to the other lawyers. Thank you.

THE WITNESS: Certainly.

THE COURT: Mr. Roberts, I think we're back to redirect.

MR. ROBERTS: We are, Your Honor.

REDIRECT EXAMINATION

BY MR. ROBERTS:

Q. I'm not going to use all of them.

A. You scared me.

Q. Doctor, as a regular part of your practice, is it common for you to review medical errors from previous providers?

A. Yes.

Q. Is it unusual for you to see variations in the way that incidents are described in the medical records from various providers?

A. No. That's a common occurrence.

Q. Did you see any discrepancies in the medical records that you reviewed for Ms. Garcia and that counsel showed you again today which would cause you to

question your causation opinions that you've given to the jury?

A. No, sir.

Q. Would you say that patient reports regarding their frequency of smoking and alcohol use vary more or less than other things in patient records?

MR. MAZZEO: Objection. Vague.

THE COURT: I'm going to let him answer. Overruled.

THE WITNESS: I would agree with that. And I'd go further to say that most people don't realize, but that information is collected by staff and not by the physicians themselves. That's part of the -- if you look at the MRG and the MR templates, that stuff's all templated.

For example, the one that said "less than a pack a day," well, "less than a pack a day" varies between zero and a pack a day. I've been -- I've done the same thing, the way my staff collects records.

And as far as the smoking, there's virtually no significance to the variability.

BY MR. ROBERTS:

Q. I believe it was -- I don't remember which one it was at this point. But you told one of the lawyers for -- for the defense that, based on your

understanding of the success of fusion surgeries for spondylolisthesis, that more often than not the patient had a good result.

A. Correct. Meaning greater than 50 percent.

Q. Greater than 50 percent.

And is that something that you would consider when determining whether it was a good idea to try a fusion?

A. Well, sure. If there was only a 10 percent success rate, there wouldn't be many fusions performed.

Q. You were asked -- shown some records from Dr. Gross where Ms. Garcia was reporting leg pain, and you were questioned about the fact that your summary of Ms. Garcia's symptoms did not include leg pain for certain months where leg pain was reported to Dr. Gross.

Do you recall that?

A. Absolutely correct. But if you look at her pain diagrams, you can see it clearly illustrated every month.

Q. And that's what I'd like to do with the jury.

Audra, could you go to Exhibit 26, Dr. Kidwell's records, page 132.

And you can tell me if this is one of the pain diagrams that you're referring to.

A. That's correct. That's October 10th, 2012.
Q. Okay. If you could blow up one of the people there, Audra.
And you -- you mentioned that this was Ms. Garcia's own hand; is that correct?
A. Correct.
Q. And there are numbers written on the body.
How was Ms. Garcia instructed to fill this out?
A. It was her pain scores.
Q. Okay. And, Audra, if you could go to the posterior view or the back-side view.
And so this was before the surgery October 10th of 2012; correct?
A. Correct.
Q. And in the lumbar region, Ms. Garcia's reporting pain in the 7 levels and all the way down the legs at the 6 levels.
A. That's correct.
Q. Okay. Audra, could we go to the next pain diagram, which is at page 130.
And, once again, we've got pain being reported down the front and back of the legs and in the lumbar; correct?
A. That's correct.

Q. Audra, could we go to page 129.

This is December 5th of 2012.

Was this the last pain diagram before her fusion surgery?

A. Yes, sir.

Q. And could you blow up the posterior view, Audra.

So we've got leg pain in the 7s and lumbars in the 8s?

A. Correct.

Q. All right. Now, let's take a look at after the surgery during the period of time where you don't mention leg pain in your reports.

A. Correct.

Q. Audra, page 128.

And this is about one month after the surgery.

And in her own hand, Ms. Garcia is showing leg pain in the front and leg pain in the back at a 5 level; correct?

A. Correct.

Q. And in the area of the fusion a 7 level?

A. Correct.

Q. The leg pain, however, is not as extensive as in presurgery diagrams. Would you agree?

A. Correct.
Q. Let's take a look at the next diagram during the period of time where your reports don't mention leg pain, page 127.
Is this a diagram from April 10th of 2015?
MR. MAZZEO: 2015?
MR. ROBERTS: I'm sorry. I misread that.
THE WITNESS: April 10th, correct.
BY MR. ROBERTS:
Q. Okay. And can you read that, Doctor? Did I get that right? Is that a 3 or a 5 down there?
A. I'll find out here in a second.
Q. Based on the sequence, I thought it was -- I think it's a 3.
MR. MAZZEO: It corresponds --
THE WITNESS: It is.
BY MR. ROBERTS:
Q. Okay. Very good. And so April 10th of 2013, does she indicate leg pain down the front of the leg?
A. That's correct.
Q. And her lumbar pain has decreased to a 5?
A. That's correct.
Q. Audra, page 126. And I can read this one.
You can confirm that I'm at May 8th of 2013, about five months out from the surgery.

A. Yes, that's correct, sir.
Q. Okay. And, once again, leg pain in the front?
A. Correct.
Q. Lumbar pain reduced to 4.
A. Correct.
Q. Audra, page 125.
Six months out from the surgery, June 11, 2013, still have the leg pain in the front?
A. Yes.
Q. And lumbar pain has gone down to a 3 on this self-report; correct?
A. Correct.
Q. So is it fair to say, during this period of six months from the surgery moving forward, every time that she saw you, she reported the leg pain to you in the front?
A. Correct.
Q. Now, Mr. Strassburg showed you a chart that he had done of some reported pain levels from Ms. Garcia.
A. Correct.
Q. And he put on there a baseline of 6 based on her emergency room report.
A. Correct.

Q. Okay. It sounds like from that that Ms. Garcia should have just stayed away from all the doctors, received no treatment, and her pain would have never been greater than 6.

Do you agree with that?

A. That's what it seems like. No, I think that's not a good expectation. All that means is that on that date she had a 6 out of 10 pain. That's all it means.

Q. You agreed that, if the pain continues after surgery -- after you do the fusion surgery and the patient still has pain, then you need to reevaluate the pain generators.

You agreed with that; correct?

A. Yeah, given enough time. Sure.

Q. When you agreed with that, did you mean to agree that, in Ms. Garcia's case, the surgery didn't resolve any of her pain generators?

A. Not at all. She was doing fabulous for quite a while.

Q. Let me -- just a sec.

You were asked about your coding and diagnosis of failed low back surgery syndrome --

A. Correct.

Q. -- after the surgery.

That wasn't your only diagnosis, postsurgery, was it?

A. No. A more exact diagnosis would be lumbar discopathy with radiculopathy.

Q. Okay. And, Audra, could we have page 659.

And this is from a date of service of May 4th of 2015. So this was about a year ago.

And, Audra, if you could just blow up the top third of the page, diagnosis.

Okay. And we've talked about the fifth diagnosis, failed low back surgery syndrome.

What other things were you indicating here? And could you briefly explain that to the jury, what each one of those codings would indicate to you?

A. Chronic pain syndrome. By definition, if pain exceeds six months and is fairly continuous during that period of time, that's chronic pain.

Number 2, sacroiliitis. That speaks to pain or degeneration or inflammation in the -- in the sacroiliac joint, in this context, thought to be painful sacroiliac joint.

Number 3, spondylosis without myopathy. That's coding shorthand for facet joint pain.

And I don't invent these codes. I just have to use them.

2210, disk protrusion lumbar. Really, take that to be lumbar discopathy, abnormal disk. That's all that means.

Failed low back surgery syndrome. I think I've talked long on that already. It's not a very good diagnosis that we're forced to use because of coding.

Next one, 724.2, low back pain. Self-explanatory.

And medication management, that's a code that I'm providing medications for her over time. It's just another code.

Q. So did you reevaluate Ms. Garcia's pain generators following her surgery?

A. Yes, I did. We -- well, no, the next step -- I'm sorry. The next step we did was a spinal cord stimulator trial because her pain was getting worse after surgery.

Did the trial. It was successful. Then Dr. Gross asked me to do the interventions of the facet joints, the hardware, and the sacroiliac joint.

Q. Now, let me stop you there.

When you say that you did the stimulator trial and it was successful, does that mean that it identified a pain generator?

A. Not to a specific -- specific level, no.

What it did is identified whether or not she would be a good candidate for placement of the stimulator should she choose to go that route.

Q. So it didn't isolate a particular level, but you knew you had coverage of where her pain was coming from?

A. Correct.

Q. And what about the rhizotomies? You -- you -- you've done one rhizotomy; correct?

A. Correct.

Q. And, in your view, was it successful?

A. Yes. To date, I think it's very successful.

Q. Does that mean that the places where you ablated the nerves were generating pain?

A. That's what you would infer, yes, sir.

Q. And I know you said some things were possible, and I believe it was the -- with the multifidus muscle --

A. Correct.

Q. -- that you're also ablating nerve?

A. Correct.

Q. Leading to that muscle, more likely than not, if her pain was just myofascial, myofascial sprain-strain, would the rhizotomies have resolved her pain to the extent they did?

A. No. Myofascial pain specifically speaks to myofascial pain syndrome which is manifested by trigger points. And trigger points are kind of their own animal.

Q. If Ms. Garcia's only injury in the collision was myofascial sprain-strain, would she still be having symptoms years afterwards?

A. No. As I said, I would expect her symptoms from a sprain-strain to resolve within three months with conservative therapy. And those are people I never get. I never see them. They get better. Well, I do see some because I see people acutely.

But all I do when I get an acute patient is put them in chiropractic or physical therapy, get them muscle relaxers, anti-inflammatories, and watch them progress. And most of them get better.

Q. What if your patients -- talking about the more likely than not, a patient that receives no physical therapy and no chiropractic care, does myofascial sprain-strain last indefinitely?

A. No. It generally gets better on their own. If you leave people alone, they'll generally get better over time. But most people need to work and function, and so we -- we treat them.

Q. You talked about a indication in your records

with Mr. Strassburg about musculoskeletal pain.
A. Correct.
Q. Tell the jury what that is. What was that intended to communicate?
A. Well, review of system, that's really taking everything out of context. Review of systems is just something we're required to collect, look for other symptoms of things that might be a red flag.
You know, if a patient's passing out every day, that's something I need to know so I can send them out to appropriate physician for that. Or if they're peeing blood -- I hate to be so graphic -- it's something I'd like to know. Maybe they have kidney cancer.
That's what review of systems purpose of is to collect other information. To ask patients to categorize them into specific categories is ridiculous. We give them examples, you know, of what it is. But I'm not going to get focused on that.
Q. Is myofascial pain a type of musculoskeletal pain?
A. Sure.
Q. Is facet pain a type of musculoskeletal pain?
A. Yes.
Q. Is disk pain a type of musculoskeletal pain?

A. Yes.
Q. You mentioned -- I think you showed a little surprise at $1,400,000 for lifetime rhizotomies, and you said you weren't familiar with the cost.
Do you recall that?
A. The cost of rhizotomies?
Q. Well, the cost -- the lifetime cost projected for Ms. Garcia.
A. Right. I'm not surprised, though, given the sacroiliac joint component of it. So ...
Q. Are you familiar with the cost of the procedure that you performed, both including your fees and the surgery center fees?
A. I can't give you the exact number, but I have a rough idea.
Q. Give us a range. An estimate, not a speculation.
A. Oh, shoot. Bilateral, probably around $12,000, I'm thinking.
Q. Okay. For your fees?
A. Yes.
Q. Plus the surgery center fees on top of that?
A. Correct. Again, I am guesstimating. I want to emphasize that.
Q. Let's see. You were shown a page from the

form that Ms. Garcia filled out at her initial visit.

And, Audra, if you could put up Exhibit 26, page 103.

This is the one that was identified by Mr. Strassburg by the Bates number, which was GJL710. It's actually Exhibit 26, page 103, where she indicated up at the top who referred us.

And she put "attorney"; right?

A. Correct.

Q. And you saw that?

Let's go to page 10 out of 10 of this same form, Audra, page 110.

And down in the bottom right-hand corner, can you tell us the date Ms. Garcia filled this out?

A. 8/15/2012.

Q. Okay. And that's about the first time you saw her; correct?

A. Correct.

Q. You told Mr. Mazzeo that you thought Dr. Gulitz had referred her to you.

A. Right.

Q. And, Audra, could we have page 385 out of Dr. Kidwell's records. And if you just blow up the top portion right there.

What do your records show as the referral

source?
A. Dr. Gulitz.
Q. And what date do you show that you received a referral from Dr. Gulitz?
A. May 24th, 2011.
Q. Okay. So that -- that's -- over a year before she filled out this form, you'd gotten a referral from Dr. Gulitz?
A. Correct.
Q. You were asked by Mr. Strassburg about weight.
And you said, I believe, that based on the records you looked at, her weight had varied from about 175 to 185 during your period of treatment?
A. 165 to 185.
Q. 165 to 185. Okay.
Audra, if you could put up Exhibit 26, page 255.
And this is from your records, but this is actually a record that was produced by Brian Lemper on 6/29/11, so six months after the surgery.
Can you see what the weight was, as indicated by Dr. Lemper?
A. 175.
Q. And in the emergency room notes, weight of

75 kilograms.

Can you do a conversion?

Well, might have do that later.

A. Let's see. 70 kilograms, roughly 155 pounds. So add 10. About 160-165.

Q. Okay. So -- and this is two days -- three days after the incident. About 165.

So it's -- it's all within the same range as when you were seeing her; is that correct?

A. Correct.

Q. To a reasonable degree of medical probability, was her back pain caused by her weight?

A. No.

Q. We've heard a lot about self-reporting by Ms. Garcia, and you do rely on that; correct?

A. Correct. I rely on that in all patients.

Q. We've also talked a little bit about palpitations of the back.

And if you remember that chart that Mr. Strassburg had up where he had the lines going across and you talked to him about palpitating and tenderness.

A. Correct.

Q. Okay. He -- he did not have a line on there for spasm, did he?

A. No.

Q. And -- and is that -- "spasm," when we see that on a medical record from a -- a medical examination, is that something the patient self-reports, or is that something the physician palpitates to feel the spasm?

A. No. It's -- that's noticed on physical examination.

Q. And is a notation of muscle spasm in the lumbar region an objective or a subjective finding?

A. Subjective.

Q. Can a patient fake a lumbar spasm?

A. No. I don't know how they could, no.

Q. Explain to the jury -- and I think they may have heard a little bit about this already.

But what -- what causes that spasm that you feel on palpitation when examining a patient?

A. Spasm is a -- it's kind of a reflex. It's your body telling you not to move because it hurts. So there's usually -- you know, over time, there's a primary problem causing the secondary effect.

The primary problem is generally ligament tears, disk pain, facet pain. And that's what's triggering the muscle spasm to remind you not to move. If you fractured your femur, your leg would go into

intense spasm to try to splint that.

Q. So let me rephrase and maybe add something another doctor told us.

Correct to say that's your body trying to keep the spine from moving because your brain knows something is wrong down there?

A. Right. Your brain is telling you, "Don't move, dummy."

Q. So let's take a look at some of the records and the history of the spasm that was objectively found from Ms. Garcia's examinations.

Audra, if you could go to Exhibit 15, page 4.

And this is The Neck and Back Clinic.

That's Dr. Gulitz, correct, the chiropractor?

A. Yes, I believe so.

Q. And we're looking at the initial report dated 1/12/11.

So this is about ten days postaccident?

A. Correct.

Q. Okay. And if you could blow up the lumbosacral examination, we see tenderness mentioned in the first sentence.

What does it indicate in the second sentence with regard to muscle spasm?

A. "Positive for muscle spasm." So that's on

direct examination by feel.

Q. Okay. And that's an objective finding which Ms. Garcia could not have been faking; correct?

A. Correct.

Q. Audra, if we go to page 14 of Exhibit 15.

And this is the -- the next day, 1/13/11, seen by Matthew Olmstead.

If we look at the assessment the next day, what do you see there?

A. January 13th, 2011.

Q. Right. And under "assessment," what's the second coding diagnosis?

A. Muscle spasm.

Q. All right. Audra, if we could go to Exhibit 16, page 1.

This is from the initial history and physical examination done by Primary Care Consultants, the physician's assistant at primary care office.

If you could go down and just look at that bottom right-hand corner, Audra.

You see "tonicity." You following?

A. Got it.

Q. Okay. What is tonicity?

A. That's code for spasm. Hypertonic means the muscles are tight and in spasm.

Q. Okay. So that means that the primary care PA found muscle spasm?

A. Correct.

Q. And if we look at the next page, page 2, Audra.

Bottom third, under "medications," we can see that, in fact, the PA prescribed an antispasmodic to decrease muscle hypotonicity; right?

A. Correct.

Q. And what did he prescribe?

A. Zanaflex.

Q. And based on your review of the records, how long did Ms. Garcia continue to take Zanaflex?

A. Ooh. I don't have that off the top of my head.

Q. Okay.

A. I think she took it for a while. In fact -- give me a second here. She continues to take it. She's been on it for a long time.

Q. She's still on it?

A. Yeah. I'm still prescribing it for her.

Q. Okay. And -- and, in fact, let's take a look at when she came -- well, hold on just a second. Let's -- before we go onto your records, she saw Dr. Lemper before you; correct?

A. Correct.
Q. Audra, could we have Exhibit 26, page 256.
And this is Dr. Lemper's examination of Ms. Garcia on June 29th of 2011, seven months after the collision, under "lumbar spine."
Okay. Did Dr. Lemper find palpable spasm in the lumbar spine?
A. Yes.
Q. And "palpable" means he felt it; right?
A. Correct. That's what "palpable" means. He palpated -- pressed on the back to feel that manually.
Q. Once again, an objective rather than a subjective finding?
A. Correct.
Q. All right. So let's take a look at your records. The first time you saw her, we're going to August 15th of 2012, about a year later.
Audra, page 5. And now I can't find it.
Do you see whether you tested -- oh, I see it. Under "lumbar spine," right in the middle. It's kind of small on my page. It's hard to read.
So at your first examination, what did you say about spasm in the lumbar spine?
A. "Severe spasm is noted in the paravertebral musculature."

Q. And that's something you felt yourself?
A. Right. And those are the big muscles of the low back.
Q. Okay. Is that the multifidus muscle?
A. No. You can't feel the multifidus muscle on exam. It's way too deep and too small.
Q. Okay. January 30th, 2013, Audra, page 28, under "diagnosis."
Are you continuing to diagnose Ms. Garcia with muscle spasm?
A. Correct.
Q. And that's something you're continuing to feel yourself?
A. Yes.
Q. That's not self-reported?
A. No.
Q. And this is sort of -- let's come full circle.
Come down to page 714, Audra.
And this is a diagnosis from just before the end of the year. We're at page 714, the very top, where it says "diagnosis."
And the -- the parens, is that -- is that the date of your diagnosis?
A. That's the date of the visit.

Q. The date of the visit. Okay.
So that's November 11th, 2015?
A. Correct.
Q. Recently.
And you're still finding spasm?
A. Correct.
Q. And you're still feeling that yourself?
A. And she's still on Zanaflex, yes.
Q. Okay. So is it fair to say that, from her initial visit to the chiropractor and the primary care, ten days after this collision, until months ago, Ms. Garcia was objectively diagnosed with muscle spasm in her lumbar region?
A. Correct.
Q. And that was not self-reported; correct?
A. No.
Q. All right. Okay. Going back to your exhibits -- and you had the records from MountainView, the emergency room?
A. Yes, sir.
Q. Okay. Audra, Exhibit 26, page 233.
Physical assessment from the emergency room, January 5th of 2011, second line, "patient appears uncomfortable and in pain, shows apparent trauma."
See that?

A. Correct.
Q. Okay. But let's look at what the emergency room found when they palpitated her lumbar region.
Audra, go to page 230 under "physical exam."
Okay. Do you see where they did a physical exam of Ms. Garcia?
A. Correct.
Q. Okay. And do you see where it says "back" right down toward the bottom of the list?
A. Correct.
Q. No back tenderness, no vertebral point tenderness or muscle spasm --
A. Correct.
Q. -- three days out from the accident.
Now, if the problem that had been causing Ms. Garcia's pain from January 12th of 2011 up until today had been preexisting the accident, would you have expected the physician to palpitate muscle spasm three days after the accident?
A. No.
Q. And I may have made my question unclear.
So you would have expected muscle spasm or you wouldn't?
A. I would expect, if spasm was a chronic preexisting condition, she would most certainly have it

on that visit. The fact that she wasn't exhibiting it just means there was no spasm that day. But if that had been a chronic preexisting problem, you'd think it would have been there.

Q. Okay. Has Ms. Garcia had palpable spasms on almost every examination from January 12th, 2011, until today?

A. Yes.

Q. And she didn't have any three days after this accident?

A. Correct.

Q. Is that objective evidence that the accident was causally related to Ms. Garcia's injuries?

A. It's objective evidence that the spasm began after her collision, it sounds like, within a week or two, and it's persisted ever since.

Q. Is that -- is that consistent with what you've told the jury about how this pain comes on slowly after the accident and grows and that's not unusual?

A. Yes.

MR. ROBERTS: Thank you, Doctor.

That's all I have, Your Honor.

THE COURT: Mr. Mazzeo?

MR. MAZZEO: Yes, Your Honor. Thank you.

THE COURT: Everybody okay for a few more minutes?

RECROSS-EXAMINATION

BY MR. MAZZEO:

Q. Okay. Doctor, is it correct that spasm can refer to sprain and strain as well? Spasm can -- withdrawn.

Spasm can -- can -- can be the result of a sprain and strain as well; correct?

A. Yes.

Q. Okay. And you said that palpating for a spasm, that's objective rather than a subjective finding; correct?

A. Correct.

Q. But isn't it a fact that the clinician who does the palpating, the -- the feel from -- of the -- what -- what a clinician feels when they palpate the back muscles might vary from one clinician to another?

A. Well, you could say that. But then the absence or presence by itself, it doesn't quantify it. So ...

Q. So --

A. So if it's there, it's there.

Q. And to some extent there's going to be a -- a

certain subjectivity based on the -- based on what the clinician feels in the back; correct?

A. I'd say there might be variability in the degree to which they report.

Q. Okay. And -- now, with respect to -- I had asked you earlier on cross-examination about your record from August 7th of 2013. And -- and let me direct your attention to what I was referring to.

This is Plaintiff's 26, page 43.

Oh, can we switch please.

Thanks, Judge.

THE COURT: Sorry about that.

MR. MAZZEO: That's all right.

THE COURT: Do you want the camera or the left side? You want the ELMO.

MR. MAZZEO: The ELMO, yeah.

MR. ROBERTS: Pete, mind if I steal my computer?

MR. MAZZEO: Sure. If you need it.

BY MR. MAZZEO:

Q. Okay. So this record, August the 7th of 2013 -- and -- and what I -- you may recall, Doctor, what I pointed out to you was that Ms. Garcia, on this date, reported to you that she's developed some pain to her right thigh --

A. Correct.
Q. -- right?
And in the way that this phrased -- this is phrased, it indicates that she's reporting this to you for the first time, that she's developed some pain to the right thigh.
Do you see that?
A. What's the date of that visit again, sir?
Q. Sure. August 7th, 2013.
A. Let me look that up.
Q. That's -- I don't know if you have the same --
A. I do.
Q. -- records.
A. I have the identical record.
Q. Plaintiff's 26, page 43.
A. Yes, I have it.
Q. Okay. So the -- I didn't think I got an answer from you.
A. I think that's the first time I actually started addressing it.
Q. Okay. And -- and -- and the way that that sentence is phrased, it's -- it's indicating -- indicative of Ms. Garcia first report -- verbalizing it to you at a session -- at a consultation with you?

A. All I can say is historically that's probably the first time that I addressed it. Clearly, her pain diagram showed that it was there.

Q. Okay. Now, on -- on redirect by Mr. Roberts, we looked at some pain diagrams that were put up on the screen; right?

A. Correct.

Q. And the pain diagrams are diagrams that are filled in by Ms. Garcia --

A. Correct.

Q. -- correct? Okay.

Now, filling in the pain diagrams is not the same as -- same thing as Ms. Garcia actually reporting to you during the consultation, "Doctor, I have -- I want to tell you that I have pain that's in my right thigh"?

A. Right. But I can't extrapolate that because the only information I have is the pain diagram and what I document on that date. So I can't extrapolate that to mean that's the first time she reported or not.

Clearly, she did report it on her pain diagrams multiple occasions, every occasion.

Q. Okay.

A. So that might be a -- remiss on my fault for not -- or my part for not identifying earlier.

Q. For picking it up?
A. I don't know. I don't know. See, this is all I have to work with and the pain diagram.
Q. Understood. So it might be remiss on your part for not picking it up from the pain diagram; right?
A. And discussing it in my notes, what it relates to.
Q. Okay. But we know that on August 7 is -- we know that she's actually verbalizing -- when you say "she reports," she's verbalizing to you at the time of the consultation that she's developed some pain to her right thigh?
A. Right. That statement, though, doesn't say when. It just says she's developed.
Q. Well --
A. And, again, looking at her pain diagrams, I can infer or actually document that she reported that pain all along.
Q. Well, reported it on -- on a pain diagram nonverbally as opposed to verbally at the time of the consultation.
A. No. You can't infer that. All we know is that that's what I document on that day. We don't know, because I don't recall, what we discussed on the

previous visits. This is the first time that I put it in my record.

Q. Well, if we look at the way the sentence is phrased, she reports that she's developed some pain to her right thigh.

I think we can extrapolate from that that she didn't tell you that three months earlier and you're just putting it into this report on August 7th; correct?

A. Well, on her pain diagram, she did tell me that.

Q. I'm not talking about the pain --

A. For whatever reason, I just didn't document it.

Q. I'm not talking about the pain diagram. I'm talking about her verbally telling you this -- this statement.

Are you saying this statement might -- might have been told to you by Ms. Garcia three months earlier? Four months earlier?

A. No. I'm saying -- because this is two years ago, three years ago -- that on that date I documented that she had right leg pain. I wrote the words "developed." It doesn't say exactly when she developed. Looking at the pain diagrams, I can assess

that she had it all along.

Q. Okay. But we're looking at the beginning of the sentence, "She reports."

A. Right.

Q. More likely than not, she's actually verbalizing this to you on August 7th at the time of the consultation? Yes or no?

A. No. I don't know if you can say "more likely than not."

Q. Okay. November 19th, 2014, we have a -- a record from -- your record where Dr. Gross -- and you can bring it up, November 19th.

A. Which year?

Q. 2014.

A. Okay.

Q. Plaintiff's 26, page 623. Okay. So that's November 19th. And you had testified on cross-examination by Mr. Strassburg that this is where she had seen Dr. Gross.

Now, it was Dr. Gross that actually prescribed and requested that you do a combined right SIJ, sacroiliac joint, plus bilateral L3-4 facet injection --

A. Plus SIJ.

Q. -- plus hardware injections --