

No. 71348

IN THE SUPREME COURT OF THE STATE OF NEVADA

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Elizabeth A. Brown  
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EMILIA GARCIA,  
Appellant,

v.

ANDREA AWERBACH,  
Respondent.

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**APPELLANT'S APPENDIX  
VOLUME XIX, BATES NUMBERS 4501 TO 4750**

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1           A.    I do.  It's not quite right, but it's close.

2           Q.    All right.  To derive the force and motion  
3 inputs that you need for the MADYMO biomechanical  
4 analysis, did you need anything more than just what  
5 I've drawn here?

6                   Do you want to come down here and show it?

7           A.    No.  That's all right.  No.  I think the --  
8 I'd just change your moment arm because you have it at  
9 an angle.  And the way you've drawn it there, it should  
10 be perpendicular.

11          Q.    Here.  Let's get it right.

12          A.    Okay.  To answer your other question, again,  
13 vehicle-specific parameters are important.  So it's  
14 more like that (witness indicating).  The moment arm is  
15 going to be perpendicular to the force.

16          Q.    All right.  Let's do it -- Doctor, here.  
17 Let's do it -- let me get this right.  Okay.

18                   Is this -- this would be the center  
19 rotation --

20          A.    Sure.

21          Q.    -- of the vehicle?

22                   And that's important; right?

23          A.    That is.

24          Q.    Okay.  And then the location impact would be,  
25 like, here?

1           A.    Sure.  I would put it here, but yeah.

2           Q.    Okay.  And that's the location of impact on  
3 the vehicle.

4                   And then the moment arm, how would that be?

5           A.    You draw that -- so if this is the force  
6 applied to the vehicle, then it would be like that.

7           Q.    Okay.  And the vehicle has a speed vector;  
8 right?

9           A.    Right.

10          Q.    And it has a motion, this 180 degrees to  
11 where it stopped; right?

12          A.    That's right.

13          Q.    Is there anything else that you needed to  
14 derive the inputs for force and motion that you needed  
15 for your biomechanical analysis?

16          A.    Besides the vehicle-specific parameters and  
17 friction?

18          Q.    Put them here.  Write them down.

19                   As to just her vehicle, what did you need?  
20                   Write big.

21          A.    Mass --

22          Q.    Bigger.  Okay.  Go ahead.

23          A.    -- moment of inertia, friction --

24          Q.    That's the coefficient of friction?

25          A.    Uh-huh.

1           -- wheel base.

2           Q.    Anything else?

3           A.    Actually, the location of -- and the size of  
4 the vehicle, tire-track width. All the  
5 vehicle-specific information is important to this.

6           Q.    Did you have that too?

7           A.    Yes.

8           Q.    All right. And you had the -- the  
9 calculation of the exact moment of rotation; right --  
10 or the center of rotation?

11          A.    Correct.

12          Q.    And is there anything else that you needed to  
13 perform this PC-Crash calculation of force and motion?

14          A.    In what I did, I also included occupant  
15 weight in the location of the driver's seat. So that's  
16 included there too.

17          Q.    Anything else that you need -- you absolutely  
18 had to have for your calculation?

19          A.    Not that I can think of, no.

20          Q.    All right. And so what you're calculating  
21 here is the force and the motion of the vehicle, and  
22 then you input that into your biomechanical analysis to  
23 calculate the force and the motion on her spine; right?

24          A.    That's correct.

25          Q.    Okay. Now, did the -- why is it that it

1 didn't matter to you whether the resting location of  
2 the vehicle was where the witnesses said?

3 MR. ROBERTS: Objection. Inconsistent with  
4 his report.

5 BY MR. STRASSBURG:

6 Q. Well, did it matter?

7 A. Did it matter that the vehicle was not in the  
8 lane?

9 Q. Yeah.

10 A. It wouldn't matter to my analysis, no.

11 Q. Why not?

12 A. Because I'm interested in the rotation and  
13 lateral motion during the impact. And the portion when  
14 the car is further down the street at a slow speed,  
15 there's not much acceleration, it doesn't matter to the  
16 loads on the lumbar spine.

17 Q. Would it matter how fast that Awerbach was  
18 going when he hit her if you assume that her vehicle  
19 only spun 180 degrees and stopped?

20 A. So his speed is only important in the sense  
21 that it applies a force -- his vehicle contact applies  
22 a force to her vehicle. Her vehicle motion wouldn't  
23 matter if he, you know, was going 20 miles an hour or  
24 10 miles an hour if the force were the same. The force  
25 is what's important.

1 Q. And --

2 A. That's from -- sorry.

3 Q. And how do you derive that force?

4 A. That's the iterative process. Because if you  
5 have a force that's too large in the location of  
6 impact, then it's going to spin the vehicle more than  
7 180. If you have a force that's too small at the  
8 location of impact, it's not going to rotate far  
9 enough.

10 Q. And does the amount of deformation of her  
11 vehicle have anything to do with calculating that force  
12 exerted by his?

13 A. It's a check.

14 Q. Explain.

15 A. Well -- so it's not necessary for calculating  
16 the motions of her vehicle, but I want to make sure  
17 that it's consistent with the facts that we have. And  
18 so the damage to the vehicle is -- it would require a  
19 force that is ten times larger, because there's that  
20 much more crush, then it would tell me I'm wrong.

21 In this particular case, the crush energy,  
22 the amount of force it takes to crush her vehicle,  
23 matches up well with the vehicle spinning the  
24 180-degrees.

25 THE COURT: Tom, would you go talk to the

1 jurors and make sure that they know that we're still in  
2 here. It's going to be a little bit.

3 THE MARSHAL: All right.

4 THE COURT: Thank you.

5 Sorry to interrupt.

6 BY MR. STRASSBURG:

7 Q. All right. So is your utilization of these  
8 physical principles and the data regarding the  
9 180-degree spin, the vehicle-specific data of her car,  
10 the crush deformation that you had, was that sufficient  
11 under the generally accepted principles of  
12 biomechanical engineering and accident reconstruction  
13 to determine the two parameters, force and motion, for  
14 this accident that you needed to input into your  
15 biomechanical analysis to figure it out on a spinal  
16 level?

17 MR. ROBERTS: Objection. Inconsistent with  
18 his report.

19 THE COURT: I'm going to let him say it.

20 THE WITNESS: So the one thing I would  
21 correct is it's the motion of the vehicle that goes  
22 into the biomechanical analysis, not even the force.  
23 It's the motion that's created.

24 Yes. Thank you.

25 /////



1 BY MR. STRASSBURG:

2 Q. All right. And what determines that motion?

3 A. Everything that we've been talking about.

4 Q. All right. So it's just -- the main factor  
5 is this spin of 180 degrees; right?

6 A. That's right.

7 Q. If it had been 360 degrees, that would have  
8 been totally different?

9 A. That's correct.

10 Q. If it would have been 480 degrees, that would  
11 have been totally different?

12 A. That's true.

13 Q. All right. So it sounds like you knew  
14 everything that you absolutely needed to calculate  
15 motion; right?

16 A. I believe so, yes.

17 Q. And --

18 A. I should say within a range.

19 Q. And what was your margin of error for what  
20 you -- what you actually knew to put into this  
21 calculation?

22 MR. ROBERTS: Objection. Beyond the scope of  
23 his report.

24 THE COURT: I'm going to let him say it for  
25 now.

1           THE WITNESS: So what I did was actually gave  
2 the upper bound in my report. But if you look at it  
3 and you look at my file, I think that I gave a  
4 particular analysis and then a plus-or-minus range on  
5 that.

6           And so, for example, for Jared's vehicle,  
7 Mr. Awerbach's vehicle, it's probably around 20 miles  
8 an hour, maybe down to 18, maybe up to 22.

9 BY MR. STRASSBURG:

10          Q. Does it matter?

11          A. It does not.

12          Q. Why not?

13          A. Again, what matters is the motion of the  
14 Santa Fe.

15          Q. Because that determines the motion of the  
16 vehicle that goes into the biomechanical analysis;  
17 right?

18          A. That's correct.

19          Q. Okay. And so what -- it sounds like what  
20 you're saying is is that this impact had a rotational  
21 component and a magnitude component, right, a lateral  
22 component?

23          A. That's true.

24          Q. And they tended to counteract each other?

25          A. That's true, with the occupant motion.

1 Q. All right. And that's all that you  
2 calculated for PC-Crash purposes, right, this motion?

3 A. That's right.

4 Q. And it didn't matter where the cars ended up?

5 A. That's true.

6 Q. Didn't matter where Awerbach started from?

7 A. May I explain why it doesn't matter?

8 Q. Yeah, I wish you would.

9 A. Okay. So when you have the vehicle rotating  
10 180 degrees, if you have a small steering input on the  
11 Santa Fe, at the end of the accident when the forces,  
12 the motions are slow -- on the vehicle, the forces were  
13 low on her vehicle -- it will drift back into her lane.  
14 And that was in my file. I think it's in "analysis,"  
15 the "PC-Crash folder" under "4" -- and there's a dash  
16 or an underscore or, like "steering input" or something  
17 like that.

18 And basically it shows that, with a small  
19 steering input, the motions -- the vehicle motions  
20 overall that are important for MADYMO are the same.  
21 It's just, at the very end, her car drifts back into  
22 her original lane as opposed to staying on the other  
23 side of the street.

24 Q. Okay. So the steering inputs, when -- when  
25 the vehicle responds to -- under control of the

1 steering wheel, right, that is not important for your  
2 analysis?

3 A. Not at the end of this accident. That's  
4 right.

5 Q. And those are -- those are what determine  
6 where the vehicles end up in their rest location. Yes?

7 A. That's correct.

8 Q. What you're interested in calculating is the  
9 motion while the vehicle is out of control; right?

10 A. The impact portion. That's right.

11 Q. And that's determined by the laws of physics  
12 based on the fact that a vehicle of this weight and  
13 mass described this motion of 180 degrees; right?

14 A. That's right.

15 Q. Now, why doesn't it matter where our back  
16 started out?

17 A. Again, it's whatever force at the impact  
18 location on the Santa Fe is necessary to rotate her  
19 vehicle around.

20 Q. And how did you -- and you back-figured that  
21 force based upon what force would be required to deform  
22 Garcia's vehicle in the way you observed; right?

23 A. No. That was a check.

24 Q. Okay. How did you calculate it?

25 A. So it's, again, based on the vehicle

1 parameters, the laws of physics, and the damage  
2 location on her vehicle. That gives what the force has  
3 to be to rotate her vehicle around during the impact.

4 Q. So that's what describes this moment arm?

5 A. The damage location describes this moment  
6 arm. That's right.

7 Q. All right. And that -- the moment arm is  
8 like a lever that it takes to rotate this mass  
9 180 degrees to this location; right?

10 A. The moment arm is what creates the torque  
11 about the center of mass from the force that's applied  
12 at the damage location to the Santa Fe.

13 Q. All right. Did you have objective, reliable  
14 evidence for every factor shown on this board that you  
15 needed to calculate the motion of the vehicle that you  
16 would input into your biomechanical analysis?

17 A. I believe so, yes.

18 Q. You didn't have to guess at any of it?

19 A. No.

20 Q. You didn't have to extrapolate any of it?

21 A. No. I did have to solve equations through an  
22 iterative process.

23 Q. An iterative process determined by the laws  
24 of physics?

25 A. That's correct.

1 Q. Okay. Let me just make sure that I ...

2 In -- in -- in biomechanical engineering,  
3 which is deemed more reliable proof, eyewitness  
4 statements of people involved in a hair-raising  
5 accident or the product of the analysis of physical  
6 forces applied to known parameters?

7 A. I always rely on objective evidence with more  
8 weight than testimony, but both are important.

9 Q. Now, there's a concern that you had no way of  
10 knowing from the photographs the amount of damage  
11 that's underneath the sheet metal.

12 Was that important for your purposes?

13 A. No. The crush analysis portion, again, is a  
14 check on the vehicle motion that we just talked about  
15 through PC-Crash. But it is very interesting that it's  
16 consistent. If you look at the force it takes at the  
17 damage location to rotate the Santa Fe through  
18 180 degrees and then you do the crush analysis, they  
19 match up very well.

20 Q. For the purposes of the analysis shown on  
21 this board, was -- the angle of impact, was that  
22 important and determinative of what you were  
23 calculating here?

24 A. The general angle is important but not the  
25 specific angle.

1 Q. What do you mean by that?

2 A. Well, again, a range of reasonable angles.  
3 It can't be, in your drawing, straight up and down on  
4 the passenger side. It's not a sideswipe. There's  
5 going to be a component into the vehicle and a  
6 component rearward on the vehicle because of the nature  
7 of the accident.

8 Q. But what determines your calculations is the  
9 fact that this vehicle describes this half circle of  
10 motion and comes to a rest; right?

11 A. That's right.

12 Q. So really whether the repair records show,  
13 you know, \$1,000 of damage or \$1,500 worth of damage,  
14 it's not really relevant to your calculation so long as  
15 they don't show \$10,000 worth of damage that's grossly  
16 out of the line; right?

17 A. So I wouldn't use dollar values, but I would  
18 use crush energy or force. But yes, that's the right  
19 idea.

20 Q. So for purposes of assisting the Court in  
21 determining whether your calculations are reliable, for  
22 purposes of what you needed to calculate this motion  
23 input for the biomechanical, were your calculations  
24 under the standards applicable in accident  
25 reconstruction generally accepted and peer reviewed?

1 Were your calculations proper?

2 A. They were.

3 Q. Were they reliable?

4 A. Yes.

5 MR. ROBERTS: Objection to the peer review of  
6 his calculations. That's certainly not in his report.

7 BY MR. STRASSBURG:

8 Q. No, no, no. It's peer review of the method  
9 that you used for your calculations.

10 Did you use a peer-reviewed valid method for  
11 calculating this motion that you inputted into your  
12 biomechanical analysis?

13 A. Yes.

14 Q. And was that calculation based upon objective  
15 information that was particularized to this particular  
16 motion by this particular vehicle?

17 A. Yes.

18 Q. And for the motion that you utilize, does  
19 your methodology result in a value that has a  
20 recognized, tested, validated margin of error in the  
21 scientific literature?

22 A. I'm sorry. One more time?

23 MR. ROBERTS: Objection. Incomplete  
24 hypothetical. No foundation.

25 THE COURT: Ask it again.



1 MR. STRASSBURG: What?

2 THE COURT: Try again.

3 BY MR. STRASSBURG:

4 Q. Okay. Does this method that you utilized  
5 here to -- to calculate the motion involved here and  
6 what it implied, does that employ -- did you employ a  
7 method that is recognized as scientifically valid in  
8 your discipline of biomechanics?

9 A. Yes.

10 Q. Based upon peer-reviewed studies validating  
11 this calculation?

12 MR. ROBERTS: Objection.

13 BY MR. STRASSBURG:

14 Q. I'm sorry. Peer-reviewed studies validating  
15 the method that you utilized to calculate this  
16 particular motion for this particular vehicular motion.

17 A. Yes.

18 Q. All right. Now, delta-v -- was delta-v  
19 critical for your -- your calculation of this motion  
20 input for the MADYMO?

21 MR. ROBERTS: Objection to form.

22 Incomprehensible.

23 THE COURT: I'm going to allow it.

24 THE WITNESS: The actual calculation of  
25 delta-v is not critical.

1 BY MR. STRASSBURG:

2 Q. Explain.

3 A. Well, the delta-v does not go into the  
4 biomechanical analysis section. What we're interested  
5 in is the motion of the vehicle. We happen to get that  
6 as a byproduct, but it's not critical.

7 Q. Okay. Has this methodology to calculate the  
8 motion involved in an accident of this movement, has it  
9 been tested in scientific literature?

10 A. That is the balance of linear and angular  
11 momentum, conservation of energy, yes.

12 MR. STRASSBURG: Judge, based upon his --  
13 again, his explanation of his testimony, I'd again  
14 plead with you to reconsider your ruling on -- that  
15 this does comport with Hallmark. Once you understand  
16 that -- that this calculation that he performed is --  
17 it's maybe not what you're used to from other cases.  
18 It doesn't depend upon rest locations and witness  
19 statements because its purpose is limited. It's  
20 more -- it's different.

21 It's to calculate an input into the next step  
22 in the analysis, an input that is determined by a -- a  
23 half-circular rotation of a vehicle of this size and  
24 weight.

25 MR. MAZZEO: Excuse me. I have a couple of

1 questions of the doctor.

2 THE COURT: I'm sure you do. I'm sure he  
3 does too.

4 Tom, can you take this -- go admonish the  
5 jurors and tell them to come back at 8:30 tomorrow  
6 morning.

7 Go ahead, Mr. Mazzeo.

8 MR. STRASSBURG: Judge, can I mark this as an  
9 exhibit, what we've been looking at?

10 THE COURT: What's next in order?

11 THE CLERK: You want it as a court's exhibit  
12 or --

13 THE COURT: A court exhibit. It's not going  
14 to go to the jury.

15 THE CLERK: It will be 8.

16 THE COURT: Go ahead, Mr. Mazzeo.

17 MR. MAZZEO: Thank you, Judge.

18

19 VOIR DIRE EXAMINATION

20 BY MR. MAZZEO:

21 Q. Dr. Scher, how many PC-Crash analysis  
22 evaluations have you performed in your career?

23 A. I don't know. Maybe in the ballpark of 250.

24 Q. And have you ever been -- have any of your  
25 PC-Crash analysis tests been deemed inadequate in any

1 court of law?

2 A. Not that I know of, no.

3 Q. Okay. And in this case, did you have all the  
4 necessary data to perform the PC-Crash analysis test?

5 A. I believe so.

6 Q. And so I just want to ask you some questions  
7 about the relative importance or the significance of  
8 certain information that's been discussed.

9 What was -- what is the significance of the  
10 vehicle specifications with respect to the PC-Crash  
11 analysis testing?

12 A. The vehicle specifications will determine the  
13 dynamics of the motion of the vehicle upon impact.

14 Q. So and -- you had those -- and that's -- so  
15 that's something -- that's -- that's -- that's data  
16 that is important with respect to the analysis?

17 A. I believe so.

18 Q. Okay. Well, more than just your belief, is  
19 it something that's used in your -- in accident  
20 reconstruction to -- for this PC-Crash analysis?

21 A. Yes.

22 Q. Okay. And what is the significance of the  
23 area of initial contact for the PC-Crash analysis?

24 A. It gives us, again, the moment arm for  
25 rotation about the center of mass from the force of the

1 department.

2 Q. And there is -- has been some discussion  
3 about the -- about the -- your diverting from the AIC,  
4 or the area of initial contact, that was identified in  
5 the traffic accident report which -- it's on  
6 Plaintiff's Exhibit 2, page 1 -- or page 2, where the  
7 investigating officer had noted 100 N/S, 27 W/E.

8 Why did you diverge from the -- from the  
9 notation indicated by the investigating officer?

10 A. If I may, the accident report that I'm  
11 looking at says, "The accident occurred" -- there's a  
12 little check box next to No. 2. It says "or," and then  
13 it has a check box next to 3. It says "feet," and then  
14 a check box next to No. 5 that says "approximate" along  
15 that line. So it says "north of Peak Drive," and it  
16 does say "approximate."

17 What was more important to me was the  
18 testimony that Mr. Garcia -- I'm sorry. Mr. Awerbach  
19 was coming out of Villa Del Sol, and that driveway or  
20 exit from the parking lot is 200 or so feet from the  
21 intersection. The police officer put 100. It was  
22 probably closer to 200. But it's the right area.

23 Q. And how did you determine that it was 200  
24 rather than 100?

25 A. From Google Earth, so satellite imagery.

1           Q.    Okay.  And -- now, what is the significance  
2 of the angle of impact between the relative vehicles  
3 involved in this accident?

4                   And, secondly, do you need to know the  
5 precise angles or the general angle?

6           MR. ROBERTS:  Objection.  Asked and answered.

7           THE COURT:  I'm going to let him go.

8           THE WITNESS:  We need the general angle  
9 within a range, which we had.  We don't need the  
10 precise angle.

11 BY MR. MAZZEO:

12           Q.    And how did you know the general angle?

13           A.    From the damage to the vehicles and  
14 descriptions of the accident.

15           Q.    Okay.  Now, is -- can you tell us something  
16 about how photogrammetry has an impact on -- or any  
17 relevance of photogrammetry with respect to PC-Crash  
18 analysis?

19           A.    It doesn't.

20           Q.    Okay.  Thank you.  And what is the  
21 significance of the resting position for your PC-Crash  
22 analysis?

23           A.    As I mentioned earlier, it's variable  
24 depending on the steering input after the main part of  
25 the impact.  So it's immaterial for my analysis.

1 What's most important is the rotation of Ms. Garcia's  
2 vehicle.

3 Q. Okay. And -- and also, Dr. Scher, with  
4 respect to the area of initial contact, what we're  
5 talking about when -- when -- and you cited that, and  
6 it's -- I don't have the -- it's okay. I don't need  
7 it.

8 THE COURT: I can give it to you if you want.

9 BY MR. MAZZEO:

10 Q. Okay. So this is Plaintiff's 1, page --  
11 Exhibit 2, page 1. And I think what you were referring  
12 to, Doctor, is the traffic accident report in the box  
13 under "occurred on."

14 Do you see that?

15 A. I do.

16 Q. And this is what you were citing?

17 A. That is.

18 Q. The --

19 A. That's correct.

20 Q. Okay. 100 feet approximately north of Peak  
21 Drive; right?

22 A. That's right.

23 Q. Okay. So when we're talking about the area  
24 of initial contact, just so there's no confusion, we're  
25 not talking about the points of contact between the two

1 vehicles; we're talking about the contact in the  
2 roadway between the two vehicles?

3 A. The location on the roadway where the  
4 accident occurred.

5 Q. Okay. With respect to the points of contact,  
6 that's important for your PC analysis; correct?

7 A. Where the vehicles touched, do you mean?

8 Q. Yes.

9 A. Yes, it is.

10 Q. And how did you determine that?

11 A. From the damage to the vehicles that was  
12 apparent in the pictures and the repair estimate.

13 Q. Okay. Thank you.

14 MR. MAZZEO: And then, Judge, I also want  
15 to -- I mean, I can wait until the end, but I want to  
16 cite -- refer you to the case of Provence v.  
17 Cunningham, 95 Nev. 4, where photographs per se are not  
18 invalid as a basis for expert testimony in accident  
19 reconstruction cases.

20 And I'll wait. I guess there's going to be  
21 an argument at the end?

22 THE COURT: I can't go past 5:00 today. So  
23 you guys are a little limited on time.

24 MR. MAZZEO: Okay.

25 THE COURT: Mr. Roberts?



1 MR. ROBERTS: Thank you, Your Honor.

2

3 VOIR DIRE EXAMINATION

4 BY MR. ROBERTS:

5 Q. Dr. Scher, could you direct us to the place  
6 in either one of your reports where you say that the  
7 only thing that matters is the rotation of Ms. Garcia's  
8 vehicle?

9 A. I don't say the only thing that matters is  
10 the rotation of the vehicle.

11 Q. And just so we're totally clear for the Court  
12 on the conclusions that you would like to offer to the  
13 jury, the first thing you said you did was the PC-Crash  
14 analysis; right?

15 A. The first thing is the accident  
16 reconstruction analysis overall.

17 Q. Right. Okay. Using PC-Crash.

18 A. PC-Crash is part of that, yes.

19 Q. And -- and here -- here are the notes that  
20 your counsel wrote down when he was asking you what had  
21 to go into PC-Crash in order to get delta-v.

22 MR. STRASSBURG: Objection.

23 BY MR. ROBERTS:

24 Q. And you told --

25 MR. STRASSBURG: I don't represent him.

1 BY MR. ROBERTS:

2 Q. You told him speed --

3 MR. ROBERTS: I'm sorry, Your Honor.

4 THE COURT: Yeah, you said "your counsel," so  
5 that's true.

6 BY MR. ROBERTS:

7 Q. Okay. This is what you told --

8 THE COURT: Just say, these are the answers  
9 that you gave to Mr. Strassburg.

10 MR. ROBERTS: Yes.

11 BY MR. ROBERTS:

12 Q. Who hired you in this matter?

13 A. Mr. Strassburg.

14 Q. Who do you send your bills to?

15 A. Mr. Strassburg.

16 Q. Who pays it?

17 MR. MAZZEO: Beyond the scope of voir dire.

18 BY MR. ROBERTS:

19 Q. So Mr. Strassburg asked you what had to go  
20 into PC-Crash, what was important. You told him speed;  
21 correct?

22 A. I did.

23 Q. And you told him angles; correct?

24 A. That's right.

25 Q. And you told him vehicle specs; right?

1           A.     That's right.

2           Q.     And you want to know the mass of the vehicle;  
3 right? And the wheel base and the center of gravity,  
4 all that stuff?

5           A.     That's right.

6           Q.     So you plugged all this into PC-Crash, and  
7 one of the things you get out of PC-Crash is delta-v;  
8 right?

9           A.     That is a result, yes.

10          Q.     And this is delta-v of Ms. Garcia's vehicle;  
11 correct?

12          A.     Actually both vehicles, but yes.

13          Q.     But what -- what you used in your conclusion  
14 was the delta-v of Ms. Garcia's vehicle; right?

15          A.     That is one of my conclusions, yes.

16          Q.     Okay. And you concluded it could be no  
17 greater than 9; right?

18          A.     That was the upper bound, correct.

19          Q.     Okay. So another one of the drawings. Okay.  
20 So Ms. Garcia's vehicle is traveling along.

21          A.     I think there's a newer version.

22          Q.     Is there? Okay.

23                 MR. STRASSBURG: That's Court Exhibit 8.

24                 MR. ROBERTS: Oh, did you tear it off?

25                 MR. STRASSBURG: Yeah, I gave it to the

1 Court.

2 THE COURT: I have clips for you.

3 MR. ROBERTS: Got two, Your Honor. Audra  
4 beat you.

5 THE COURT: You got some?

6 MR. ROBERTS: Yes.

7 BY MR. ROBERTS:

8 Q. Okay. I have got now Court's Exhibit 8. Is  
9 that right? So Ms. Garcia's vehicle is traveling this  
10 way; right?

11 A. Down on the page, that's right.

12 Q. Okay. She's traveling southbound. And if  
13 she's going 30 miles an hour, that's her velocity. But  
14 there's no delta-v at this point as long as she's not  
15 accelerating or decelerating or moving laterally;  
16 right?

17 A. That's right.

18 Q. So now Mr. Garcia's -- excuse me.  
19 Mr. Awerbach's vehicle hits her. And the delta-v that  
20 you're calculating is caused by Mr. Awerbach's vehicle;  
21 right?

22 A. By the contact with it, yes.

23 Q. By the contact with it. Energy from  
24 Mr. Awerbach's vehicle is transferring to Ms. Garcia's  
25 vehicle and causing it to accelerate.

1 A. I would agree with that.

2 Q. Okay. And the reason you need to know the  
3 mass is the amount of energy Mr. Awerbach's vehicle  
4 has, one component is mass and another component is  
5 velocity; right?

6 A. That's true.

7 Q. So the more -- assuming the exact same angle  
8 of impact, the greater the speed, the higher the  
9 delta-v; right?

10 A. In general, yes.

11 Q. Assuming the same speed, the higher the  
12 angle, the less delta-v; right?

13 A. The delta-v direction will change, but maybe  
14 not the magnitude.

15 Q. Okay. Thank you. That is more accurate.

16 So in this case, before you even get to -- to  
17 MADYMO -- did I say that correctly?

18 A. I believe so.

19 Q. Okay. And that's Mathematical --

20 A. Dynamic Model.

21 Q. Thank you. Mathematical dynamic model.

22 In your report of August 21st of 2014, you  
23 provide national weighted estimates and percent of  
24 restraint far-sided occupants injured in lateral  
25 impacts with a delta-v between 5 and 10 miles an hour,

1 characterized by severity; right?

2 A. Let me pull that up. You're looking at  
3 which?

4 Q. I'm looking page 17 of your  
5 August 21st, 2014, report.

6 A. Page 17. Bear with me.

7 I'm there.

8 Q. Okay. So you look at some data from  
9 recognized sources, and you determine that, for  
10 delta-v's between 5 and 10, here are the reported  
11 injuries and reported injuries to the lumbar spine of  
12 two severities; right?

13 A. Yeah. There's more to it. So these are  
14 lateral impacts, single collisions. There's not  
15 multiple collision. These are far-side occupants. So  
16 there's more to it than just that. But, yes, the  
17 tables in here and the text describes it.

18 Q. And then you give the conclusion that "Based  
19 on the NASS/CDS data, it is unlikely that an individual  
20 would sustain AIS 2+ lumbar spine pathologies from an  
21 accident similar to the subject accident."

22 And the things that make it similar are  
23 lateral impact; right? Which is undisputed?

24 A. That's right.

25 Q. Far-sided, which undisputed, and delta-v;

1 right?

2 A. Those are all true.

3 Q. So one of the fundamental opinions you want  
4 to give is solely based from -- at least from a  
5 disputed standpoint, on delta-v; right?

6 A. No. So this is a check on the biomechanical  
7 and engineering analysis portion. And this actually  
8 comes in as a way of looking at delta-v's overall and  
9 injury likelihood. And so some of these may be pure  
10 lateral impacts and no rotation; some may have  
11 rotation. But the point being that, with or without  
12 it, we have zero cases with lumbar spine AIS 2+  
13 injuries.

14 Q. Right. And the database you used is delta-v  
15 between 5 and 10.

16 A. That's part of the query.

17 Q. And in this case you've calculated a delta-v  
18 of 9 using PC-Crash; correct?

19 A. 9 is the upper bound.

20 Q. Right. So let's assume that we changed a few  
21 of these things around a little bit and we got an upper  
22 bound of 11. Then this table would no longer apply;  
23 right? We'd have to look at different data.

24 A. I could do that, sure. Yes.

25 Q. So then what you told the Court is that you

1 took other data from your PC-Crash simulation and put  
2 it into MADYMO?

3 A. The output of PC-Crash into MADYMO.

4 Q. Right. And so this is very detailed output  
5 from PC-Crash that goes into your biomechanical  
6 program; right? And let's take a look at it. We don't  
7 have to -- to argue about semantics.

8 What you put into MADYMO was X, Y, and Z  
9 position and yaw, pitch, and roll rotation of the  
10 vehicles during the duration of the accident; right?

11 A. That's correct.

12 Q. And so it's not just the rotation of the  
13 vehicle that's important to you and that you entered  
14 into MADYMO; it's how fast the vehicle rotates around;  
15 right? Rotation by time.

16 A. Sure. All of these are time histories, of  
17 course.

18 Q. And this is your Attachment D. And all of  
19 this information that you put into MADYMO is the output  
20 from PC-Crash after you enter speed, angle, and all of  
21 the other things that you told Mr. Strassburg.

22 A. This is output, that's correct.

23 Q. Okay. And then MADYMO calculates sheer  
24 forces on the spine; right?

25 A. It does.



1 Q. Okay. And you calculated an axial force or  
2 compressive force; right?

3 A. Right. So let's be clear there is a force  
4 that has components in different directions.

5 Q. And the two you mentioned in your report as,  
6 in your words, most significant were the compressive  
7 axial force and the shear force.

8 A. That's right.

9 Q. And in your report you show the shear force  
10 going perpendicular to the -- to the body; right?

11 A. I show an anterior-posterior force.

12 Q. Right. And the force of the accident being  
13 balanced by the force of the ligaments in the muscles  
14 and the skeleton?

15 A. Not sure what you mean. Sorry.

16 Q. Force from the accident, resistive force of  
17 spine, ligaments, and muscles.

18 You prepared this; right? It's part of what  
19 you want to tell the jury?

20 A. I did, yes.

21 Q. And then what you want to tell the jury is --  
22 and this is page 65 of the PowerPoint that's been  
23 provided -- here is your occupant motion rotation only,  
24 and it shows that the occupant would experience a force  
25 making it go over toward the door of the vehicle;

1 right?

2 A. That's right. A rotational motion of the  
3 vehicle creates an outward motion for the occupant.

4 Q. Okay. And that would be a different type of  
5 force than you think happened in this case; right?

6 A. No, I think that's present in this case.

7 Q. The force from side to side?

8 A. There is some small shear force laterally.  
9 It's provided in my file. But as you can see, it's  
10 very small.

11 Q. Right. And reason that you say it's small  
12 and are going to tell the jury it's small is because in  
13 this case we've got rotational force which counteracts  
14 the lateral -- the -- the lateral force counteracts the  
15 rotational force; right?

16 A. It's close enough, yes. It's not quite how I  
17 would say it, but sure.

18 Q. Okay. And -- and then I think there's some  
19 slides in here where you actually show those two forces  
20 as counteracting in addition to the slide I just  
21 showed.

22 A. That's right.

23 Q. Now, in your reconstruction from your  
24 PC-Crash input, you have Ms. Garcia's vehicle going  
25 from the No. 1 travel lane going south, across the

1 median, and over into the No. 1 northbound lane; right?

2 A. In the animation that I showed, yes.

3 Q. Okay. And you would agree that it takes  
4 lateral force to move the vehicle from one side of the  
5 road over to the other side of the road.

6 A. Sure.

7 Q. And if the vehicle is staying in its lane,  
8 you've got more rotational force, and it's not being  
9 offset by the lateral force the way your calculations  
10 show.

11 A. Yeah. That would be physically impossible  
12 from what you described. It has to move laterally.  
13 And the only way it could get back into its original  
14 lane would be with the steering input that I mentioned  
15 earlier at the end of the accident sequence.

16 Q. So based on your calculations and the  
17 assumptions you've made about angles of impact, it has  
18 to move laterally?

19 A. Based on the laws of physics.

20 Q. Let's talk about crush for a minute. You  
21 would agree that there are no pictures or photographs  
22 you reviewed looking down from the top of the vehicle;  
23 right?

24 A. That's true.

25 Q. And so you attempted to use photogrammetry to

1 estimate crush; is that right?

2 A. That's right.

3 Q. And in your report you said that, since you  
4 couldn't actually go out and measure the crush, you had  
5 to come up with a range?

6 A. That's right.

7 Q. And you overstated that range; correct? You  
8 overestimated crush as a conservative measure?

9 A. That's right.

10 Q. Would you agree with me that, in order to  
11 conserve energy, as you have talked about doing in the  
12 laws of physics, that you've got a certain amount of  
13 energy that goes into an accident -- a collision, and  
14 those energies on one side have to equal the total  
15 energies on the other side?

16 A. You mean before and after the impact?

17 Q. Correct.

18 A. That's correct.

19 Q. So if there's more crush, there's less  
20 delta-v of Ms. Garcia's vehicle, because more of the  
21 energy, holding speed constant, angles constant, more  
22 crush equals less delta-v?

23 A. In general that's the right idea. In the  
24 number ranges that we're talking about, it makes a very  
25 minor impact. No pun intended.

1 Q. Mr. Garcia's vehicle was damaged on the  
2 passenger side; correct?

3 THE COURT: Ms. Garcia or Mr. Awerbach's?

4 MR. ROBERTS: I'm sorry, Your Honor. It gets  
5 that time of day; I start misstating everything.

6 BY MR. ROBERTS:

7 Q. Mr. Awerbach's vehicle was damaged on the  
8 passenger side; right?

9 A. That's correct. The passenger side of the  
10 front -- I'm sorry. It's front damage, more on the  
11 passenger side.

12 Q. Okay. So -- so you've got his vehicle. The  
13 angle goes like this; right?

14 A. Not sure which way is front on your paper for  
15 the vehicle.

16 Q. Okay. If this is Mr. Garcia's vehicle --

17 A. Why don't we use -- can we use something else  
18 where -- something that's more directional?

19 THE WITNESS: Can we use the tissue box, Your  
20 Honor?

21 THE COURT: How about this?

22 MR. ROBERTS: Okay.

23 THE WITNESS: Thanks.

24 MR. ROBERTS: Thank you.

25 /////

1 BY MR. ROBERTS:

2 Q. All right. So the spine is the front of the  
3 vehicle. You got Mr. Awerbach coming in like this, and  
4 then you got him turning left; right?

5 A. Correct.

6 Q. Assuming Ms. Garcia's going straight down the  
7 road, the vehicle -- the damage to Mr. Garcia's vehicle  
8 would be on the driver's side; right?

9 MR. SMITH: Mr. Awerbach.

10 BY MR. ROBERTS:

11 Q. Mr. Awerbach's vehicle would be on the  
12 driver's side. So if Mr. Awerbach turns left as you  
13 state, the -- and Ms. Garcia's parallel, the damage is  
14 going to be on the driver's side; right?

15 A. If you angle it in like that, sure. But if  
16 you have the contact -- may I?

17 Q. Sure.

18 A. Okay.

19 If you have the contact coming in like this,  
20 and she's swerving this way (witness indicating) -- and  
21 I am pointing -- she is driving down the street swerved  
22 to the left. So on the paper she's going to the right.  
23 He's coming in this way, to the right on the paper.  
24 And, remember, there's contact with the wheel. And  
25 that's contacting the driver's side of his vehicle.

1           The wheel rotates around as she's moving out  
2 this direction. That would account for the scuffs, the  
3 marks that we see on the bumper of the Forenza, and it  
4 matches up well with how the impact that actually  
5 created the force on both vehicles.

6           Q. But in order to make that work, you've got to  
7 turn Ms. Garcia's vehicle at an angle heading over into  
8 the northbound lanes; right?

9           A. A slight degree, which is what she testifies  
10 to.

11          Q. Does she testify to what the angle was or did  
12 you have to guess at that?

13          A. I wouldn't say it's a guess. I would say  
14 we'd --

15               MR. MAZZEO: Objection, Judge. There's  
16 nothing in -- in -- in the -- the amount of angle by  
17 Ms. Garcia. There's no testimony regarding that.

18               THE COURT: So you didn't want him to testify  
19 about it?

20               MR. MAZZEO: Withdrawn.

21               THE COURT: The question was did she testify  
22 to what the angle was, or did you have to guess; right?

23               MR. ROBERTS: That was the question.

24               MR. TINDALL: The objection, then, would be  
25 vagueness, whether he was guessing about the testimony

1 or guessing about the angle.

2 THE COURT: I'm going to let him answer.

3 THE WITNESS: I used what I thought were  
4 reasonable estimates of what it could be.

5 BY MR. ROBERTS:

6 Q. And the reason that you felt your estimates  
7 are reasonable is that's the angles that you had to use  
8 in order for the rest of your calculations to come up  
9 the way you wanted them to; right?

10 A. Well, I wouldn't quite say it like that  
11 because I didn't have any way that I wanted them to  
12 come up with. What I would say is that, in order for  
13 everything to be consistent, it had a very narrow range  
14 of angles that she could have turned at. She can't  
15 turn 45 degrees and then have the damage to her  
16 vehicle, the damage to Awerbach's vehicle, her rotation  
17 of 180 degrees match up. It wouldn't work.

18 Q. And -- and, actually, if you read her whole  
19 testimony, she says she saw something coming really  
20 fast at the corner of her eye and tried to swerve. But  
21 as a reconstructionist, you know about  
22 perception-reaction time, and you know that she  
23 probably didn't have time to turn at all. In the time  
24 where she barely saw him out of the corner of her eye,  
25 she didn't have 2.5 seconds to perceive and react and



1 input steering motion, did she?

2 MR. MAZZEO: Objection, Judge. Relevance to  
3 the scope of inquiry for -- for establishing his  
4 credibility for doing the PC-Crash analysis. This --

5 THE COURT: Overruled.

6 THE WITNESS: I think it is possible for her  
7 to have initiated a swerving motion.

8 THE COURT: Finish up, Mr. Roberts.

9 MR. ROBERTS: Thank you.

10 BY MR. ROBERTS:

11 Q. And, in fact, her quote from her deposition  
12 was, "I thought I could swerve because I did see him  
13 coming really fast."

14 MR. STRASSBURG: Page 22.

15 BY MR. ROBERTS:

16 Q. And, finally, you're not telling us that your  
17 report is incorrect when it says in two places that you  
18 tried to validate your PC-Crash inputs and your  
19 simulation by verifying that the final resting place of  
20 the vehicle matched the location set forth by the  
21 witnesses; right?

22 A. I probably should have been more precise in  
23 my language in terms of what I meant by that, and,  
24 specifically, it's Ms. Garcia's vehicle rotating  
25 180 degrees.

1           Sorry. I'm not a lawyer. I'm an engineer.  
2 I don't use words as well as you guys.

3           Q.    Okay. So when you said "final resting  
4 place," you didn't mean final resting place; you meant  
5 the rotation and motion of the vehicle before it ended  
6 up in the resting place.

7           A.    No. I mean the final orientation of the  
8 vehicle.

9           MR. ROBERTS: Okay. Your Honor, I'm sorry.  
10 Thank you for your indulgence.

11          THE COURT: You guys done?

12          MR. MAZZEO: Yes.

13          MR. STRASSBURG: Sure.

14          MR. MAZZEO: Judge, I'd just like to make  
15 one -- not for the witness. I'm done with the witness.  
16 But I -- I -- you cited Hallmark earlier, and I just  
17 wanted to distinguish that from this case.

18          THE COURT: Okay.

19          MR. MAZZEO: All right. So Hallmark is the  
20 distinguishable, as you -- as you put into the record,  
21 you had stated that Tradewinds did not introduce any  
22 evidence; that Dr. Bowles attempted to recreate the  
23 collision by performing an experiment.

24               Well, in this case Dr. Scher did recreate the  
25 collision by -- by -- he performed a check and actual

1 reconstruction that focused on the -- obtaining the  
2 180-degree spin, and he used all those factors -- I  
3 don't need to go through all of them again, but the  
4 vehicle specs, the points of impact, the area of  
5 contact, or the -- in the roadway, which really wasn't  
6 relevant for the analysis. But he used -- he used the  
7 actual area of initial contact in the roadway.

8           And -- and I cited earlier the reference to  
9 Provence v. Cunningham which is a case after the --  
10 that 1968 case you had cited.

11           THE COURT: Choat, Levine?

12           MR. MAZZEO: Yeah, regarding photographs.

13           And this is -- this case, the Provence case,  
14 is 95 Nev. 4 and 588 P.2d 1020. And that's a 1979  
15 case, and -- where the Court ruled that photographs are  
16 not per se invalid as a basis for expert testimony in  
17 accident reconstruction cases.

18           So I just wanted to add that to the arguments  
19 that we cited earlier.

20           And also, Judge -- oh, that's right. And in  
21 the Provence case, the Court noted that expert  
22 testimony further -- the expert witness further  
23 testified that the precise area of impact could not be  
24 determined on the basis of the available information  
25 since the angle of impact and the speed of the vehicles

1 were unknown and no marks were made by the motorcycle  
2 upon the pavement at the time that the impact occurred.

3 He did testify as to -- the expert did --  
4 testify as to the range of probabilities, which  
5 included the possibility that the accident had occurred  
6 in the northbound lane.

7 So based on the cases that we cited and the  
8 testimony of Dr. Scher, as to all the data that he  
9 replied upon and the fact that it satisfies the  
10 requirements of the PC-Crash analysis, I would  
11 encourage the Court to change its prior decision or  
12 ruling in excluding him as an expert with respect to  
13 the accident -- the PC-Crash analysis.

14 MR. ROBERTS: And in Provence, it was  
15 rebuttal evidence that was deemed admissible and the  
16 court said, "You just put on a witness that had no  
17 greater foundation than him. You can't now be heard to  
18 say that their rebuttal expert can't give opinions on  
19 the same level of information. So it's not in  
20 evidence."

21 THE COURT: Okay, guys. I understand the  
22 distinction that you have tried to draw.  
23 Unfortunately, I think his calculations in MADYMO are  
24 still based on the output from the PC-Crash. The  
25 PC-Crash analysis is based on speed, angles -- I mean,

1 that's where you get the delta-v from. And I think all  
2 of the information that went into that is,  
3 unfortunately, more assumption, conjecture, and  
4 generalization.

5 I don't take any pleasure in not allowing you  
6 to put him on. That's -- I think that's what I have to  
7 do in the case. You haven't changed my mind. I'm  
8 sorry.

9 So thanks for being here, Dr. Scher. I don't  
10 think we're going to need you any further. Appreciate  
11 your time.

12 When we start tomorrow morning, I'm guessing  
13 that you guys have more witnesses.

14 MR. ROBERTS: Well, they had originally asked  
15 to take Poindexter, I believe, out of order tomorrow  
16 because of his schedule. We're still willing to  
17 accommodate that, but we're also ready to go if they  
18 don't need that anymore.

19 MR. MAZZEO: Yeah. No, we didn't ask to take  
20 him out order. We had scheduled Dr. Poindexter for the  
21 defense case, which we anticipated starting days before  
22 Friday. So he's been scheduled for Friday for several  
23 weeks now. And so we -- yeah, we do plan on calling  
24 him tomorrow morning. That's his only --

25 THE COURT: Okay.

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MR. MAZZEO: -- availability.

THE COURT: Okay. All right. Start at 8:30,  
get through as much as we can.

Thanks, guys. Off the record.

(Thereupon, the proceedings  
concluded at 5:05 p.m.)

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CERTIFICATE OF REPORTER

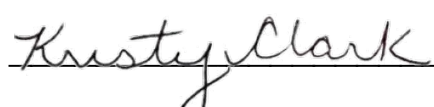
STATE OF NEVADA )  
COUNTY OF CLARK ) ss:

I, Kristy L. Clark, a duly commissioned  
Notary Public, Clark County, State of Nevada, do hereby  
certify: That I reported the proceedings commencing on  
Thursday, February 25, 2016, at 10:50 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  
25th day of February, 2016.

  
KRISTY L. CLARK, CCR #708

<p>BY MR. MAZZEO: [3]  171/19 174/10 175/8  BY MR. ROBERTS: [16]  67/23 71/15 72/4 177/3  177/22 177/25 178/5  178/10 178/17 180/6  189/5 189/24 190/9 192/4  193/9 193/14  BY MR. STRASSBURG: [50]  5/23 8/13 11/14 20/17  23/5 26/19 28/15 31/25  32/16 34/17 35/8 35/25  37/7 39/12 40/4 40/24  43/16 59/2 60/16 62/6  63/9 64/12 65/6 66/3  80/4 81/2 85/21 88/13  90/5 90/25 93/6 94/8  95/4 97/2 98/3 99/9  104/19 105/12 111/24  112/10 148/14 149/5  158/4 160/5 160/24 162/8  168/6 169/2 169/12  169/25  MR. MAZZEO: [27] 4/16  79/21 127/20 128/3 132/4  133/6 134/5 139/14 140/5  144/1 144/7 144/19  144/25 170/24 171/16  176/13 176/23 178/16  191/14 191/19 193/1  194/11 194/13 194/18  195/11 197/18 197/25  MR. ROBERTS: [85] 4/18  8/11 11/12 20/10 22/20  23/2 26/17 28/7 31/22  32/14 34/13 35/2 35/20  36/16 37/5 39/10 40/2  40/22 43/10 58/22 60/12  62/2 62/4 63/7 63/16  64/5 65/4 66/1 67/12  67/20 70/5 70/8 70/12  70/19 71/7 80/21 85/18  88/10 90/3 90/23 93/4  93/24 95/2 98/1 99/7  104/16 104/23 105/2  111/18 112/6 112/17  113/24 114/13 114/21  114/24 127/17 127/19  130/9 132/19 134/2  143/24 146/10 148/18  158/2 160/16 161/21  168/4 168/22 169/11  169/20 174/5 176/25  178/2 178/9 179/23 180/2  180/5 189/3 189/21  189/23 191/22 193/8  194/8 196/13 197/13  MR. SMITH: [13] 48/17  48/20 48/25 49/4 53/1  54/4 56/17 56/24 57/9  57/21 58/5 58/7 190/8  MR. STRASSBURG: [80]  4/17 5/3 8/10 11/11 20/8  22/23 23/4 26/16 28/9  28/13 32/13 34/12 35/3  35/6 35/18 35/24 36/20</p>	<p>37/3 39/9 39/25 40/21  43/9 43/14 46/22 46/25  52/7 53/25 54/15 55/22  56/3 56/7 56/12 56/15  57/13 60/10 62/1 62/3  63/5 63/15 64/3 65/3  65/25 70/3 70/6 70/9  70/15 70/23 71/2 71/4  71/10 71/13 71/23 81/1  88/9 90/2 90/22 93/3  93/23 95/1 96/25 97/25  99/6 122/10 122/21  132/23 140/6 140/19  141/1 141/25 143/22  143/25 168/25 170/11  171/7 177/21 177/24  179/22 179/24 193/13  194/12  MR. TINDALL: [1] 191/23  MS. ESTANISLAO: [4]  57/2 57/4 58/10 58/21  THE CLERK: [4] 5/10  5/15 171/10 171/14  THE COURT: [147] 4/4  4/11 4/19 5/6 5/19 8/12  11/13 20/12 20/15 22/21  23/3 26/18 28/10 31/23  32/15 34/16 35/4 35/21  36/18 36/22 37/2 37/6  39/11 40/3 40/23 43/15  46/20 46/24 47/2 48/13  48/19 48/23 49/3 54/16  54/24 55/2 55/6 55/10  55/13 56/2 56/4 56/9  56/14 56/16 56/18 56/23  56/25 57/3 57/5 57/12  58/3 58/6 58/8 58/11  58/16 58/23 60/11 60/15  62/5 63/6 63/8 63/17  64/4 64/7 64/10 65/5  66/2 67/15 67/18 70/7  70/22 79/23 80/2 80/24  85/20 88/12 90/4 90/24  93/5 93/25 95/3 97/1  98/2 99/8 104/18 104/25  105/5 111/20 112/7  112/20 112/23 113/21  114/6 114/18 114/23  122/16 127/18 128/1  130/7 132/22 132/24  133/2 134/10 139/18  140/8 140/20 140/22  141/23 143/20 143/23  144/6 144/18 144/22  148/6 148/19 159/24  160/3 160/18 161/23  168/24 169/1 169/22  171/1 171/9 171/12  171/15 174/6 175/7  176/21 176/24 178/3  178/7 180/1 180/4 189/2  189/20 191/17 191/20  192/1 193/4 193/7 194/10  194/17 195/10 196/20  197/24 198/1  THE MARSHAL: [6] 4/7  4/10 56/22 58/12 58/15</p>	<p>160/2  THE WITNESS: [31] 5/14  5/17 54/23 54/25 55/3  55/8 55/12 56/1 57/15  63/18 71/1 71/3 71/5  71/8 71/12 71/25 85/19  94/1 104/17 105/6 111/22  112/9 148/20 160/19  161/25 169/23 174/7  189/18 189/22 192/2  193/5  \$  \$1,000 [1] 167/13  \$1,500 [1] 167/13  \$10,000 [1] 167/15  '  '2007 [1] 50/3  .  .7 [2] 103/8 138/9  .8 [2] 103/7 138/7  .9 [2] 103/8 138/9  0  0 inches [1] 94/21  0 miles [1] 84/17  0.8 [1] 75/4  1  10 [4] 17/3 55/7 182/10  183/15  10 degrees [1] 74/1  10 miles [3] 153/23  158/24 181/25  10,000 [1] 14/8  10,000 pounds [1] 14/10  100 [3] 173/7 173/21  173/24  100 feet [7] 38/14 68/17  68/25 69/13 72/14 116/11  175/20  1020 [1] 195/14  10:00 [1] 48/5  10:30 [1] 48/5  10:50 [2] 4/2 199/7  10th [2] 2/15 115/25  11 [4] 17/3 49/13 49/18  183/22  12 [1] 37/5  129 [1] 127/25  13 [2] 39/10 39/14  13529 [1] 1/24  14 [5] 40/2 40/6 76/19  116/19 136/24  14 miles [2] 76/9 116/3  148 [1] 3/6  15 [2] 40/22 41/2  15-minute [2] 48/5 48/6  1500 [1] 2/5  16 [2] 43/10 43/18  17 [2] 182/4 182/6  171 [1] 3/7  177 [1] 3/5  18 [2] 76/24 162/8  180 [5] 75/17 86/24</p>
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<b>1</b>	<b>3</b>	<b>6:00 p.m [1] 38/14</b>
180... [3] 150/20 159/7 164/13	3.58 [2] 7/10 7/12	<b>7</b>
180 degrees [15] 78/16 78/18 78/21 142/8 142/11 142/24 154/2 156/10 158/19 161/5 163/10 165/9 166/18 192/17 193/25	3.71 [1] 7/22	702 [4] 2/5 2/11 2/16 2/21
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180-degrees [1] 159/24	30 miles [9] 38/16 83/19 84/15 115/14 115/18 136/25 142/23 143/16 180/13	<b>8</b>
19 [2] 97/1 97/4	30 years [1] 141/18	80 miles [1] 84/16
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2.5 [1] 192/25	36 [4] 64/4 64/5 65/4 65/8	938-3838 [1] 2/11
20 [12] 76/17 76/19 76/24 83/25 98/1 98/5 115/18 115/19 115/22 115/22 116/6 136/24	360 degrees [2] 86/23 161/7	95 [2] 176/17 195/14
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27 [2] 90/23 173/7	5940 [1] 2/20	
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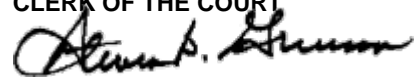
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1 CASE NO. A-11-637772-C  
2 DEPT. NO. 30  
3 DOCKET U  
4

5 DISTRICT COURT  
6 CLARK COUNTY, NEVADA

7 \* \* \* \* \*

8  
9 EMILIA GARCIA, individually, )  
10 Plaintiff, )  
11 vs. )  
12 JARED AWERBACH, individually; )  
13 ANDREA AWERBACH, individually; )  
14 DOES I-X, and ROE CORPORATIONS )  
15 I-X, inclusive, )  
Defendants. )  
16

17 REPORTER'S TRANSCRIPT  
18 OF  
19 JURY TRIAL  
20 BEFORE THE HONORABLE JERRY A. WIESE, II  
21 DEPARTMENT XXX  
22 DATED FRIDAY, FEBRUARY 26, 2016  
23  
24 REPORTED BY: KRISTY L. CLARK, RPR, NV CCR #708,  
25 CA CSR #13529

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24 \* \* \* \* \*

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1 LAS VEGAS, NEVADA, FRIDAY, FEBRUARY 26, 2016;

2 8:34 A.M.

3  
4 P R O C E E D I N G S

5 \* \* \* \* \*

6  
7 THE COURT: We're back on the record,  
8 Case No. A637772. We're outside the presence of the  
9 jury.

10 What do we got, guys?

11 MR. STRASSBURG: Judge, the defendant, Jared  
12 Awerbach, would move into the record Court Exhibits 9,  
13 10, and 11, which are the reports of Dr. Scher and his  
14 PowerPoint from yesterday.

15 THE COURT: Okay. I think that's important  
16 for appeal. It will be part of the Court record.

17 What else?

18 MR. SMITH: We just wanted to briefly discuss  
19 Dr. Poindexter's opinions before he takes the stand  
20 this morning just to alert the Court to the prior order  
21 that was entered by Judge Allf.

22 There was an order on February 25th of 2015.  
23 It's an order that Judge Allf wrote herself. There is  
24 a portion of it in response to a -- ordering on a  
25 motion to strike where she explains on page 3 of the

1 order beginning at line 18, "As to Dr. Poindexter, the  
2 Court grants the motion to strike as to the billing  
3 records because they were not timely disclosed.  
4 Dr. Poindexter is limited to opinions set forth at the  
5 time of the expert disclosure deadline. To remain  
6 consistent with previous rulings, Dr. Poindexter is  
7 allowed to consider the opinions of others as part of  
8 his opinion, but they are foundational only."

9           There are two parts of that that I just want  
10 to bring to your attention. The first is on the  
11 billing records. His only billing record or billing  
12 opinion that he offers prior to the expert disclosure  
13 deadline is that he agrees with Dr. Oliveri's opinions  
14 regarding Pacific Hospital and Dr. Gross. As you've  
15 heard, Dr. Oliveri says that he agreed with the Pacific  
16 Hospital record bill, and he had some changes to  
17 Dr. Gross's bills. But Dr. Poindexter can't just  
18 parrot Dr. Oliveri's opinion. I guess he could say  
19 that he agrees with it if he's on the stand, but that's  
20 the extent of the billing opinions.

21           With respect to other opinions, he has some  
22 detail of what other defense experts say in his report,  
23 some of whom have been excluded, including Nurse  
24 Rockholt and Dr. Scher. He can't repeat their opinion  
25 because he doesn't have any foundation to offer

1 accident reconstruction, biomechanical, or billing  
2 opinions.

3           And, in fact, with respect to the bills, I  
4 also want to bring to the Court's attention that he  
5 admitted in his deposition he had not actually reviewed  
6 the line items on the bills or reviewed them in any  
7 detail. So before the defense attempts to offer any  
8 billing opinions, if they want to -- and we haven't  
9 discussed this and they may not. But if they intend to  
10 offer any billing opinions, they have to lay some  
11 foundation because he admitted in his deposition, which  
12 was after the expert disclosure deadline, that he had  
13 not actually reviewed the line item list.

14           THE COURT: Okay.

15           MR. MAZZEO: Yes. And I -- and I -- I  
16 appreciate Mr. Smith bringing this up prior to his  
17 testimony. I'm aware of the scope of -- scope of the  
18 orders that limit Dr. Poindexter's opinions at trial,  
19 and I believe his testimony will be within the confines  
20 of the orders that were provided.

21           THE COURT: Okay. If there's an issue, just  
22 raise it when it happens.

23           Anything else, guys?

24           MR. MOTT: One housekeeping, Your Honor. And  
25 we can replace these at some other point, but just to

1 get it on the record real quick.

2 We had to make additional redactions to some  
3 of the medical records -- so Exhibits 26, 22, and 8 --  
4 for reference to insurance on them. And one of them  
5 had social security number on them. So I -- it's  
6 Dr. Lemper's records, Dr. Gross's records, and the  
7 Ultimate Collision Repair Center.

8 I don't know that any will come up. So I  
9 don't know that it's necessary to do it now and  
10 actually get started and we can --

11 THE COURT: We can do it during a break.

12 MR. MOTT: Okay. Thank you.

13 THE COURT: All right. We ready, guys?

14 MR. MAZZEO: Ready. Ready, Your Honor.

15 THE COURT: All right. Let's go.

16 (Discussion was held off the record.)

17 THE MARSHAL: Jury entering.

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

20 THE MARSHAL: Jury is present, Judge.

21 THE COURT: Thank you, Tom.

22 Go ahead and be seated. Good morning, ladies  
23 and gentlemen. We're back on the record, Case  
24 No. A637772.

25 Do the parties stipulate to the presence of

1 the jury?

2 MR. ROBERTS: Yes, Your Honor.

3 MR. MAZZEO: Yes, Your Honor.

4 MR. STRASSBURG: Yes, Judge.

5 THE COURT: Okay. Folks, so you got stuck  
6 out in the hallway yesterday, and then I sent you home  
7 without bringing you back in. Sometimes things like  
8 that happen. And I know I told you at the beginning of  
9 trial, sometimes scheduling things like that -- and  
10 it's just outside of our control.

11 I'm going to tell you that the Court  
12 concluded yesterday that there was inadequate  
13 foundation for Dr. Scher's testimony. So you're  
14 instructed to disregard his testimony that you heard  
15 yesterday.

16 This morning -- we are still not finished  
17 with the plaintiff's case, but I believe the defense  
18 has another expert that is scheduled to be here. So  
19 we're going to take that expert out of order.

20 Mr. Mazzeo, go ahead.

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

22 At this time we call Dr. Curtis Poindexter.

23 THE COURT: Come on up, Doctor. If you come  
24 all the way up on the witness stand. Once you get  
25 there, please remain standing and raise your right hand



1 to be sworn.

2 THE WITNESS: Good morning.

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

7 THE WITNESS: I do, yes.

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

10 THE WITNESS: Curtis Poindexter,  
11 P-o-i-n-d-e-x-t-e-r.

12 MR. MAZZEO: May I proceed, Your Honor?

13 THE COURT: You may.

14

15 DIRECT EXAMINATION

16 BY MR. MAZZEO:

17 Q. Dr. Poindexter, thank you for taking time out  
18 of your schedule to be with us today.

19 A. Welcome.

20 Q. And would you please -- we're going to go  
21 over some preliminary background information from you.

22 Would you please state your occupation to the  
23 jury.

24 A. I'm a specialist in physical medicine and  
25 rehabilitation. We're called physiatrists also. Let

1 me tell what that encompasses.

2 We deal with any neuromuscular problem from  
3 head to toe. Could be neck, back problems. Could be  
4 strokes. My subspecialty is brain injury rehab. I  
5 deal with a large number of -- excuse me -- patients  
6 that have spinal problems, pre and postsurgery. I deal  
7 with any person with joint problems pre and  
8 postsurgery.

9 So a variety of things that would incur any  
10 kind of nerve or bone or muscle damage.

11 Q. Thank you. By the way, Dr. Poindexter, is  
12 the monitor blocking your vision or view of any of the  
13 jurors?

14 A. No.

15 Q. You're fine. Okay. Great.

16 And would you please tell the jurors your  
17 educational background from high school on.

18 A. I attended college at the University of  
19 Texas, San Antonio. Obtained a biology degree -- a  
20 bachelor of science degree in biology. I then went to  
21 the University of Texas Health Science Center in San  
22 Antonio for medical school and obtained an MD degree  
23 there.

24 And then I went to a four-year residency in  
25 rehab medicine in New Orleans, Louisiana, in the LSU

1 Medical Center and Charity Hospital System and  
2 graduated from there as a rehab doctor and then came to  
3 Las Vegas, worked for a doctor for a year, and then  
4 went on my own -- in my own practice starting in about  
5 January of 1993 until now.

6 Q. Okay. Thank you. And would you please  
7 describe and tell the jurors any postgraduate training  
8 and experience you have in your area of specialty.

9 A. I didn't go to a fellowship. I've gone to a  
10 couple of different courses for certain parts of the  
11 specialty but didn't attend a fellowship. After I went  
12 to practice here, didn't have any more time; had a very  
13 busy practice since then.

14 Q. Now, Doctor, are you board-certified?

15 A. I am board-eligible. And in rehab medicine,  
16 I have certification in -- with the American Academy of  
17 Pain Management, which is a multidisciplinary academy.

18 Q. And you -- you gave us a description of  
19 your -- the scope of your work as a physiatrist,  
20 physical medicine and rehabilitation doctor.

21 How does that -- how is that different from a  
22 pain medicine doctor?

23 A. Well, a pain medicine doctor can cover  
24 essentially two specialties: my specialty in rehab  
25 medicine or an anesthesiologist, which does pain

1 management.

2           Anesthesiologists, their route would be to  
3 deal with the same kind of patients, but they likely  
4 would provide a variety of spinal injections,  
5 epidurals, nerve blocks whereas -- and some in my field  
6 of rehab medicine can do the same thing if they have  
7 the training. A small percentage of rehab doctors do  
8 that. And the vast majority of the rehab doctors in  
9 pain management don't perform those injections, but we  
10 deal with the same kind of patients for pain disorders  
11 in trying to decrease their pain and improve their  
12 functioning.

13           Q. And what, if any, consultant positions have  
14 you held during the course of your career?

15           A. I've had a few of those. I'm a medical  
16 director for a brain injury program, the Nevada  
17 Community Enrichment Program. And I've been their only  
18 medical director for the last 22 years.

19           I was a medical director for a place called  
20 NeuroRestorative, which is owned by The MENTOR Network  
21 out of Illinois, but I worked in Florida for about  
22 three and a half years and resigned from that position  
23 in March of last year. And I've worked with brain  
24 injury patients there with all of their care for brain  
25 injury rehab and some very intense problems with

1 psychosis-associated brain injury also there.

2 I was a comedical director for Horizon  
3 Specialty Hospital here in Las Vegas back in the '90s  
4 for two or three years and helped to coordinate care  
5 for the inpatient -- inpatients in the hospital.

6 I was the -- a medical director for an  
7 outpatient facility at HealthSouth years ago, when they  
8 had their facilities here in town. And that was back  
9 also in, I think, the '90s.

10 Q. Thank you, Doctor. And by the way, when did  
11 you -- what states do you have -- are you licensed to  
12 practice medicine?

13 A. Nevada and Florida.

14 Q. And what -- what year did you obtain your  
15 license?

16 A. Nevada was in September 1991. Florida was  
17 approximately four years ago, four and a half years  
18 ago.

19 Q. Okay. Thank you. And as a medical doctor,  
20 are you required to complete continuing medical  
21 education courses?

22 A. Yes. We have to provide 40 continuing  
23 medical credits per two years. That could be done at a  
24 conference, or it could be done online. There's a  
25 variety of sources we can go through to get those.

1 Q. Now, during the course of your career, have  
2 you given any presentations?

3 A. Only a couple. One was in Florida about two  
4 years ago for various case managers concerning the  
5 brain injury program there and what we offered there.  
6 I can't remember the other one. Several years ago, I  
7 presented something in a conference.

8 Q. Thank you. And what professional  
9 associations and affiliations do you belong to?

10 A. AMA; ACRM is Academy of Rehab Management;  
11 AAPM&R is a rehab academy also. And then a couple  
12 societies here in Las Vegas: Clark County Medical  
13 Society; one other I can't remember now.

14 Q. Do you consider yourself well versed in the  
15 anatomy of the spine?

16 A. Yes.

17 Q. And would you tell the jurors your -- the  
18 nature and scope of your medical practice.

19 A. The vast majority of my practice is  
20 evaluating and treating patients with all the types  
21 I've mentioned before and including covering medical  
22 director of services for the entities that I've talked  
23 about.

24 Three fourths of my practice is patient care.  
25 About a fourth is medical-legal situations where I do

1 record reviews; IMEs where I see a patient one time,  
2 look at their records, give an opinion; second opinions  
3 in a medical-legal setting; or second-opinion IMEs for  
4 a work comp patient or injury.

5 Q. And would you describe your experience in  
6 diagnosing and treating spinal injuries and conditions.

7 A. Vast. I've seen thousands and thousands of  
8 patients with spinal problems, neck, mid back, and  
9 lower back, and dealing with the vast majority of  
10 diagnoses and problems.

11 Q. And what percentage of the forensic work that  
12 you do, the medical-legal work that you do, is for  
13 plaintiffs versus defendants?

14 A. About 85 percent would probably be  
15 defendant -- defendant-type work. And about  
16 15 percent, maybe 20 percent of the times would be  
17 plaintiff work where I have a treating patient and  
18 I'm -- I've come to court for them.

19 Q. And how do you account for that discrepancy,  
20 or why do you think there is that discrepancy? Why do  
21 you -- why do you do more for the defense than the  
22 plaintiff?

23 A. In rehab medicine, we -- we are trained to  
24 provide a very conservative approach for treatment, to  
25 help people move along in their care as conservatively

1 as possible with limited procedures, limited surgeries,  
2 and try to improve their functioning without a -- an  
3 evasive procedure. Sometimes that's not possible.

4 But we're the ones that work up patients to a  
5 point where they're either plateaued and they're  
6 finished with their care and they're good or they're --  
7 they need something else like a surgery. But we work  
8 them up completely until they get to that point.

9 Q. Now, are the terms "physiatrist" and  
10 "physical medicine and rehab physician"  
11 interchangeable?

12 A. Yes.

13 Q. They are. Okay.

14 And -- and -- and I'm not sure if I caught  
15 your answer earlier when you were talking about the  
16 scope of your role as a PM&R doctor.

17 Does your work include designing  
18 comprehensive pain-centered treatment plans or, in  
19 other words, life-care plans or medical plans for  
20 patients?

21 A. I have performed four or five life-care plans  
22 for patients for catastrophic or lifelong problems.

23 Q. Okay. And do you have -- what is your --  
24 what special training, education, and experience do you  
25 have in performing medical record reviews, as you've



1 done in this case?

2 A. All of my training up to this point led me to  
3 have the ability to do those things. We have -- we're  
4 the most comprehensive doctors that look at the whole  
5 picture in a patient and look at everything they  
6 possibly could need for treatment to get to the end of  
7 their care.

8 MR. MAZZEO: Your Honor, at this time I'll --  
9 going to move the Court to recognize Dr. Poindexter as  
10 an expert in physical medicine and rehabilitation.

11 THE COURT: Any objection?

12 MR. ROBERTS: Yes, Your Honor. We don't  
13 agree.

14 THE COURT: I think he's laid the proper  
15 foundation. He'll be recognized.

16 MR. MAZZEO: Thank you, Judge.

17 THE WITNESS: Pardon me. Is there any more  
18 water, by any chance?

19 THE COURT: Is that empty?

20 THE WITNESS: It's empty, yes, sir.

21 MR. MAZZEO: Here. I'll leave this up for  
22 you.

23 BY MR. MAZZEO:

24 Q. Okay. Doctor, in this case, would you tell  
25 the jurors the nature of your assignment.

1           A.    I was asked to provide a record review of a  
2 vast -- a vast amount of records concerning an auto  
3 accident case which Ms. Garcia was involved in, to  
4 review all of what has occurred in her case, to review  
5 her -- any problems related to the accident and any  
6 appropriate treatment plan, trying to see how she would  
7 get to the end of care for any injuries that incurred.

8           Q.    And did your record review include an  
9 assessment for the necessity of Dr. Oliveri's life-care  
10 plan?

11          A.    Yes.

12          Q.    Thank you. And as a result of your record  
13 review, you drafted a report from that record review  
14 dated October 13th of 2014; correct?

15          A.    Yes.

16          Q.    Okay. And then after that, you had also  
17 reviewed additional records through -- treatment  
18 records for Ms. Garcia through December of 2015;  
19 correct?

20          A.    Yes.

21          Q.    Okay. And by the way, did your subsequent  
22 review of the -- of the additional records through  
23 December of 2015 change any of the opinions that you  
24 made with respect to your original findings from your  
25 record review?

1           A.     No.

2           Q.     Okay.  Now, would you tell us what a forensic  
3 medical record review consists of.  And I -- and I know  
4 you -- I know you touched upon it.  Or is it the same  
5 answer?

6           A.     It just looks at everything available to you  
7 concerning the initial event of the accident, whatever  
8 information you have available to you, any initial  
9 treatments, substance treatment testing, symptoms the  
10 patient experiences, objective findings or lack of  
11 objective findings, what the tests showed, what the  
12 next step might be for treatments, and how the plan of  
13 care should go along to get a patient to fruition and  
14 end their care.

15          Q.     And what is your responsibility as a -- as a  
16 physician when you perform a medical record review?

17          A.     To give a in-depth and objective impartial  
18 opinion.

19          Q.     What assumptions do you make prior to  
20 undertaking a medical record review in a medical-legal  
21 claim case?

22          A.     I don't make any assumptions.

23          Q.     Okay.  And what steps do you take to ensure  
24 an objective evaluation is performed?

25          A.     Well, I practice -- I practice every day.  So

1 I consider that -- I do that same thing in record  
2 review. So I look at what occurred.

3 And in my training, I -- I am well versed in  
4 spinal problems and back problems and what should occur  
5 in a case, just to go through the process and see what  
6 did occur and if it's appropriate or I agree with it or  
7 don't agree with it.

8 Q. Thank you. And, of course, you were paid to  
9 perform this medical record review; correct?

10 A. Yes.

11 Q. How much were you paid?

12 A. I don't actually know the exact figure.

13 Q. If not exactly, if you can't find the bill,  
14 then at least approximation.

15 A. Approximately \$2,000. I don't remember the  
16 exact figure for the record review. Subsequent review  
17 might have been \$700, \$800.

18 Q. Okay. And are you paid to offer any  
19 particular opinion as you testify here in court today?

20 A. No.

21 Q. Okay. But you are paid for your time to  
22 testify in court; correct?

23 A. Yes.

24 Q. What are you being paid for your time today?

25 A. I charge, for a half day, \$3,500.

1           Q.    Okay.  Thank you.  And are all the opinions  
2 you'll express today to a reasonable degree of medical  
3 probability?

4           A.    Yes.

5           Q.    Thank you.  What percentage of spinal care is  
6 provided by nonsurgeons?

7           A.    The vast majority, probably 80 to 85 percent.

8           Q.    And what practitioner provides the most  
9 spinal care, in your estimation?

10          A.    The most would be physiatrists like myself.  
11 You can have some primary care doctors taking care of  
12 their own patients in their practice.  But if they have  
13 a complicated situation or problem, they would usually  
14 refer out to somebody like myself.

15          Q.    Okay.  And just -- we have to be mindful of  
16 the court reporter.  She's straining now.  I see her.

17          A.    I'm from Texas.  I apologize.

18          Q.    So if you would -- and I might remind you at  
19 times just to slow it down a little.

20          A.    Yes.

21          Q.    Okay.  Thank you.  And what percentage of  
22 people -- of patients with axial skeletal spine  
23 problems submit to elective fusion surgery?  Just an  
24 approximation, if you know.

25          A.    Submit to it, you're saying?

1 Q. Yeah.

2 A. Small percentage. Probably 20, 25 percent.

3 Q. Okay. And who do you think is the best  
4 diagnostician for diagnosing spinal injuries and  
5 conditions?

6 A. I think a doctor like myself, a physiatrist,  
7 because we do a comprehensive evaluation of a patient.  
8 And we look at the whole picture, and we look at  
9 everything a patient might need.

10 Q. Okay. Thank you. Now, what is the -- what  
11 is the physician's primary obligation in evaluating a  
12 patient complaining of symptoms and -- and pain?

13 So when a patient comes to you, not  
14 necessarily in a medical-legal setting but in your own  
15 practice, a patient comes to you, what is -- what is  
16 your primary obligation when you evaluate a patient?

17 MR. ROBERTS: Objection. Irrelevant.

18 MR. MAZZEO: Foundation, Judge, and  
19 background.

20 THE COURT: I'm going to allow it for  
21 foundational basis.

22 MR. MAZZEO: Thank you, Judge.

23 THE WITNESS: My goal is to try to determine  
24 if -- what -- where the source of pain they have comes  
25 from.

1           Pain is subjective. I need to look at their  
2 subjective complaints, and I need to look if there's an  
3 objective nature to the complaints or a cause for that.  
4 And if I can't find something objective, I reassure  
5 them and we may do some treatment. And then we move  
6 their care along if I don't have any evidence of major  
7 acute problems and neuromuscular deficits and try to  
8 achieve the highest level of functioning for them. And  
9 hopefully that is a decrease or resolution of their  
10 pain.

11 BY MR. MAZZEO:

12           Q. Okay. And -- and can you further describe  
13 what you mean by, I guess, objectifying a patient's  
14 subjective complaints?

15           A. Objective findings could be on examination.  
16 If you see things on examination or you -- when you're  
17 working with a patient, if you have some weakness that  
18 shouldn't be there, if you have a loss of a reflex  
19 that -- that's supposed to be equal, if you have  
20 atrophy of muscle that's gotten smaller, if you have a  
21 distribution of numbness or tingling that you can  
22 document as certain dermatome, we call it, a certain  
23 area that comes from a certain nerve. Could be  
24 bruising. Could be a fracture. Could be obvious  
25 things that we can see or things we determine when we

1 examine somebody and look at their level of how their  
2 nerves and muscles operate.

3 Q. Thank you. And what sort of tests do you  
4 do -- do you perform to assist you in objectifying a  
5 patient's subjective complaints?

6 A. If indicated, you might do X rays, you might  
7 do CT scans or MRI scans. If there's a concern for a  
8 nerve involvement or nerve damage, you might do what's  
9 called an EMG, which is a electrical test to determine  
10 pathology to a nerve.

11 Q. Okay. And just as an aside, were any EMG  
12 testing done in this case -- in this case?

13 A. I did not see any, no.

14 Q. Okay. So, now, I want to ask you about --  
15 we've heard terms during trial about radiating pain and  
16 radiculopathy and radicular pain.

17 Can you tell the jury the difference between  
18 radiating pain and radiculopathy?

19 A. Well, radiculopathy is a true problem in  
20 pathology to a nerve. The term is misused in many,  
21 many cases.

22 There's referred pain or radiating pain that  
23 is subjective. The patient's complaining of a pain  
24 from one spot to another spot or numbness or tingling  
25 and burning that's in an area. But that's not



1    radiculopathy.

2           The term "radiculopathy" I see in many, many  
3    diagnoses and many, many records that I review that  
4    have -- has never been proven. But that's a common  
5    term that's misused or a misnomer, we say. You have to  
6    really prove radiculopathy or damage to a nerve when  
7    you label person with that.

8           Q.    Okay. Thank you. And how do you test for  
9    and confirm radiculopathy if a patient is -- has true  
10   radicular symptoms?

11          A.    Well, the ultimate test is an EMG. That is  
12   the most sensitive test for looking for radiculopathy.  
13   That's -- you can determine -- you can see certain  
14   things on the testing that show you positive findings  
15   or -- or irritation or nerve damage.

16          Q.    Now, what about -- what would you attribute a  
17   patient's complaints of numbness running down the legs  
18   to? Would that be radiculopathy, radiating pain, or  
19   something else?

20               MR. ROBERTS:  Objection. Incomplete  
21   hypothetical.

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

24               THE WITNESS:  It is a complaint they have.  
25   We have to see if it's something that's worrisome,

1 something that I would be concerned about. And that's  
2 when we go into an examination. We go into the how an  
3 accident might occur, how the pain started. And we  
4 look at -- if we can objectify that symptom, a lot of  
5 us can have numbness sometimes after you have a sprain.  
6 You can have tingling after you have a sprained arm or  
7 ankle or leg.

8 That can easily go away in a couple of days,  
9 or it can go away in a few weeks or months. It doesn't  
10 mean there's radiculopathy there. And a lot of -- most  
11 symptoms like that are temporary unless you have a  
12 proven radiculopathy.

13 BY MR. MAZZEO:

14 Q. Now, what experience do you have in  
15 diagnosing and treating patients with spondylolytic  
16 spondylolisthesis?

17 A. It's not as common a problem, but I have done  
18 that in my practice for 24 years. It's not as common  
19 you would have, say, a bulging disk or herniated disk,  
20 but you would say a slippage of -- of a vertebral area.

21 Q. Okay. And -- and would you tell us, what is  
22 the -- what would be the constellation of symptoms  
23 associated with trauma to a preexisting  
24 spondylolisthesis?

25 A. Trauma to preexisting?

1 Q. Yes.

2 A. Well, you're going to have acute pain.  
3 You're going to have edema noted on testing. You're  
4 going to have a person that can't range their back very  
5 well. They can't -- they possibly have to sit down.  
6 They can't walk very well. They may have sharp  
7 shooting pain down their leg. And they may have  
8 numbness, tingling, and burning from that acute event.  
9 That would happen without a preexisting listhesis or it  
10 can happen with a preexisting degenerative listhesis  
11 that has worsened.

12 Q. Okay. And in what way does traumatic injury  
13 to a preexisting spondylolisthesis impact one's  
14 functionality? I know you just -- you gave us some  
15 examples.

16 A. It would change your ability to -- to do the  
17 things you were already doing before that. You would  
18 not be able to walk as far. You would not be able to  
19 bend as far. You would not be able to -- your  
20 endurance for sitting and standing would be changed.  
21 You would have to seek treatment. You would have to  
22 take pain medications. You would have to possibly  
23 begin the therapy and try to work on things the -- the  
24 problem that occurred.

25 Q. Okay. And -- and what diagnostic test are

1 used to confirm an acute trauma to a spondylolisthesis?

2 A. That's -- in general, could be starting off  
3 with X rays. CT scan can be utilized because it  
4 helps -- you can see the bones really easily on CT  
5 scan. And in many cases MRI scan is done also. You  
6 can tell if that's -- if there's an acute nature of the  
7 problem or to assess the -- the problem that's there.

8 Q. Okay. Now, based on your training and  
9 experience that you've had in diagnosing and treating  
10 patients with spondylolytic spondylolisthesis, what is  
11 your opinion whether traumatic injury to a preexisting  
12 spondylolisthesis will or can result in a gradual  
13 worsening of symptoms over days, weeks, or months?

14 MR. ROBERTS: Objection. Foundation.

15 THE COURT: Overruled. I'm going to let him  
16 answer.

17 THE WITNESS: A gradual onset doesn't occur.  
18 It's an acute event that would cause problems and sharp  
19 pain and difficulty the patient did not have before  
20 that.

21 BY MR. MAZZEO:

22 Q. When you say it's not gradual but it's an  
23 acute event, what -- what -- what is your opinion  
24 regarding the onset of symptoms following a -- an  
25 injury to a -- an acute injury to a spondylolisthesis?

1           A.    It should occur immediately.  Should occur  
2 within the first few minutes or couple hours.  It  
3 should -- and the gradual nature of something happening  
4 would be more of the degenerative process that you  
5 expect to increase if it's a gradual-type onset or  
6 worsening.

7           Q.    What is your opinion whether -- whether,  
8 based on your review of the records in this case,  
9 whether Ms. Garcia had any discogenic or facet joint  
10 injury related to the motor vehicle accident?

11          A.    I did not see that from her injury.

12          Q.    Okay.  And what objective medical evidence  
13 have you reviewed in this case, based on the medical  
14 records you reviewed, which might support Ms. Garcia's  
15 theory that she had discogenic or facet injury related  
16 to the motor vehicle accident?

17          A.    What objective testing?

18          Q.    What objective medical evidence have you  
19 reviewed in this case that might support her theory  
20 that she has discogenic or facet joint injury related  
21 to the motor vehicle accident, if any?

22          A.    I didn't see any objective evidence of acute  
23 injury from her accident in regards to the  
24 spondylolisthesis.

25          Q.    And regards to the disks or facet joints.

1           A.    Not in the disk -- she has small disk bulges  
2 that are degenerative in nature that occur with time  
3 and aging, as does facet arthropathy or hypertrophy  
4 occurs with aging.

5           Q.    Thank you. Now, during the course of your  
6 review of the medical records, is it correct to say  
7 that you were also provided with reports of various  
8 diagnostic and imaging studies?

9           A.    Yes.

10          Q.    Okay. And would those have included X rays  
11 as well MRIs that were taken on 1/26 of '11, 8/19 of  
12 2011, and 11/19 of 2012?

13          A.    Yes.

14          Q.    Okay. Now, with respect to the -- the report  
15 that you reviewed for the imaging study performed on  
16 January 26 of 2011, what notable findings were made by  
17 the radiologist regarding the L4-5 and L5-S1?

18          A.    I don't have it. I need to pull that. But  
19 she had a couple of small -- very small disk  
20 protrusions, I would consider minuscule disk  
21 protrusions, like 2-millimeters, I think they were.  
22 She had a degenerative spondylolisthesis of the  
23 slippage, which is probably considered Grade I to II.

24          Q.    Let me just stop you for a second, Doctor,  
25 since I put something up on the screen.

1           This is in evidence. This is the Las Vegas  
2 Radiology report for the MRI taken on January 26th of  
3 2011. And that's Plaintiff's 19, page 5 and 6. So  
4 it's for your review.

5           A. In the first, the top three, the first disks  
6 were normal. L1-2, L2-3, L3-4 were normal. No signs  
7 of degenerative changes.

8           She had also, in the lower thoracic spine,  
9 some disk desiccation, which is considered -- as mild  
10 is considered degenerative changes also.

11           The area where we normally have the most  
12 degeneration in our lumbar spine would be the last  
13 three levels, L3 through S1. That's where the majority  
14 of bending occurs when we do activities. And -- and  
15 with repetitive bending or various bendings over years  
16 of our life, we're going to have more degenerative  
17 changes there. Not everyone has a listhesis or  
18 slippage, but some people do.

19           Q. Okay. And I'm going to show you both -- this  
20 is the second page of the report. And we're not going  
21 through all the findings. We've gone through these  
22 findings a number of times with treating physicians for  
23 the plaintiffs. So I'm not going to go through this,  
24 each and every one.

25           But the question I want to ask you is, are

1 there any findings on this -- this particular MRI  
2 report that are indicative of -- that pertain to acute  
3 injury or a preexisting condition?

4 A. There's no signs of acute injury. There's --  
5 there's definitely findings of preexisting condition  
6 and problems.

7 Q. Okay. And when it refers to -- just a couple  
8 of references. When it refers to facet joint  
9 hypertrophic changes, is that something that's  
10 long-standing, or is that something that arises from an  
11 acute injury?

12 A. That's long-standing.

13 Q. Okay. And the reference to mild narrowing of  
14 the lateral recess and to neuro foramina, is there any  
15 indication that that's an acute event or preexisting  
16 age-related change?

17 A. That's preexisting age-related-type changes.

18 Q. Okay. What is -- what is the most  
19 susceptible structure in the spine in a patient who has  
20 a spondylolytic or pars defect spondylolisthesis?

21 A. The most susceptible -- adjacent nerves  
22 would -- could be susceptible to compression or  
23 irritation.

24 Q. Okay. And as well as the pars, would you  
25 include the pars defect on that? Is that susceptible



1 to further --

2 A. Right. Pars defect led to the listhesis or  
3 the slippage, and that could be worsened.

4 Q. Okay. Is there any indication on -- on -- on  
5 this MRI finding taken two weeks, a little -- I guess  
6 more than two weeks after the subject event that there  
7 is -- that the pars defect or the spondylolisthesis  
8 would be deemed unstable?

9 A. No.

10 Q. Okay. I want to show you the MRI report from  
11 November 19th of 2012. And that's Plaintiff's 19,  
12 page 13. And I want to direct your attention to the --  
13 about the bottom half of the page referring to the  
14 "L1-2 disk demonstrates a posterior bulge."

15 A. Yes.

16 Q. That's -- those are bulges at -- at both  
17 L1-2, L2-3, L3-4?

18 A. Yes.

19 Q. And, based on what you're reading and from  
20 your prior review, any indication that those were --  
21 occurred as a result of an acute injury or age-related  
22 change or something else?

23 A. If it's an acute injury, something that  
24 occurred from the first one to the second one, most  
25 likely it's degenerative changes, and they've

1 developed. And they weren't there before on the prior  
2 MRI scan. There's no evidence of an acute injury that  
3 occurred on this -- with this MRI finding either.

4 Q. Okay.

5 MR. ROBERTS: Objection. Foundation. He  
6 hasn't reviewed the prior MRIs.

7 THE COURT: I think I've got to sustain that,  
8 at least at this point.

9 BY MR. MAZZEO:

10 Q. Okay. Based on -- based on what the --  
11 and -- based on the radiologist's statements and  
12 impressions on this MRI -- and I'm going to go to the  
13 second page. With respect to the -- did the  
14 radiologist note any -- did he indicate that the bulges  
15 that appeared at L1-2, L2-3, and L3-4 were  
16 traumatically induced?

17 A. No.

18 Q. Did he indicate, make any reference to any  
19 finding that might be considered an acute event, such  
20 as edema, swelling, or something else?

21 A. No.

22 Q. Okay. And after reviewing that report,  
23 any -- any -- do you have any opinion as to whether  
24 the -- the findings on this pathology or this MRI  
25 report are based on a -- an acute trauma or age-related

1 change?

2 A. So it's not related -- there's no evidence of  
3 acute trauma. They're highly suggestive of  
4 degenerative change and some worsening of the spinal  
5 elements.

6 Q. Okay. Now, following a -- an acute event,  
7 what is the most significant time for -- for -- for --  
8 when is the most significant time for taking a history  
9 of a present illness?

10 A. If you can, immediately, you have really good  
11 recall from a patient. If you can't, very shortly  
12 after that within the same few -- three hours of the  
13 same day.

14 Q. Okay. And what medical records -- when  
15 you're doing a medical record review or even evaluating  
16 a patient for the first time, what medical records  
17 would contain the most accurate reporting of the  
18 history of a present illness following an event?

19 A. The first doctor that saw the patient.

20 Q. Okay. And what is the importance of a  
21 patient's recalling events and reporting symptoms  
22 contemporaneous with an event versus reporting events  
23 and symptoms more remote -- remote from the event?

24 A. In general, the human behavior and memory  
25 issues, the first -- the first immediate recall is the

1 best. The farther away from an event, you're going to  
2 have some memory issues and things that are forgotten  
3 or patient cannot remember exactly how something  
4 occurred.

5 Q. And how would you characterize the accuracy  
6 of self-reports made closer to an event versus those  
7 that are made more remote in time from the event?

8 A. Much more accurate.

9 Q. Okay. And how does a patient's self-report  
10 of -- regarding symptoms impact causation typically?

11 A. Well, they -- they help you with determining  
12 causation. They're -- they're not always accurate.  
13 You have to determine if a -- and pain is subjective,  
14 so people are sometimes fearful, sometimes angry,  
15 sometimes upset describing pain, describing something  
16 that occurred if it's an acute event.

17 You have to -- that's why you have to  
18 objectify things you're hearing and try to find as much  
19 information as you can to determine what occurred that  
20 led to them having -- experiencing pain.

21 Q. Okay. Now, one of the records that you  
22 reviewed in this case was the record from MountainView  
23 Hospital; is that correct?

24 A. Yes.

25 Q. All right. We're going to talk about that

1 for a few minutes.

2 And I'm going to put that up on the screen  
3 for you. I'm not asking you to recall all the  
4 information that's contained within.

5 So this is Plaintiff's 18, page 1. And this  
6 is one of the records that you reviewed in connection  
7 with your record review; correct?

8 A. Yes.

9 Q. Okay. And can you tell us, what did  
10 Ms. Garcia report and what did you ascertain that she  
11 reported as to when the symptoms started following the  
12 accident on January 2nd of -- of 2011.

13 A. Well, note here says she felt fine after the  
14 accident. She was pain-free after the accident, and  
15 her symptoms started that day of being seen, which was  
16 January 5th of 2011.

17 Q. Okay. I'm going to move right now to the  
18 physical examination that is on the second page. And  
19 what is the -- from what -- I'm not going to ask you  
20 about each one. I'd rather you tell us. What is the  
21 significance of the physical examination and the -- the  
22 findings that are indicated in this report with respect  
23 to Ms. Garcia?

24 A. They're essentially all normal findings. She  
25 was in no acute distress per the ER doctor's note.

1 We -- it's a -- we do a visual exam and a physical  
2 exam. So we visually see how the patient's responding,  
3 how they're acting, if they can sit still, if they have  
4 to sit and stand, or they have to move around a lot.

5 She essentially, throughout the whole entire  
6 exam, had a normal exam. Normal range of motion.

7 There was no evidence of neurologic deficits. Motor  
8 function was good. Sensory function was normal.

9 Nothing that was -- that I could see that was positive  
10 on exam -- for exam findings.

11 Q. Okay. One second, Doctor.

12 I know some of the words are -- are small, so  
13 I just want to bring this closer to the jury.

14 Okay. What's the significance of "no motor  
15 deficit with no sensory deficit"? What does that mean?

16 A. Those help you determine the severity of a  
17 problem, if you have a concern as a doctor, to do more  
18 things. If she -- that means she has normal strength.  
19 She has no weakness in certain areas of arms or legs.  
20 The -- the doctors said they were equal. And no --  
21 essentially no deficits. The sensation of --  
22 throughout her body, when he examined her, was  
23 normal -- or she examined her was normal.

24 Q. Okay. And what was the -- what was the  
25 emergency room physician's clinical impression?

1           A.     Mentioned low back strain, and there's a  
2 mention of motor vehicle accident.

3           Q.     And -- and what was Ms. Garcia's status at  
4 discharge, if you can tell from this report? I don't  
5 know if you can see the whole thing.

6           A.     It just went out.

7                     Condition was stable, and she was discharged  
8 from the ER.

9           Q.     Doctor, takes a little while to get into a  
10 groove of slowing it down for the court reporter.

11          A.     Yes.

12          Q.     We want to make sure we get all of your  
13 testimony today. So --

14                    Okay. Now, you also reviewed Dr. Gulitz's  
15 consultation report from January -- January 12th of  
16 2011; is that correct?

17          A.     Yes.

18          Q.     And that would be -- just put on the screen.  
19 That would be this document, Plaintiff's 15, page 1.

20          A.     Yes.

21          Q.     This is just one page of it, of course.

22                    And put on page 4 of Dr. Gulitz's report.

23 And I know it's hard to see. I apologize. There we  
24 go. Is that better? Try to have the whole thing in  
25 there.

1           So what was -- what is the -- the result or  
2 significance of the lumbosacral exam?

3           A.    Can you move that back to the side? Just  
4 part of it's cut off on the left side.

5           Q.    This way?

6           A.    Or you can't get it all. Now I see.

7           Q.    I can -- I can decrease it. There we go.  
8 Does that help?

9           A.    I'm sorry. Your question now?

10          Q.    Just the significance or the result of  
11 Dr. Gulitz's lumbosacral exam.

12          A.    Mentioned of 2+ tenderness in the paraspinal  
13 region, which is the muscles along the lower lumbar  
14 spine on both sides. Mentioned positive for muscle  
15 spasm. Kemp's test positive. Testing on left and  
16 right elicited local back pain, the note said.  
17 Consisted of lumbar facet inflammation and lumbosacral  
18 strain/sprain. The straight leg raise test was -- on  
19 the right was positive 20 degrees, which would be  
20 extremely positive and very low level of range of  
21 motion. It's positive on the left -- I'm sorry. Let  
22 me see here. And positive for lumbar pain at  
23 45 degrees, which can be a positive -- a common  
24 finding. With a straight leg raise testing, you can  
25 have low back pain that's -- makes it a negative test.



1 If you don't have radicular pain, it's not a positive  
2 test.

3 Q. Okay.

4 A. Left side was positive again at 20 degrees  
5 and positive for local back pain at 45 degrees, same as  
6 the other side. It's -- it's highly unusual to -- for  
7 me to review this note, after I've reviewed the note  
8 from the ER doctor that had normal exam, and try to  
9 explain how this exam could be this way on this note.

10 Q. Okay.

11 A. It's highly unusual. I -- I see many, many  
12 spinal patients. I do these exams all the time. It's  
13 unusual for days to lapse and then have this kind of  
14 exam and positive straight leg raise testing.

15 Q. Sure. And, now, the doctor notes "radiating  
16 pain." What's the significance of that finding, if  
17 any?

18 A. It's just a complaint of pain. You're trying  
19 to -- again, you have to localize where that might be  
20 coming from or where the source is.

21 Q. Okay. And what is the -- what is the  
22 significance of the lack of neural signs?

23 A. Then you're looking for evidence of  
24 neurologic -- positive neurologic findings. There were  
25 no -- with the statement of lack of neural signs, means

1 there's no concern for a neurologic deficit that would  
2 be worrisome concerning motor function or -- or sensory  
3 function.

4 Q. Okay. Now, also -- in addition, you also  
5 reviewed Dr. Cash's report of -- of 2/16 of 2011?

6 A. Yes.

7 Q. And let me just put that on the screen for  
8 us. This is Plaintiff's 23, page 23. Again, the  
9 wording is -- it's kind of small. Let me see if I can  
10 put this on the screen. That's kind of tight. So let  
11 me reduce that.

12 All right. I know it's kind of small, but,  
13 anyway, this -- so what I want to ask you about -- and  
14 I want to direct your attention, actually, to  
15 Dr. Cash's physical examination of the lumbar spine.  
16 And what physical examination did Dr. Cash perform on  
17 Ms. Garcia's lumbar spine on this day?

18 A. Palpation for -- which mentioned of  
19 tenderness and muscle spasms. And then there was a  
20 range of motion exam with what I would consider  
21 extremely limited range of motion and unusual findings.

22 Q. And so specifically what Dr. Cash has on the  
23 report is 20 degrees flexion, 10 degrees extension.

24 A. Yes.

25 Q. Right? And -- and -- and you contend that's

1 severely limited?

2 A. That would be considered very poor range of  
3 motion that the patient did not have in the ER.

4 Q. Okay. And would you please stand up and --  
5 and show for the jury what 10 degrees extension would  
6 look like, what 20 degrees flexion would look like, if  
7 you can stand with your profile to the jury?

8 A. If you're straight up like this, you're  
9 neutral position. If you're looking at -- forward  
10 flexion of full would be if you're going all the way  
11 down 90 degrees. Some people can touch the toes; some  
12 people can't touch the toes. That's considered full  
13 flexion.

14 If you're going to 20 degrees of flexion,  
15 you're probably doing something like this. That's --  
16 that means a person can't put their clothes on, can't  
17 bend over touch their toes, can't put their shoes and  
18 socks on, have a hard time doing most things.

19 Extension of 10 degrees would be even less  
20 than that, maybe something like this where you're  
21 hardly even able to move.

22 That's unusual for -- in this setting to have  
23 that kind of findings with another doctor and nobody  
24 else before that saw that on examination.

25 Q. And when you saw this in the report, did you

1 have any question about the accuracy of Dr. Cash's --  
2 this -- this finding or his ability to calculate  
3 20 degrees flexion, 10 degrees extension? Did you have  
4 any -- what -- what -- did this raise any red flags for  
5 you?

6 A. Yes. I have a concern for what led to that  
7 exam finding. Is the patient holding back, not  
8 performing full effort? Is the doctor not assessing it  
9 properly? A variety of things can go on.

10 Q. And what's your understanding as to whether  
11 Ms. Garcia was working full-time at about the time that  
12 she saw Dr. Cash on 2/16 of 2011?

13 A. The whole time through the records that I  
14 saw, she was working full-duty and full-time.

15 Q. Okay. And based on Dr. Cash's flexion and  
16 extension range of motion for the lumbar spine, what is  
17 your opinion as to whether Ms. Garcia would be able to  
18 engage in activities of daily living as well as perform  
19 her full eight-hour work duties if her -- she had a  
20 range of motion of only 20 degrees flexion, 10 degrees  
21 extension?

22 MR. ROBERTS: Objection. Foundation.

23 THE COURT: I'm going to sustain that till  
24 you lay some foundation about what he knew about that.

25 MR. MAZZEO: Oh, okay.

1 BY MR. MAZZEO:

2 Q. Do you have any knowledge -- in the course of  
3 your reviewing records, did you -- did you come to  
4 learn that Ms. Garcia worked as a cage cashier at  
5 Aliante Casino?

6 A. Yes.

7 Q. Okay. And did you learn to any extent what  
8 the nature and scope of her duties included?

9 A. I've seen a lot of cage cashiers for  
10 treatment. They have to -- used to be, years ago, they  
11 had to carry bags of coins, which we have now ticket  
12 machines. They have to still carry bags of money.  
13 They have to do a lot of bending, pulling things out of  
14 drawers, stacking things on shelves in various areas.  
15 So it's a fairly physical job.

16 Q. Okay. Now -- so, now, getting back to my  
17 prior question, based on Dr. Cash's finding of  
18 20 degrees flexion, 10 degrees extension, do you have  
19 an opinion as to whether or not Ms. Garcia, if she, in  
20 fact, was limited to that -- to those numbers, would be  
21 able to engage in her duties of activities of daily  
22 life as well as performing her work duties?

23 MR. ROBERTS: Objection. Foundation.

24 MR. MAZZEO: Just laid it, Judge.

25 THE COURT: You laid it as to the work but

1 not to the activities of daily living.

2 MR. MAZZEO: Oh, okay.

3 THE COURT: Sustained.

4 MR. MAZZEO: Fair enough.

5 BY MR. MAZZEO:

6 Q. And, Doctor, when -- when -- do you know what  
7 I mean when I refer to "activities of daily living"?

8 A. That's part of my specialty, assessing  
9 activities of daily living.

10 Q. And so why don't you tell the jury what is  
11 meant by that term, "activities of daily living"? What  
12 activities are we talking about?

13 A. You know, getting out of bed, taking a  
14 shower, putting your clothes on, caring for yourself,  
15 grooming, eating, all of the things you would do at  
16 your home before you got ready to leave your house.  
17 Going to the restroom -- not being graphic -- wiping  
18 yourself after you go to the restroom. Those kind of  
19 things are issues that you look at what the person is  
20 able to do in their daily activities around their  
21 house.

22 Q. Okay. Would activities of daily living  
23 include driving, walking, pushing, pulling?

24 A. They -- yes, they could.

25 Q. Okay. All right. So based on Dr. Cash's

1 evaluation that was performed on February 16 of 2011  
2 and his -- his indication that Ms. Garcia only had a  
3 20-degree flexion and a 10-degree extension, do you  
4 have any opinion as to whether, if Ms. Garcia did, in  
5 fact, have that restricted range of motion, whether she  
6 would be able to engage in, let's say, her work-related  
7 duties that you described a minute ago?

8       A.     If she truly had those findings in that --  
9 that examination of her lack of -- of a range of  
10 motion, she wouldn't be able to take a shower, put her  
11 clothes on. She definitely wouldn't be able to work  
12 full-duty as a cage cashier if that was true -- if that  
13 were true findings.

14       Q.     Okay. And what is your opinion as to whether  
15 Ms. Garcia should have received a surgical consultation  
16 from Dr. Cash six weeks post motor vehicle accident  
17 based on your review of the records up to that point?

18       A.     Completely unnecessary.

19       Q.     And what is your opinion as to whether  
20 Ms. Garcia was a candidate for spinal reconstructive  
21 surgery recommended by Dr. Cash and Dr. Gross?

22               MR. ROBERTS: Objection. Beyond the scope of  
23 his expertise.

24               MR. MAZZEO: Judge, I'll withdraw that. I  
25 can lay a foundation for that.

1 THE COURT: Okay.

2 MR. MAZZEO: Thank you.

3 BY MR. MAZZEO:

4 Q. So during the course and scope of your work  
5 as a physiatrist, did -- does there come a time when  
6 you will make a determination whether you will refer a  
7 patient for a surgical consultation?

8 A. Yes.

9 Q. Okay. Tell us about that.

10 A. As I said before, we're the doctors that work  
11 the patient up fully to try to improve their care and  
12 improve their functioning and do it in as conservative  
13 a manner as possible. There are times people are going  
14 to -- to need surgery or they're going to have a  
15 problem -- if it's a surgical problem, we try to treat  
16 and we try to keep them out of surgery. Sometimes we  
17 can't, and we've maximized their benefit, and we send  
18 them off to a surgeon for an opinion to see if they can  
19 arrange surgery if we know they're probably going to  
20 need it.

21 And that could be with a herniated disk.  
22 That could be with nerve damage. That could be with  
23 spondylolisthesis like this. And there's four grades  
24 of spondylolisthesis, 1 to 4. Grades I and II don't  
25 have spinal ligament rupture. Grades III and IV have



1 led to spinal ligament rupture, meaning more chance for  
2 instability, more chance for slippage, and more chance  
3 for nerve damage.

4           Throughout my whole entire career, I send  
5 people on to surgery when it's indicated or to get an  
6 opinion, see what their thoughts are, if they think  
7 surgery would benefit them, and see if they agree with  
8 me whether it would or would not benefit them.

9           Q.   And so what is your opinion as to whether  
10 Ms. Garcia was a candidate for a spinal fusion surgery  
11 that was recommended by Drs. Cash and Dr. Gross?

12           MR. ROBERTS:  Objection, Your Honor.  Beyond  
13 the scope of his expertise.

14           He's never performed a spine surgery.  He's  
15 not qualified to perform a spine surgery.  And he just  
16 said, if one of his patients needed a recommendation --

17           THE COURT:  Come on up, guys.

18           MR. MAZZEO:  Thank you, Judge.

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

21           THE COURT:  Withdraw that one.

22           MR. MAZZEO:  Yes, Your Honor.

23           THE COURT:  Okay.

24           MR. MAZZEO:  Thank you.

25   /////

1 BY MR. MAZZEO:

2 Q. Now, in addition, Doctor, in conjunction with  
3 your record review, you had reviewed various records  
4 from -- that were given to you with respect to  
5 treatment provided by Dr. Lemper; is that correct?

6 A. Yes.

7 Q. And in the -- in -- and if you recall -- if  
8 not, I can show you any records -- what was -- what is  
9 the significance of Ms. Garcia complaining and  
10 reporting to Dr. Lemper of radiating pain in the neck  
11 and in the low back?

12 A. Well, it could be significant or it could not  
13 be significant. That's why we have -- as I stated  
14 before, you have to evaluate if there is a radicular  
15 nature of a problem.

16 Q. No, not -- I said radiating pain.

17 A. Well, the same -- a radiating pain-type  
18 situation, you have to determine if that's happening.  
19 It could be something that's going to be temporary and  
20 go away. You have to figure out if that's a -- from a  
21 spinal element and a spinal problem. And in many -- in  
22 the vast majority of cases, it's not.

23 Q. Okay. And earlier you gave us the  
24 distinction between what's referred to as radiating  
25 pain and pain that would be -- originate from a

1    radiculopathy or radicular pain; correct?

2           A.    Radiculopathy is true pathology that does --

3           Q.    Slow down.

4           A.    Sorry.

5                   Radiculopathy is true pathology to a nerve  
6   that can -- that usually causes radiating symptoms:  
7   pain, numbness, tingling, and burning. Radiating  
8   pain or referred pain is a symptom subjectively that  
9   may not be coming from a spinal element and it doesn't  
10  confirm radiculopathy.

11          Q.    Okay. And so -- and you've reviewed all the  
12  records from Dr. Lemper; is that correct?

13          A.    Yes.

14          Q.    And he treated Ms. Garcia from June 29th of  
15  2011 through June of 2012?

16          A.    If I remember, yes. Yes.

17          Q.    Okay. And -- and you know that Dr. Lemper  
18  had provided several injections, one on August 30th of  
19  2011, which was a selective nerve root block?

20          A.    Yes.

21          Q.    Okay. And Dr. Lemper contends that -- that  
22  Ms. Garcia obtained relief from this selective nerve  
23  root block when she reported a relief in symptoms  
24  shortly following the procedure.

25                   Would you agree that this was diagnostic of

1 any condition?

2 MR. ROBERTS: Objection. Beyond the scope of  
3 his expertise.

4 THE COURT: I think this is within his  
5 expertise. Overruled.

6 MR. MAZZEO: Thank you, Judge.

7 THE WITNESS: I, first of all, don't know --  
8 I cannot explain what Dr. Lemper was doing the whole  
9 time at the time he saw the patient.

10 If this was my patient, I'm not certain what  
11 nerve I'd ask for a selective nerve block with. Why is  
12 he doing that test -- that -- that -- that injection?  
13 There's nothing confirmed that she has pathology,  
14 nothing confirmed she has the need for injecting around  
15 a certain nerve.

16 If you inject around a certain nerve, you've  
17 got to put numbing medication there, it's going to feel  
18 better. You're going to numb the area. That's not  
19 diagnostic at all. And then why is it being done on  
20 this patient?

21 Q. Okay. And okay --

22 MR. ROBERTS: Objection. Move to strike.  
23 Beyond the scope of his expertise.

24 THE COURT: Come on up for a minute.

25 /////

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

3 THE COURT: All right. I'm going to strike  
4 the answer for now, folks. There's going to be  
5 questions that may get into parts of that.

6 BY MR. MAZZEO:

7 Q. Doctor, can you tell us your experience in  
8 working with --

9 No, actually, tell us your -- tell us your  
10 knowledge and experience and involvement with  
11 procedures such as selective nerve root blocks and  
12 medial branch blocks.

13 How does that -- do you come across these  
14 procedures in the course of -- of your treating  
15 patients with spinal problems?

16 A. Yes, throughout my entire career.

17 If I can indulge the Court and explain more  
18 what a physiatrist does, that would help out probably.

19 Q. Please do that. Thank you.

20 A. As I said before, in physiatry we are the  
21 doctors that are the most skilled in physical  
22 examination and working a patient up. And we -- I  
23 encompass all these things in my practice.

24 To work a patient up to a point where, if you  
25 think they need an injection -- okay. I don't perform

1 injections. I don't perform the surgery. But I'm the  
2 most skilled person to determine if they're going to  
3 need an injection, if they're going to need a surgery.  
4 Then I send them on to somebody else.

5 We assess these things daily. And for  
6 thousands of patients, I have addressed these things.  
7 Again, I don't perform them, but I know when somebody's  
8 going to possibly need a nerve root block or  
9 possibility of epidural injection. Or I know, if I've  
10 worked them up, they're going to need surgery because  
11 nothing else has worked for them.

12 We encompass this every day in my practice,  
13 and all physiatrists do.

14 MR. ROBERTS: Objection. Foundation. Move  
15 to strike.

16 THE COURT: I'm going to allow it.

17 MR. MAZZEO: Thank you, Judge.

18 BY MR. MAZZEO:

19 Q. And is it correct to say or can you tell us  
20 whether or not you understand the mechanics behind a  
21 selective nerve root and a medial branch block?

22 A. I understand the -- the -- what we're trying  
23 to achieve, the mechanics of the -- where you're  
24 injecting and what you're doing at the time of the  
25 needle insertion. I don't deal with them, so I can't

1 explain all that to you.

2 But what we're trying to achieve is  
3 improvement in symptoms and some diagnostic information  
4 in that area to -- to prove that a nerve is being  
5 compressed or has been damaged.

6 Q. Okay. Thank you. Now, based on your review  
7 of Ms. Garcia's medical records prior to this selective  
8 nerve block by Dr. Lemper, would it be your opinion --  
9 what would be your opinion as a physiatrist whether or  
10 not Ms. Garcia would have needed a selective nerve root  
11 block and/or whether you would have recommended her for  
12 a selective nerve root block?

13 A. I don't see her, from all the records I  
14 reviewed, needing one. I don't see -- what concerns me  
15 in this case is that she -- her symptoms were never the  
16 same. They were different with all healthcare  
17 providers. They were sometimes tender and sometimes a  
18 long list of symptoms that were not present before.

19 It looks to me like the vast majority of  
20 things that occurred in this case were done because of  
21 her complaints subjectively without anything being  
22 proven or objectified. And a lot of these things go on  
23 in these kind of cases, which is embarrassing to me as  
24 a doctor. A vast majority of these things that are  
25 done in this kind of case is not needed, and there's no

1 objective reasoning for doing it.

2           Because if you look at her examinations,  
3 they're totally normal. She has 5 out of 5 strength in  
4 many cases. That is excellent strength. She has no  
5 neuromuscular deficits. There's no signs of spinal  
6 problem or nerve damage or any kind of limitations from  
7 the spine except that she has a listhesis that's been  
8 there and that was not traumatic in nature.

9           MR. ROBERTS: Objection. Beyond the scope of  
10 his report. Move to strike.

11           May we approach, Your Honor?

12           MR. MAZZEO: It's within his qualifications,  
13 Judge.

14           THE COURT: Come on up.

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

17           THE COURT: All right. We're going to give  
18 you a quick little break, folks.

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



1 Internet, or radio.

2           You are not to conduct any research on your  
3 own, which means you cannot talk with others, Tweet  
4 others, text others, Google issues, or conduct any  
5 other kind of book or computer research with regard to  
6 any issue, party, witness, or attorney involved in this  
7 case.

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

11           Let's take about 10 or 15 minutes. My plan  
12 is to give you a break now and then probably another  
13 break around lunchtime. And then we'll go till 2:00,  
14 like I told you yesterday.

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

17           THE COURT: All right. I'll go ahead and  
18 excuse you.

19           We're outside the presence of the jury.

20           Just to memorialize the bench conference, at  
21 least this one, that -- there's an objection to the  
22 scope of the doctor's opinion as it relates to his  
23 criticism of the pain management treatment. My  
24 understanding is that he testified contrary to that,  
25 that he wasn't critical of Dr. Lemper's treatment in

1 the deposition.

2 If there's something in the report -- and I  
3 don't know how many reports he did. But if there's  
4 something in his report where he's critical of the pain  
5 management, just let me know that.

6 MR. MAZZEO: I have it -- well, something in  
7 his deposition testimony where he does definitively  
8 state it was unnecessary.

9 THE COURT: Okay.

10 MR. STRASSBURG: Reading from page 100.

11 "QUESTION: Do the records that you  
12 received from Dr. Klein affect your opinions in  
13 any way?

14 "ANSWER: They definitely conform with my  
15 opinions, and I would agree wholeheartedly with  
16 Dr. Klein's recommendation and reports except  
17 for maybe we disagree on the recommendations of  
18 Dr. Lemper's injections.

19 "QUESTION: What do you mean by that?

20 "ANSWER: He said they were okay to do,  
21 and I don't think they were necessary.

22 "QUESTION: You don't think they were  
23 necessary in relation to the motor vehicle  
24 accident; right?

25 "ANSWER: Correct. For any injuries from

1 the accident.

2 "QUESTION: Okay."

3 MR. ROBERTS: And, Your Honor, that conforms  
4 with what we said at the bench where he said, one -- I  
5 believe it was on page 29 and 30 -- that his opinions  
6 were limited to whether the treatment was caused by the  
7 accident --

8 MR. SMITH: Page 66, Your Honor.

9 MR. ROBERTS: -- where he said, "Your  
10 opinions are limited to whether the treatment  
11 Ms. Garcia received was necessitated by the accident?"

12 "ANSWER: Yes."

13 In what was just read by Mr. Strassburg, he  
14 was saying it was not necessary as a result of the  
15 accident, not that it was inappropriate.

16 And, in fact, he specifically said just a --  
17 just -- so Mr. Smith was clarifying the scope of his  
18 opinions, whether it wasn't necessary because of the  
19 accident or whether it wasn't appropriate at all.

20 He was asked at the bottom of page 60, "Okay.  
21 Without tying it to the auto accident, was there any  
22 treatment that was not appropriate for Dr. Lemper to  
23 perform?"

24 "ANSWER: No."

25 And what he just clearly stated was, without

1 regard to the accident, without including any preamble  
2 that I didn't think it was necessary because of the  
3 accident, he said it wasn't appropriate. He even went  
4 so far as, I believe, to express ethical concerns with  
5 the fact that it was done.

6 And that's clearly beyond the scope of his  
7 report

8 (Multiple speakers)

9 MR. ROBERTS: -- well, then it was a compound  
10 answer, and he answered beyond the question he was  
11 asked.

12 But, Your Honor, this was not in his report.  
13 And it was specifically disclaimed as an opinion when  
14 it was clarified in his deposition, so he shouldn't be  
15 able to offer it now for the first time.

16 THE COURT: I think the --

17 MR. MAZZEO: Judge -- Judge -- I'm sorry.

18 THE COURT: I think the deposition testimony  
19 is at least equivocal. I think he at least offered an  
20 opinion that he didn't agree with the treatment. So I  
21 think you're on notice of the opinion, and you can deal  
22 with it on cross.

23 MR. MAZZEO: Thank you, Judge.

24 THE COURT: I'm not going to strike that  
25 answer.

1 MR. MAZZEO: Thank you.

2 THE COURT: Anything else that we need to

3 make a record on now, guys?

4 MR. MAZZEO: No.

5 MR. ROBERTS: Can't tell you anything right

6 now, Judge.

7 THE COURT: Okay. Off the record.

8 (Whereupon a short recess was taken.)

9 THE MARSHAL: Jury entering.

10 (The following proceedings were held in

11 the presence of the jury.)

12 THE MARSHAL: Jury is present, Judge.

13 THE COURT: Thank you, Tom.

14 Go ahead and be seated. Welcome back, folks.

15 We're back on the record, Case No. A637772.

16 Do the parties stipulate to the presence of

17 the jury?

18 MR. ROBERTS: Yes, Your Honor.

19 MR. MAZZEO: Yes, Your Honor.

20 THE COURT: Doctor, just be reminded you're

21 still under oath.

22 THE WITNESS: Yes, sir.

23 THE COURT: Mr. Mazzeo, go ahead.

24 MR. MAZZEO: Thank you, Judge.

25 /////

1 BY MR. MAZZEO:

2 Q. And, Doctor, just let me remind you just to  
3 slow it down a little bit because everything that's  
4 being said in the courtroom is being recorded. So ...

5 A. Yes.

6 Q. And it's my remiss for not, you know,  
7 directing --

8 A. I have done this for years. It's not your  
9 fault. I'm trying to work on it.

10 Q. Okay. All right. Great. Thank you.

11 So, Doctor, in addition to the treatment  
12 records from Dr. Lemper that you reviewed, is it  
13 correct that you also reviewed Dr. Kidwell's  
14 consultation and treatment records for that time period  
15 that we had discussed earlier?

16 A. Yes.

17 Q. Okay. And -- and with respect to the  
18 treatment and care rendered by Dr. Kidwell, between  
19 August of 2012 and February of 2014, what is your  
20 opinion as to whether the care rendered by Dr. Kidwell  
21 was reasonable and necessary with regard to the subject  
22 accident?

23 A. I don't think it was necessary at all in  
24 regards to the accident.

25 Q. Okay. And on -- September 27th, 2012 -- just

1 directing your attention to that date, which was the  
2 date that Dr. Kidwell had performed the selective nerve  
3 root block bilaterally at L5-S1.

4 And based on your review of all the medical  
5 records, what's your opinion as to whether that  
6 selective nerve root block would have been appropriate  
7 for Ms. Garcia?

8 A. I don't think it was necessary or appropriate  
9 in regards to the -- any injuries that might have  
10 occurred in the accident. And if it was my patient, I  
11 probably -- I would not have sent her for those either.

12 Q. Okay. Now, Dr. Kidwell had -- also  
13 Dr. Kidwell had referred to Ms. Garcia's fusion as a  
14 failed low back surgery syndrome, and he referred to  
15 that as a garbage bag diagnosis that was really not  
16 applicable.

17 Can you tell the jurors what is meant by this  
18 term "failed low back surgery syndrome"?

19 A. Yeah. It's a term -- it's a thing that  
20 patients are lumped into when they have a back surgery  
21 that doesn't go well, that doesn't heal well, have  
22 ongoing problems, ongoing issues that didn't get  
23 corrected.

24 We see it a lot. I think it's a term that  
25 got generated from surgeons because all surgeons

1 suggest their surgery was perfect but the patient  
2 didn't get better. So one of those terms that people  
3 are lumped into. And we see a lot of problems  
4 postfusion with these kind of issues.

5 Q. Okay. And when you say you see a lot of  
6 these problems, as a physiatrist, as a treating  
7 physician, you see a lot of these problems postfusion?

8 A. Yes.

9 Q. Okay. And -- and so basically this -- failed  
10 low back surgery syndrome, does it refer to a  
11 constellation of symptoms or pain complaints following  
12 a surgical procedure?

13 A. It could be the same or similar complaints as  
14 before the surgery. It could be a total set of  
15 different complaints after the surgery. It could be  
16 various similarities. Could be a worsening of the  
17 condition. The patient in that setting is not better  
18 and are usually worse off, and their functioning has  
19 decreased.

20 Q. And based on your -- your experience and  
21 training as a physiatrist and all the years of  
22 experience you have in treating patients postfusion,  
23 what are some of the reasons for the pain complaints  
24 that might arise following a fusion surgery as to -- as  
25 to the cause of the pain, I should say?



1           MR. ROBERTS:  Objection.  Beyond the scope of  
2 his report.

3           MR. MAZZEO:  Within the scope of his  
4 expertise, Your Honor.  And it came out in trial  
5 testimony by Dr. Kidwell.

6           THE COURT:  I think I'm going to allow it.

7           THE WITNESS:  The reasons for --

8           MR. MAZZEO:  I'm sorry.  Go ahead.

9           THE WITNESS:  The reasons for it could be --  
10 have a lot of factors.  In general, when you're  
11 changing the anatomy of a patient that was there from  
12 birth, you're adding either a plate and screws, you're  
13 adding a bone from their own -- a piece of their own  
14 bone, you're adding a cage, you're adding some type of  
15 metal -- usually, nowadays, titanium -- that's a source  
16 of pain.

17           Even if you have a reason to do surgery and  
18 you stabilize an area, rarely is a patient going to  
19 have -- be pain-free afterwards.  In many cases,  
20 they're significantly worse off, and they have to deal  
21 with those issues.

22 BY MR. MAZZEO:

23           Q.  Okay.  So before we continue with  
24 Dr. Kidwell's treatment, I want to show you -- go  
25 through some records.  The other day, while Dr. Kidwell

1 was on the stand, I showed him a number of records  
2 from -- the treatment records for the first couple of  
3 months following the subject accident. And I was  
4 specifically showing him the reporting of pain symptoms  
5 by Ms. Garcia to the various medical providers.

6           So the first record I'm going to show you  
7 is -- and we looked at this earlier. This was  
8 Plaintiff's 18, page 1. And what I want to direct your  
9 attention to, Doctor, is -- is what you already  
10 testified to, that -- what Ms. Garcia reported when she  
11 reported her symptoms -- according to this record, she  
12 reported them -- that the symptoms started that day on  
13 January 5th of 2011.

14           A.    Yes.

15           Q.    Right? Okay. And -- and then I want to show  
16 you -- this is Dr. Gulitz's record from January 12th of  
17 2011. And can you identify -- just under mechanism of  
18 injury, just want to direct your attention to what  
19 Ms. Garcia says regarding the -- regarding the onset of  
20 symptoms following the accident.

21           A.    Stated that she was -- the highlighted area  
22 stated that "After the collision she was shaky,  
23 nervous, in pain, and upset." That --

24           Q.    And what -- oh, go ahead.

25           A.    -- doesn't correlate well at all with

1 other -- what occurred day one in the ER or at all with  
2 what the records show.

3 Q. Okay. And then I want to show you Dr. Cash's  
4 report. This is Plaintiff's 23, page 3. This is  
5 from -- let me reduce the -- the size here. This is  
6 from 2/16 of 2011.

7 What does -- and I also have it highlighted.  
8 What does Ms. Garcia report to Dr. Cash approximately  
9 six weeks after the accident as to when the --  
10 regarding her symptoms?

11 A. "The patient fought through the pain over the  
12 next four days because she did not want to miss work."

13 Q. Okay. Now, this statement -- as a  
14 physiatrist in your -- reviewing this record, what  
15 would you -- what would you -- what would the statement  
16 mean to you as to when she's indicating the pain  
17 symptoms started?

18 A. To Dr. Cash, she stated the pain -- she's  
19 referring to the pain starting immediately after the  
20 accident and she fought through it for four days.

21 Q. Okay. And then I'm going to show you  
22 Dr. Gross's report of May 31st of 2011 and just direct  
23 your attention to history of illness. Read this and  
24 identify where -- what she states to Dr. Gross as to  
25 the -- her symptoms starting after the accident and

1 what they were.

2 A. Well, it states, "She recalls being jerked  
3 side to side with forward flexion of her body. She was  
4 dizzy, dazed, confused, and nauseated. She was in  
5 shock."

6 Q. Okay.

7 A. That, again, does not correlate well with the  
8 other records.

9 Q. And that statement to Dr. Gross on this date,  
10 when she makes this reference, what is your  
11 understanding as to what she is saying as to -- as to  
12 when she's indicating that the symptoms started  
13 following the accident?

14 A. Immediately, because then she refers to the  
15 police coming to the scene.

16 Q. Okay. And -- and the reference to dizzy,  
17 dazed, confused, and nauseated, does that comport with  
18 what she reported to the emergency room physician on  
19 January 5th of 2011?

20 A. No.

21 Q. Dr. Kidwell testified the other day,  
22 indicating that those various statements that she made  
23 regarding when the symptoms started after the accident  
24 was not really significant.

25 Would you agree?

1           A.    I don't know how a doctor could state that.  
2 Those are important things we look at when we assess a  
3 patient's condition and when things started. Whether  
4 it's an injury or whether it's something else that  
5 occurred, you have to know, you know, what is -- what  
6 was -- the source be and how -- when they started and  
7 how -- how they affected her.

8           Q.    And so with -- would you consider these  
9 statements to be consistent with one another or  
10 inconsistent?

11          A.    Her statements to various healthcare  
12 providers were very inconsistent. The most important  
13 one is the ER doctor, and none of these things were  
14 going on. But every time she saw a healthcare  
15 provider, it's a constellation of symptoms that seemed  
16 to be -- have an expanding list, some similar but a  
17 whole lot of different things going on that doesn't  
18 make a lot of sense.

19          Q.    Now, as a physiatrist, whether you're doing a  
20 medical record review or evaluating a patient and  
21 you've reviewed these records, what's the takeaway from  
22 the inconsistency in these statements for you as a  
23 physiatrist in evaluating a patient?

24          A.    I'd like to get to the bottom of it, but it's  
25 less concerning for a -- an acute problem or for a

1 significant problem because, obviously, she was  
2 experiencing pain from an emotional standpoint, and  
3 they're not consistent from what -- having these  
4 records available, not consistent. I'd like to find  
5 out what occurred from day one and how -- being  
6 inconsistent is a real problem. They should not occur  
7 that way. If you had a true traumatic event, you're  
8 going to have consistent findings and symptoms.

9 Q. Okay. What's your understanding, after  
10 reviewing Dr. Kidwell's records for all of the  
11 follow-up consultations he had with Ms. Garcia, as to  
12 what was the primary purpose for the consultations that  
13 he had? What was the form of treatment he provided to  
14 her on each visit?

15 A. Spinal injections, for the most part.

16 Q. Well, on each and every visit?

17 A. Not each visit, but he -- there was -- he --  
18 he was also providing her pain -- pain meds but spinal  
19 injections intermittently throughout the time he saw  
20 her.

21 Q. Well, yeah. And we identified -- I think I  
22 identified one for you. The jury's -- has seen the  
23 various procedures he's -- he's provided.

24 But I'm -- I'm not talking about procedures.  
25 I'm talking about the consultation visits that

1 Ms. Garcia had with Dr. Kidwell. And I know you  
2 reviewed his records through -- well, through the  
3 December of 2015.

4 A. Right. I've reviewed records through then.  
5 I'm not sure -- I don't understand your question. I  
6 apologize.

7 Q. Fair enough. Okay. Give me one moment.

8 Doctor -- okay. Doctor, so I'm going to show  
9 you the synopsis of -- of the medications that -- this  
10 is for the consultations, not procedures. Okay? And  
11 so is it -- what -- is your understanding that -- that  
12 the primary purpose for consultation with Dr. Kidwell  
13 was for pain prescription medications?

14 A. Right. This is what it looks like through  
15 the -- throughout treatment, plus he did, like,  
16 intermittent spinal injections. He provided her with  
17 regular refills for medications that changed at times.

18 Q. Okay. And we will go to the bottom of the  
19 page. Okay.

20 MR. ROBERTS: Objection, Your Honor. He's  
21 just displayed something that's excluded.

22 THE COURT: You got it down now, so...

23 MR. ROBERTS: Thank you. Withdrawn.

24 MR. MAZZEO: Okay.

25 /////

1 BY MR. MAZZEO:

2 Q. And, Dr. Poindexter, so from reviewing  
3 Dr. Kidwell's records, what is your opinion as to why  
4 he provided monthly medication management prescriptions  
5 to Ms. Garcia from -- from the time that he saw her  
6 through, let's say, February of 2014?

7 A. He's essentially seeing her for monthly pain  
8 management, which, you know, I do myself for a certain  
9 situation. But he's seeing her for monthly pain meds,  
10 refills, and adjustments of those meds, but other meds  
11 were given that were not -- that were for depression or  
12 anxiety, variety of things like that too, during his  
13 visits.

14 Q. Okay. And, now, moving on, directing your  
15 attention to Dr. Gross's operative report of  
16 12/26/2012, did you review that in conjunction with  
17 your medical record review?

18 A. Yes.

19 Q. Okay. And do you have -- as a physiatrist,  
20 do you have an understanding -- and I think you've --  
21 well, strike that.

22 As a physiatrist, do you have an  
23 understanding as to the success rate for patients who  
24 receive a one- or two-level fusion surgery, low back?

25 A. Success rate in the terms of stabilization



1 or -- or symptom relief?

2 Q. It's a good question. Both.

3 A. Well, there's a fairly high level of success  
4 rate for stabilization, but there's a very low level  
5 for success rate for improvement of symptoms and --  
6 and -- and functioning.

7 Q. And what is your understanding as to -- in  
8 addition to the -- strike that.

9 In addition to the operative report, you also  
10 were provided records from follow-up consultations with  
11 Dr. Gross after the fusion surgery; correct?

12 A. Yes. So, many times after the surgery.

13 Q. Okay. And what is your -- what is your  
14 understanding of any new symptoms that Ms. Garcia  
15 experienced after Dr. Gross's fusion surgery in  
16 December of 2012?

17 A. It's my understanding -- were they still  
18 present?

19 Q. Well, of -- of -- of whatever pain complaints  
20 Ms. Garcia made following the -- the surgery.

21 A. She still had a variety of pain complaints --  
22 low back pain, some leg pain, some numbness issues --  
23 that varied in nature at different times and varied in  
24 intensity at different times.

25 Q. Okay. And -- and just backing up to -- to

1 that reference to the failed low back surgery syndrome.

2           Based on your review of -- of the records and  
3 Ms. Garcia's continuing reporting of pain complaints,  
4 would her postsurgery pain reporting fall within the  
5 classification for failed low back surgery syndrome?

6           MR. ROBERTS: Objection. Beyond the scope of  
7 his report.

8           THE COURT: I'm going to allow this. I think  
9 it's general.

10           THE WITNESS: Yes. She had a lot of symptoms  
11 beforehand, and she had a lot of symptoms -- variety of  
12 symptoms afterwards, and she's been lumped into the  
13 term of failed low back syndrome.

14 BY MR. MAZZEO:

15           Q. Okay. And did you come to any -- did you  
16 formulate any opinions as to why Dr. Gross was doing  
17 these follow-up consultations with Ms. Garcia after the  
18 surgery continuously?

19           A. Well, my experience in medical practice is  
20 highly unusual. Usually a surgeon performs a  
21 procedure. They have two or three follow-ups at times,  
22 and the patient is then released and discharged from  
23 care. You don't have a scenario where surgeons  
24 continue seeing patients for multiple visits for a long  
25 period of time afterward. They're -- that's just --

1 scenario doesn't occur. It's not normal, not  
2 customary.

3 Q. Now, Dr. Gross and Dr. Kidwell contend that  
4 the fusion surgery was successful despite Ms. Garcia  
5 having continued pain come -- pain in the back and the  
6 buttocks.

7 Would you agree with that opinion?

8 A. I don't know how it's successful. It didn't  
9 really change her overall pain complaints.

10 Q. Okay. Now, moving on to another area. What  
11 is the correlation between smoking and its impact on  
12 the spine?

13 A. Smoking can affect the small capillaries that  
14 feed -- course blood supply it to an area, and that's  
15 going to affect healing rates and going to -- could  
16 lead to nonunion of a fusion.

17 Q. What's your understanding of Ms. Garcia's  
18 smoking history at the time of the accident and around  
19 the time of the surgery?

20 A. There were some reference in records of --  
21 suggesting that she stopped smoking. I think there was  
22 some record -- a record that stated she stopped for  
23 some time prior to surgery. I don't know exact time  
24 frame.

25 Q. Okay. I'm going to show you a record here

1 from Dr. Kidwell. And it's Plaintiff's 26, page 66.  
2 And this is from November 7th of 2012. And in this  
3 record it indicates "The patient does not smoke."

4 Do you see that?

5 A. I see it, yes.

6 Q. Okay. And I'll have a question for you in  
7 one moment.

8 I also want to show you Dr. Gross's report of  
9 November 13th, which is six days later, where she  
10 indicates to Dr. Gross in less than a week that "She  
11 agreed to fully quit smoking to enhance the fusion  
12 rate, and I explained that to her."

13 Do you see that?

14 A. Yes.

15 Q. And do you find a -- an inconsistency between  
16 what she told Dr. Kidwell on November 7th of 2012 and  
17 then Dr. Gross on November 13th of 2012 regarding her  
18 reporting -- representation about smoking or not  
19 smoking?

20 A. It seems opposite concerning the act of  
21 smoking.

22 Q. Okay. And is that something that is  
23 significant or it's not a big deal; don't worry about  
24 whether she made a mistake or reported something  
25 inconsistent like that?

1           A.    Well, it's very big deal for surgical  
2 healing.

3           MR. ROBERTS:  Objection.  Move to strike.  He  
4 said the opposite thing in his report.

5           THE COURT:  I -- I'll let you deal with it on  
6 cross.

7           MR. MAZZEO:  Thank you, Judge.

8 BY MR. MAZZEO:

9           Q.    Now, following your medical record review,  
10 did you come to any conclusions about the injury  
11 sustained by Ms. Garcia?

12          A.    I stated that she had suffered only soft  
13 tissue -- mild soft tissue strain/sprain-type injuries.

14          Q.    Okay.  And what -- what injuries and  
15 diagnoses do you believe are attributable to the  
16 subject accident?

17          A.    Usually what I -- what I would say further in  
18 regards to this accident, it would be minimal in  
19 nature, but they were cervical -- which is neck -- and  
20 lumbar -- which is the low back -- and -- but they'd be  
21 minimal in nature, and they would require a shortened  
22 treatment plan.

23          Q.    What -- what did -- what opinion do you have  
24 as to whether or not Ms. Garcia suffered an  
25 identifiable permanent injury to her neck or low back?

1           A.     She did not suffer that in relation to the  
2 accident.

3           Q.     Given Ms. Garcia's constellation of symptoms  
4 postaccident, what is your opinion as to the  
5 appropriate treatment Ms. Garcia needed in connection  
6 with her injuries?

7           A.     She should have been seen by initial doctor  
8 if she had a concern. And she later did, at the ER.  
9 Normally you don't go to the ER; you see a primary care  
10 doctor, clinic doctor, and they can refer you out or --  
11 and they can start treating you. But you assess them  
12 and likely would be put -- place a patient in physical  
13 therapy and work on their condition, try to improve  
14 their symptoms.

15          Q.     Okay. Now, in the course of your record  
16 review, you were also provided with Dr. Oliveri's  
17 comprehensive medical evaluation and life-care plan;  
18 correct?

19          A.     Yes.

20          Q.     And you were asked to -- to evaluate whether  
21 Dr. Oliveri's life-care plan was necessary and  
22 appropriate with respect to any injuries Ms. Garcia  
23 sustained in connection with this accident --

24          A.     Yes.

25          Q.     -- correct? Okay.

1           Now, Dr. Oliveri associates all of  
2 Ms. Garcia's diagnoses, treatment, injections, surgery,  
3 and future medical needs to the motor vehicle accident.

4           Do you agree? And if not, why not?

5           A. I don't agree at all. I think that's kind of  
6 absurd. That's not taking into account all the aspects  
7 of the medical records and the patient's problems and  
8 complaints from day one.

9           Q. Dr. Oliveri testified that he never created a  
10 life-care plan for any patient not in litigation.

11           In your experience, are there patients  
12 with -- who do not have a legal claim who might need a  
13 life-care plan?

14           A. Yes.

15           Q. Tell us about that.

16           A. Could be a person that falls in their house  
17 and has a head injury and they need -- if they have  
18 health insurance, they may determine what their needs  
19 were down the road the rest of their life, and you can  
20 do a life-care plan for that to determine what services  
21 they're going to need, because they're going to need  
22 lifelong service in that situation.

23           It's not just always due to an accident.

24           Q. Okay. Dr. Oliveri estimated the life-care  
25 plan for 40 years out for Ms. Garcia.

1           Have you formulated any opinions that -- with  
2 regard to Dr. Oliveri's recommendation that she needs  
3 future medical treatment for 40 years out from -- from  
4 this point?

5           A.    In regards to accidents, it's completely  
6 unnecessary and absurd to suggest that from this  
7 accident.

8           Q.    Okay. Now, Dr. Oliveri also testified that  
9 he noted that all the findings on the January 26th,  
10 2011, MRI were age-related or degenerative in nature.  
11           Do you agree?

12          A.    Yes.

13          Q.    Okay. Dr. Oliveri note -- stated that there  
14 was no indication on any of the imaging studies  
15 showed -- which showed any acute or traumatic injury to  
16 any structures.

17           Do you agree?

18          A.    I agree, yes.

19          Q.    Now, Dr. Oliveri had testified that neither  
20 Dr. Cash nor Dr. Gross ever identified any objective  
21 finding of an acute injury from any imaging study.

22           Do you agree with that?

23          A.    I do, yes.

24          Q.    Dr. Oliveri stated that the McGill Pain  
25 Questionnaire and the Oswestry Low Back Disability



1 Questionnaire are both very subjective self-appraisals.

2 Would you agree with that?

3 A. Yes.

4 Q. Do you -- by the way, in the course of your  
5 treating patients who complain of low back pain, do you  
6 administer either a McGill questionnaire or Oswestry  
7 Low Back Disability Questionnaire?

8 A. I do at times. I don't with every patient,  
9 but I do at times utilize that. It is still something  
10 you have to take into account, subjective nature, and  
11 see if there's improvements over a period of time with  
12 those -- each entity.

13 Q. Okay. Now, also, Dr. -- Dr. -- during the  
14 course of your review of Dr. Oliveri's comprehensive  
15 medical evaluation, he referred to a primary diagnosis  
16 of motion segment injury with aggravation of a  
17 previously asymptomatic spondylolytic spondylolisthesis  
18 based on Ms. Garcia's complaints and his review of the  
19 MRI and X ray reports and Dr. Lemper's blocks.

20 Two questions. Do you agree that -- with  
21 Dr. Oliveri that Ms. Garcia's sustained a motion  
22 segment injury?

23 A. No.

24 Q. And do you know what the term refers to when  
25 I say "motion segment injury"?

1           A.    My assumption is they're referring to the  
2 segment of the spine where she has spondylolisthesis  
3 and changes there that occurred from the accident or  
4 from a trauma.

5           Q.    Okay.  And have you ever reviewed  
6 Dr. Oliveri's -- any other reports from Dr. Oliveri  
7 that he's created in the medical-legal claim setting?

8           A.    Yes.

9           Q.    How many times?

10          A.    Multiple.  I don't know a number, but  
11 multiple times.

12          Q.    Okay.  And this reference to motion segment  
13 injury, is this the first time you've seen it in one of  
14 Dr. Oliveri's reports?

15          A.    I don't think it's the first time.  It's --  
16 each time I reviewed one of the reports was not the  
17 same scenario as this, but I don't think it's the first  
18 time I have seen that.

19          Q.    Okay.  And Dr. Oliveri testified the other  
20 day to the jury, and he said the motion segment injury  
21 included an implication of both facet joints and the  
22 disks.

23                   And do you -- what is your opinion as to  
24 whether Ms. Garcia sustained a motion segment-type  
25 injury, as described by Dr. Oliveri, to her facet

1 joints and the disks?

2 A. That's just not present in this case. So you  
3 have -- from day one, you don't see that scenario, and  
4 you don't -- and not -- and not concerned about that  
5 scenario from day one.

6 Q. Now, Dr. Oliveri testified that the relief  
7 that Mr. -- Ms. Garcia experienced within 30 minutes or  
8 40 minutes after Dr. Lemper's procedure could be due to  
9 the effects of anesthesia and narcotics as well as  
10 Ms. Garcia's non-weight-bearing position on the gurney  
11 prior to discharge.

12 Do you agree with that? And if so, why?

13 A. I do. You can see improvement by  
14 positioning. You can see improvement with -- just the  
15 numbing agents can help you feel better. It's not  
16 diagnostic, but you can see those things on a regular  
17 basis.

18 Q. Now, Dr. Oliveri also testified on the stand  
19 that he contends that the motor vehicle accident caused  
20 an aggravation of a preexisting condition but that he  
21 did not do any apportionment.

22 If -- if an injury -- if an incident,  
23 traumatic event, caused an aggravation of a preexisting  
24 condition, in your experience as a physiatrist and --  
25 would apportionment be appropriate or inappropriate?

1           A.    Apportionment is required.  You have to do  
2 apportionments.  It's -- you're dealing with a  
3 preexisting problem; you're dealing with a postinjury  
4 accident problem.  You have to do apportionments.  To  
5 not do it is highly unusual.

6           Q.    Okay.  Now, Dr. Oliveri also recommended that  
7 Ms. Garcia needed -- will need future lumbar fusion  
8 surgery for an adjacent segment breakdown.

9                   Can you tell us what that means and whether  
10 you agree or not?

11          A.    Adjacent segment breakdown could be a level  
12 above or below where you have a fusion site.  And  
13 because of the fusion, you're going to move -- that's  
14 going to start moving together, to stable.

15                Above and below you're going to have bending  
16 and motion there.  So you are going to expect to have  
17 more motion there and aggravation or -- or changes  
18 there with time and, depending on the person's  
19 activities, whether at work or home.

20                So that's -- an adjacent segment breakdown  
21 could occur.

22          Q.    And do you agree that Ms. Garcia's a  
23 candidate for a -- an adjacent segment breakdown as a  
24 result of this accident?

25          A.    Not as a result of the accident.  Having a

1 surgery fusion is a common thing you might see but not  
2 in all cases. But as a result of the accident, the  
3 surgery is unnecessary, shouldn't have been performed.  
4 And now she has other problems that she's dealing with  
5 because of fusion.

6 Q. Thank you.

7 Now, you also -- you reviewed Dr. Oliveri's  
8 life-care plan for future medical treatment.

9 Do you believe -- or what is your opinion as  
10 to whether Ms. Garcia will need any future medical  
11 treatment related to this accident?

12 A. I don't agree she has a need for future  
13 medical treatment. And the extensive nature that he  
14 placed in there is just not appropriate when we look at  
15 all the facts of the case.

16 Q. Okay. What is your opinion as to whether any  
17 of the treatment, diagnostic studies that were  
18 performed, the interventional injections, or the  
19 operational procedures after August 20 -- 2011 were  
20 related to the subject accident?

21 A. After August 2011?

22 Q. Yeah.

23 A. I don't -- they're not -- I would not have  
24 performed -- they're not necessary.

25 Q. And are all your opinions that you've stated

1 today to a reasonable degree of medical probability?

2 A. Yes.

3 Q. Have you ever evaluated a patient who did not  
4 have a medical-legal claim who was prescribed the  
5 amount of treatment recommended and given by the  
6 doctors in this case?

7 A. Outside of a medical-legal claim?

8 Q. Right.

9 A. Outside of a personal injury situation?

10 Q. Outside of medical-legal, personal injury.  
11 Outside of medical-legal claim where a third party is  
12 being -- sought to be held accountable.

13 A. It's highly unusual. But it's very, very  
14 common in personal injury cases. It's highly uncommon  
15 outside of the personal injury arena. It's very common  
16 within that arena.

17 And we're governed by appropriateness of our  
18 care and treatment that we ask for and proceed with  
19 outside a personal injury claim. You don't see this  
20 kind of stuff going on with regular treatment of these  
21 kind of problems.

22 Q. Now, several of Plaintiff's -- Ms. Garcia's  
23 treatment providers who've testified here at trial  
24 contend that, because Ms. Garcia was, one, asymptomatic  
25 prior to the accident; two, that she complained of pain

1 postaccident; three, which did not resolve within a  
2 period of time, within six months or a reasonable  
3 period of time, that it was not just a simple sprain  
4 and strain that she sustained and that it -- that it  
5 was more.

6 Do you -- do you have an opinion regarding  
7 that?

8 A. Just because -- just because a person has  
9 ongoing symptoms doesn't mean it requires a fusion  
10 surgery, more extensive workup, more extensive  
11 injections or medications and refills.

12 It may be that patients' subjective  
13 complaints you can't quantify or objectify, you don't  
14 keep treating their complaints. In this situation, I  
15 think that's what occurred. I think that's why she had  
16 the surgery, because there's objective complaints that  
17 were not verified with objective findings.

18 Q. Now, Doctor, you've testified -- you  
19 testified earlier today that you don't believe that --  
20 that you don't believe that Ms. Garcia sustained an  
21 acute injury to the preexisting listhesis in her L5-S1  
22 of the low back; correct?

23 A. Correct.

24 Q. However, if a patient did sustain an acute  
25 injury or has pain associated with a listhesis, what is

1 the appropriate treatment you would recommend as a  
2 physiatrist for that patient?

3       A.     Take this situation. If I saw this patient  
4 and I found out she had a listhesis like this and it's  
5 Grade I or Grade II, I'd do everything I could from  
6 conservative standpoint to strengthen the area and  
7 provide core strengthening for her, which is going to  
8 include fairly extensive therapy to get her on track,  
9 and then transfer her over to, like, a gym setting to  
10 prevent possibly that from advancing more and requiring  
11 surgery.

12             Because you can live with this kind of --  
13 this kind of situation, and many people do. And we  
14 keep them in -- if you keep a person in good shape,  
15 flexible, strong core, you -- it cannot advance, and  
16 you can deal with things down the road without a  
17 problem.

18       Q.     Okay. Now, also Drs. Kidwell, Dr. Lemper,  
19 Dr. Gross contend that Ms. Garcia had a progressive  
20 worsening of pain which went beyond the six months  
21 postaccident which implicated the facet joints and the  
22 disks.

23             Do you agree with that assessment?

24       A.     I do not. She had some facet arthritis. She  
25 had minimal disk bulges. They were not bulging onto



1 anything. There's no neurologic deficits. There's no  
2 compression of nerve roots. She had patent foramen,  
3 which is the hole where the nerves come out.

4 I don't understand what occurred in this case  
5 and why it occurred. There's no reason for all the  
6 things that did occur. She has -- had a stable spine,  
7 and she had -- except for listhesis that was already  
8 preexisting. And she did not have a worsening  
9 condition or acute traumatic event to that condition.

10 Q. Okay. And all your opinions today are to a  
11 reasonable degree of medical probability?

12 A. Yes.

13 Q. Thank you, Doctor.

14 MR. MAZZEO: I'll pass the witness.

15 THE COURT: Mr. Strassburg? Mr. Tindall?

16 MR. STRASSBURG: Do you want to go, or you  
17 want me to?

18 MR. ROBERTS: Go ahead.

19 MR. STRASSBURG: Okay.

20

21 CROSS-EXAMINATION

22 BY MR. STRASSBURG:

23 Q. Good morning, Doctor.

24 A. How you doing?

25 Q. I'm Roger Strassburg. We briefly met

1 outside. I talk for the defendant Jared Awerbach in  
2 this case. And I -- I have a couple of questions as  
3 well.

4 Now, does the term "medical mechanism" have  
5 any meaning for you?

6 A. Well, we -- I -- it's referring to the  
7 mechanism of events or injuries. You have to worry  
8 about what -- the mechanism that led to a person's  
9 problem. So ...

10 Q. You've given testimony here today and -- and  
11 previously that there's no acute event that caused the  
12 spondylolisthesis or nerve compression. You recall?

13 A. Yes.

14 Q. Can you explain using the analysis of the --  
15 the medical mechanisms that are generally known to  
16 cause spondylolisthesis to explain the basis for your  
17 opinion that none of them occurred here.

18 A. Well, with a listhesis, that's caused by  
19 what's called a pars defect in the person's spine. And  
20 that can come from trauma, or you could have a  
21 congenitally weak spine and you could have  
22 hereditary-type issues in your spine that lead to more  
23 advanced degeneration in a more quicker period of time  
24 that would lead to a breakage of that and have a pars  
25 defect there that could then lead to a slippage that

1 can gradually become worse.

2 In general, these are degenerative nature.

3 And they don't happen to everybody's spine, but they do  
4 happen in a certain part of the population.

5 Q. If the pars defect broke in Ms. Garcia's  
6 body, would you expect there to be evidence of that  
7 fact on the MRIs or the X rays?

8 A. You may not be able to see it on the X rays.  
9 You would see a slippage. But the evidence should be  
10 shown on a CT or an MRI scan of acute changes and edema  
11 or swelling in the area that would be an acute nature  
12 that the radiologist would see and report.

13 Q. And did you see any evidence of such reports  
14 from radiology in her file?

15 A. No.

16 Q. Now, what about nerve compression? Are there  
17 any recognized medical mechanisms that cause nerve  
18 compression of the nerve roots at L5-S1, L4-L5 that you  
19 could utilize to explain the basis for your opinion  
20 that there wasn't any nerve compression here?

21 A. Well, her foramen, or the holes where the  
22 nerves come out, that we have at each level in our  
23 spine were fairly patent, meaning they were fairly  
24 open.

25 Even with the slippage and listhesis that she

1 had, you didn't see nerve compression. You didn't see  
2 any signs of the nerve being irritated or any kind of  
3 pathology. And that can come from that listhesis which  
4 starts to cause traction on a nerve, or it can come  
5 from a large herniated disk. It can come from a tumor.  
6 It can come from advanced arthritis changes in the  
7 foramen that narrows down completely around the nerve  
8 root that can lead to those kind of problems.

9 Q. All right. Why don't you come down here and,  
10 just for review, remind us all what your analysis is  
11 here. Let's get -- see if we can get close for  
12 everyone's benefit.

13 A. Okay. This is -- so you have the lumbar part  
14 of -- the thoracic spine and the lumbar spinal  
15 vertebra, they're stacked here. You have disks between  
16 each one of these. In the sacrum, they're usually  
17 fused and there's no disk here. Each level, you have  
18 nerves coming out of the foramen at each level of your  
19 spine.

20 Q. And the foramen are these holes here?

21 A. Yes. These are facets where they hook -- the  
22 bones hook together. And you get arthritis there. If  
23 that's bad enough, that can press onto a nerve root.

24 If you have a slippage, like we talked about,  
25 it can go forward or it can go backwards, retro or

1 anterior. And you can -- when it goes forward or  
2 backwards, then you can start putting traction on these  
3 nerves, because the bone is slipped, and narrow down  
4 that foramen.

5 We don't have that in this case. We have a  
6 slippage that's stable but not acutely worsened and not  
7 causing pressure on the nerve. And there's no acute  
8 nature of the event.

9 Q. Would you expect -- if there was narrowing of  
10 a foramen that impinged upon a nerve root, would you  
11 expect that to be visible on any of the MRIs or X rays?

12 A. Yes.

13 Q. And was it?

14 A. No.

15 Q. Now, if you -- there's another way to look at  
16 nerve roots, isn't there?

17 MR. ROBERTS: Objection. He didn't review  
18 the X rays or MRIs.

19 MR. STRASSBURG: It was --

20 MR. ROBERTS: I think Mr. Strassburg --

21 MR. STRASSBURG: It was reports, Judge. I  
22 apologize if I was -- for my inaccuracy.

23 Thank you for your correction. And feel  
24 free.

25 /////

1 BY MR. STRASSBURG:

2 Q. Let's take off L1.

3 And can you, using this, looking down from  
4 the top -- which you guys call axial; right?

5 A. Yes.

6 Q. Okay. And could you explain from this view  
7 how a spondylolisthesis might cause nerve root  
8 compression that could lead to pain.

9 A. Well, the same kind of procedure, but you're  
10 looking at it from a different view. You're going to  
11 be able to see, say, this bone forward on this bone  
12 and --

13 Q. You're indicating the vertebra?

14 A. Right. The vertebra being -- slipping  
15 forward or sometimes backwards and causing some  
16 traction where you have compression on the nerve root  
17 that can lead to a radiculopathy or radicular symptoms  
18 that -- to prove a radiculopathy, you can do that with  
19 further testing like an EMG study. In this case you  
20 don't have the slippage causing traction or pressure on  
21 a nerve root.

22 Q. Let's put the disk in -- bring the disk into  
23 the picture.

24 Can that lead to compression on a nerve?

25 A. Yes. Because you can have a herniation --

1 usually it's more laterally or anteriorly. You can  
2 have pressure to one side. If you have a herniation,  
3 it can herniate back -- I'm sorry. The most common --  
4 the -- where we have a problem with the nerve is  
5 posteriorly. It can posteriorly herniate out to here  
6 on a nerve.

7 In her case she has minimal 2- or  
8 2.2-millimeter disk bulges or protrusions that are --  
9 we all see in everybody's spine as we go through life  
10 and get older.

11 Q. Would -- the disk protrusions mentioned in  
12 the radiological reports, would -- would they be enough  
13 to actually bring the disk protrusion in contact with  
14 the nerve root?

15 A. No.

16 Q. Now --

17 MR. ROBERTS: Objection. Beyond the scope of  
18 his report.

19 THE COURT: Overruled. He's talked about the  
20 report, so I'm going to let him talk about that.

21 BY MR. STRASSBURG:

22 Q. All right. Now, would you show everybody  
23 where the facets are.

24 A. Well, they -- this is the area -- well,  
25 they're hooked -- the facet joints are here where they

1 hook together, posterior elements, and they hook  
2 together right here for each vertebra going down your  
3 spine.

4           They can help stabilize your spine. And  
5 with -- and -- and with movement, you can compress  
6 these when you go backwards or extension. If you have  
7 arthritis changes there or a tumor there or a fracture  
8 there, you can have acute pain extending your back  
9 backwards.

10       Q.   And were any of those conditions remarked  
11 upon in the radiological reports?

12       A.   Just facet arthritis but no -- it was mild.

13       Q.   Okay. Now, what is the function of these  
14 facet joints?

15           Let me ask it -- I'll withdraw that.

16           With regard to stabilizing the spine and  
17 preventing movement of these disks forward, do the  
18 facet joints have any function in that regard?

19       A.   It prevents your move -- it does help prevent  
20 some move -- translation, we call it. They're part  
21 of -- stabilizing part of the spine. They can help  
22 prevent abnormal motion.

23           It's -- the structures of the spine that we  
24 normally have when we're born is a complicated  
25 situation, but it -- but -- and it changes with time.



1 But they are elements that are posterior elements that  
2 help with some stability.

3 Q. And if the forces on the spine try to move  
4 the L5 vertebra forward, would the facet joints  
5 obstruct that attempted motion or not?

6 A. Some of them. More likely, you're going to  
7 have a -- you have ligaments that are holding things in  
8 place also. You have an anterior longitudinal ligament  
9 that goes up and down the whole entire spine that  
10 helps. When that -- as I mentioned, with a Grade III  
11 or IV listhesis, that ligament can be torn.

12 Q. All right. And would that show up on MRIs?

13 A. Yes.

14 Q. And if the facet joints were damaged by a  
15 trauma, would that show up on an MRI?

16 A. Yes.

17 Q. And would that be the kind of condition that  
18 a radiologist would be expected to comment on in the  
19 report?

20 A. Yes.

21 Q. And did any of them?

22 A. No.

23 Q. Okay. You can go back.

24 Any other medical mechanisms that are known  
25 to medicine as having the potential to cause pain that

1 you haven't mentioned?

2 A. Well, I did kind of mention tumors. Spinal  
3 cord injuries themselves -- damage to the spinal cord  
4 can be a problem and cause pain.

5 Q. And none of that was implicated here?

6 A. No.

7 Q. Now, let me get this up here for Mr. Blurton.  
8 Yeah, you know what to do.

9 JUROR NO. 1: I know what to do.

10 MR. STRASSBURG: Okay. It's coming. And  
11 I'll show everyone else the poster.

12 Is that up?

13 THE WITNESS: Yes.

14 BY MR. STRASSBURG:

15 Q. Do you mind coming down here, sir?

16 A. You talking to me?

17 Q. Huh?

18 A. Want me to come down?

19 Q. Yeah, you.

20 A. Okay.

21 Q. Now, we -- we've talked about this chart  
22 before. And let me just direct your attention to  
23 the -- the chart of the -- the course of chiropractic  
24 care that's reflected in the medical proof that's been  
25 stipulated into evidence here, this chiro care from

1 January 12th, 2011, after she saw the lawyer, to  
2 May 20th, 2011, and then the orthopedic consult with  
3 Dr. Cash on February 16 where he gave a recommendation  
4 of surgery and noted that her lower back was showing  
5 40 percent improvement from chiro and physical therapy.

6 But the only thing it would have been would  
7 have been the chiro care. But it would have been  
8 40 percent low back improvement.

9 And then let me direct your attention here to  
10 the Select Physical Therapy, which was from  
11 August 17th, 2012, to September 15, 2012, consisting of  
12 ten visits with Select Physical Therapy. And I'd also  
13 draw your attention to this dotted line here which  
14 marks on the chart where the surgery performed by  
15 Dr. Gross, lumbar decompression with instrumented  
16 fusion, L4-5 and S1, when that took place in  
17 California.

18 Now -- and then there were also some  
19 assessments performed by --

20 MR. ROBERTS: Objection. Not in the form of  
21 a question.

22 THE COURT: I guess.

23 MR. MAZZEO: He's laying the -- laying the  
24 foundation, Judge. He's acclimating the witness to the  
25 chart.

1 MR. STRASSBURG: Just shoot me, Judge.

2 THE COURT: Just get to a question.

3 BY MR. STRASSBURG:

4 Q. Given this proof, if she was your patient, at  
5 the -- at the end of this physical therapy, would you  
6 say, "Okay. Okay. She's a candidate for surgery. I'm  
7 not even going to try any more physical therapy" or  
8 would you do something else?

9 MR. ROBERTS: Objection. Beyond the scope of  
10 his expertise and report.

11 THE COURT: The way you asked it was. You  
12 have to rephrase the surgery part of the question.

13 MR. STRASSBURG: What's that?

14 THE COURT: I'm going to sustain the  
15 objection. It's beyond his expertise. You have to  
16 rephrase the surgery part of the question.

17 BY MR. STRASSBURG:

18 Q. Okay. Is -- is part of your expertise to  
19 determine when a patient with Ms. Garcia's profile  
20 should be referred to a surgeon for surgery?

21 A. Yes.

22 Q. All right. And how can you do that if you're  
23 not a surgeon?

24 A. That's the -- that's the biggest part of what  
25 we do in physiatry. We manage the patient and we work

1 them up totally. We are the ones that do the whole  
2 picture with a patient concerning testing, examination,  
3 giving a history, sending to therapy or a chiropractor,  
4 assessing that when they come back for follow-up,  
5 determining what they need for future-type treatments.

6           If -- if I've worked a patient up to that  
7 point and they don't need anything else, then I may  
8 discharge them and see them at some point in the  
9 future. If they have a spinal problem that might be a  
10 surgery and I have not get them where they -- the level  
11 I want them to be at for level functioning, then -- and  
12 if indicated, I would send them to a surgeon for a  
13 surgery.

14           We do that with regularity in physiatry.

15       Q.    So is determining when physical therapy and  
16 conservative treatment has run its course and -- and  
17 reached a medical plateau, is that part of your  
18 discipline, your expertise?

19       A.    It's -- it's part of my entire practice.

20       Q.    Okay. So if -- if you were -- if she was  
21 your patient and you got to here at the end of the  
22 Select Physical Therapy course and you were seeing some  
23 improvement from conservative methods, would you stop  
24 all conservative treatment and say she -- that  
25 conservative therapy has failed? Or would you keep

1 trying it longer?

2       A.    I would -- I would -- you could stop and  
3 have -- and -- and learn to deal with the pain she has.  
4 But I would probably, in her situation, give her more  
5 conservative treatment, stabilize her spine more with  
6 core strengthening, because you can do that in these  
7 situations. You may not make a person pain-free, but  
8 you can improve their functioning. And they can go  
9 through everyday life even with a listhesis like this.

10       Q.    Can you explain to us what core strengthening  
11 is.

12       A.    Essentially, your -- your -- your core is in  
13 this area here. So you have to work on anterior and  
14 posterior muscles. You're working on abdominal muscles  
15 and the lumbar muscles for strengthening that core as a  
16 stabilizing force for your spine especially in this  
17 kind of situation.

18               You try to stabilize it best as possible with  
19 exercises, weight loss, flexibility exercises, and  
20 nutrition to -- to improve that level of functioning in  
21 that person's lumbar spine. And you -- you try to keep  
22 them from going to surgery or advancing their problem.

23               In her case, she's essentially Grade I or  
24 Grade II. She would not have required surgery with  
25 the -- all the information and symptoms that I have

1 available to look at.

2 Q. Now, if -- if I direct your attention to the  
3 pain self-reporting to Select Physical Therapy at 6 out  
4 of 10.

5 Do you see that?

6 A. Yes.

7 Q. And then go all the way down here to the end,  
8 November 2016. Matt Smith Physical Therapy charts are  
9 at 7 out of 10 with activity, 4 out of 10 resting. All  
10 right.

11 So comparing these two virtual end points,  
12 would you -- can you offer any opinion as to whether  
13 the treatment between this point and that point was  
14 medically effective?

15 A. It wasn't effective.

16 Q. Now, let me direct your attention to this  
17 point here. She appears on May 25th, 2011, with  
18 Dr. Gross.

19 MR. ROBERTS: I apologize, Your Honor.  
20 I couldn't see the chart.

21 MR. STRASSBURG: Huh?

22 MR. ROBERTS: You said treatment from here to  
23 here was not medically effective.

24 What was the end point?

25 MR. STRASSBURG: That's fair. That's fair.

1 I meant -- the "here" is September 15th, 2012, Select  
2 Physical Therapy. The "there" is Matt Smith,  
3 November 18th, 2016.

4 MR. ROBERTS: Okay. I would object to  
5 anything after 2014 because he hasn't reviewed it at  
6 the time of his report.

7 MR. MAZZEO: Your Honor, can we approach  
8 please?

9 THE COURT: Sure.

10 MR. MAZZEO: Thank you.

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

13 THE COURT: Objection's overruled.

14 BY MR. STRASSBURG:

15 Q. And where were we? Here?

16 May 25th, 2011, Gross charts her as no  
17 significant leg pain but some pressure; right?

18 A. (Witness nods head.)

19 Q. And there's a break here. So that's really  
20 occurring down here.

21 MR. MAZZEO: Excuse me, counsel. The screen  
22 went off.

23 MR. STRASSBURG: I hate that. No, no. I got  
24 it.

25 I may have to run back and put more money in



1 the meter. All right.

2 BY MR. STRASSBURG:

3 Q. Can you account for -- if you can offer any  
4 medical explanation for how come she shows up at  
5 Kidwell's office on August 15th, 2012, pain at 8 out of  
6 10; and the last time that Select Physical Therapy puts  
7 her through their mill, she's at 6 out of 10.

8 Are you aware, based on your review of the  
9 record, of anything that could account for that  
10 difference?

11 A. Her work activities could be.

12 Q. Okay.

13 A. Nothing else other than that that I can think  
14 of.

15 Q. So just normal activities of daily living?

16 A. And -- and possibly that she doesn't deal  
17 with pain very well. She has a -- I think she has an  
18 emotional component to her pain. And her pain is kind  
19 of a sine wave, and she has expanding list of symptoms.

20 So I can't explain the reason for all the  
21 symptoms or the high level and up-and-down nature of  
22 the symptoms.

23 Q. Now, is that unusual with just Ms. Garcia? I  
24 mean, is this -- this is the first time you've --  
25 you -- you've had that experience, or is this fairly

1 common?

2       A.    It can be common.  It's not common throughout  
3 the whole entire population, but I've seen it happen  
4 with people in various situations.  And a lot of times,  
5 there's an emotional component and/or, like I  
6 mentioned, work-related, sports-related,  
7 hobby-related-type things that might lead to a higher  
8 level of pain.

9       Q.    And when you say there's an emotional  
10 component, what do you mean by that?

11       A.    Pain is subjective.  We all deal with pain in  
12 different ways.  We all experience pain in different  
13 ways.  We -- and in her case, she does have some  
14 emotional problems from before.  She had some  
15 depression.  She had anxiety.  She was already getting  
16 treated for that with Dr. Kidwell -- Prozac, Valium,  
17 those kind of medications.

18               So one of the ways to explain it would be  
19 that situation.  She doesn't possibly assess her pain  
20 very well.  She doesn't deal with pain very well.  And  
21 her level of pain goes up and down, and you get a  
22 longer list of symptoms.

23               It doesn't make a lot of sense.  That's why  
24 we have to objectify it if we can.

25       Q.    Does pain hurt more when your attention is

1 drawn to it?

2 A. Yes.

3 Q. And is your attention drawn to things that  
4 you feel emotional about?

5 A. Yes.

6 Q. Now, in this chart, we've charted the  
7 evidence from Dr. Kidwell's medical charts showing her  
8 self-reports of pain. And we established with  
9 Dr. Kidwell that, you know, whatever our disagreements  
10 are, that they are highly variable.

11 Would you agree?

12 A. Yes.

13 Q. Can -- bless you.

14 Can you account for that high degree of -- of  
15 variability in terms of a -- a condition that involves  
16 physical impingement upon a nerve root?

17 A. No. If you have true physical impingement or  
18 trauma or pathology of a nerve root, you're going to  
19 have very consistent symptoms over and over again --  
20 leg pain, numbness. It'll be a consistent-type  
21 situation.

22 You may vary a little bit in your pain scale  
23 on the day, but you're going to have consistent  
24 symptoms, pattern of symptoms. Always going to be  
25 there.

1           Q.    And that's not shown on this chart here;  
2 right?

3           A.    No.  No, it's not shown in the records.

4           Q.    Can you account for this degree of  
5 variability in self-reports of pain over this period of  
6 time in terms of herniation of a disk pressing upon a  
7 nerve root?

8           A.    No.  It's not related to that.

9           Q.    Okay.  How about degenerative changes of the  
10 spine?

11          A.    No.  You can have pain from that, but it's  
12 not related.  It's not -- you wouldn't see it up and  
13 down in a sine wave-type thing of symptoms.  You'd have  
14 consistent symptoms also.

15          Q.    Can you offer any medical mechanism that  
16 would account for, in a patient with Ms. Garcia's  
17 clinical profile, for this high degree of variability  
18 in pain self-reporting from August 15th, 2012, to  
19 December 9th, 2015?

20          A.    Not from an objective physical standpoint,  
21 no.

22          Q.    Doctor, why don't you go back to the stand,  
23 please.

24                   For purposes of -- of your opinions, would it  
25 have any relevance to you as to the degree of

1 effectiveness of the conservative treatment?

2 A. Yes.

3 Q. Okay. And how would that -- why would that  
4 be?

5 A. If you're having positive improvements -- and  
6 you mentioned earlier 40 percent improvements --  
7 you're -- you're expecting that kind of improvements,  
8 and you're expecting to work on that and expand on that  
9 by addressing those issues from a conservative  
10 standpoint.

11 Q. All right. Let me -- would you come down  
12 here and -- and let me just show you this chart of the  
13 chiropractic and other conservative records.

14 And do you see where we've highlighted here  
15 the indications of improvement with respect to her  
16 complaints for the head, the neck, and the mid back  
17 from the beginning of the chiro care to the end, five  
18 months later?

19 Do you see that?

20 A. That -- that represents improvements with the  
21 yellow line?

22 Q. The highlighting indicates the areas of the  
23 records where the chiropractor charts an improvement.

24 A. Okay.

25 Q. Now -- and up here you see an MRI report from

1 August the -- August 18th, 2011, studies and another  
2 one from October 17th, 2014, of the neck and back area.

3 And do you see up here that -- well, who can  
4 see that? Hold on. Don't go anywhere.

5 A. Okay. Okay.

6 Q. Maybe you can see this one where it says  
7 there are C5-6, C6-7 mild intervertebral disk bulges.

8 Do you see that?

9 A. Yes.

10 Q. And then there is a -- here's the other one.

11 Well, let me -- here, let me -- there are  
12 mild right lateral annular bulges from T2-T3 through  
13 T4-5, mild facet joint hypertrophic changes in the  
14 thoracic spine, end plate changes, and Schmorl's nodes  
15 in the -- the middle back.

16 Do you see that?

17 A. Yes.

18 Q. And would you tell us, what is a hypertrophic  
19 change in a facet joint?

20 A. That essentially is arthritis in a facet  
21 joint. That's another term for it.

22 Q. And could you tell us what end plate changes  
23 are?

24 A. End plates are the top and bottom of the  
25 vertebral body. So you can have degenerative changes

1 on top or bottom.

2 Q. And can you tell us what a Schmorl's node is?

3 A. A Schmorl's node is something identified many  
4 years ago. It's a benign node or finding,  
5 circular/oval finding, in a bone that is benign and  
6 doesn't mean anything, but it's been seen to be in some  
7 people's vertebra.

8 Q. Okay. Now, I'm just going to rotate the  
9 chart. And can you see here in March where the  
10 chiropractic evidence essentially indicates that she is  
11 pain-free for this head, neck, and mid back treatment?  
12 Do you see that?

13 A. Yes. I think -- yes.

14 Q. Okay. All right. Now, is that surprising to  
15 you that a patient that has these radiological  
16 conditions in her neck would nevertheless be able to  
17 recover from chiro care from her complaints of pain in  
18 the neck?

19 A. Not surprising. You should expect that from  
20 the treatments.

21 Q. Even though there's -- you know, there could  
22 be bulges and other abnormalities in the radiology  
23 studies?

24 A. There's sources of pain, but you can also  
25 have -- they could be silent. You have no symptoms

1 from them. They're benign -- they're -- they're  
2 minimal and degenerative in nature, and they don't  
3 always cause pain.

4 Q. All right. And as a rehabilitationist, would  
5 improvement in this -- this area make you inclined to  
6 try more conservative therapy or less?

7 A. Depends on the improvement. If I have a  
8 patient that becomes pain-free or near pain-free, I  
9 probably would not be doing any more treatments in that  
10 area.

11 I have to -- we never talked about this, but  
12 patient with a spondylolisthesis, which is in the  
13 lumbar spine, you kind of avoid chiropractic treatments  
14 because you can make it worse and you can have --  
15 affect the slippage. In the neck and mid back, you  
16 expect to have some improvement.

17 MR. ROBERTS: Objection. Nonresponsive. Not  
18 in his report.

19 THE COURT: You can't talk over him. She  
20 didn't even get what he said, so...

21 MR. ROBERTS: I apologize, Your Honor.

22 Objection. Nonresponsive. Beyond the scope  
23 of his report. Move to strike.

24 THE COURT: I'm going to allow it.  
25 Overruled.



1           Go ahead.

2 BY MR. STRASSBURG:

3           Q.   And what -- what about chiropractic treatment  
4 is -- is contraindicated for spondylolisthesis?

5           A.   Manipulation or adjustments of the spine are  
6 expected to make that situation worse. So you avoid  
7 those things.

8           Q.   Okay. Now, which is more vulnerable to  
9 whiplash injury, a neck -- in an automobile accident  
10 with a belted-in driver. Which is more vulnerable, the  
11 neck or the lumbar back?

12          A.   The neck.

13          Q.   Why?

14          A.   Because the hypermobility of your head, which  
15 is like a bowling ball on top your shoulder -- with  
16 improved nature of cars and headrests, high headrests,  
17 more security features -- I mean, more safety features,  
18 there's less chance for injury. But the hypermobility  
19 of the head can lead to a whiplash-type injury in the  
20 neck. Much less of a problem in the lumbar spine.

21          Q.   From the standpoint of a rehabilitation  
22 medicine expert, which part of the spine has the most  
23 robust, strong vertebral structures, the neck or the  
24 lumbar region?

25          A.   Lumbar.

1           Q.    Can you characterize the difference in  
2 degree?

3           A.    Well, you can see on a spine.  It shows  
4 lumbar spine.  That's much more wider, sturdier,  
5 larger.  As you go from the neck down, things get  
6 wider, sturdier, and larger.  You carry -- your center  
7 of gravity is right here.  You carry all your weight --  
8 or most of your weight in this area, so you're going to  
9 have to have more stable structures.

10          Q.    Thank you, sir.

11                Bear with me a moment.

12                You know, Doctor, why don't you return to the  
13 witness box.  I'm not going to ask you any more  
14 questions.

15                MR. MAZZEO:  Wait, Roger.  Sorry.

16                MR. STRASSBURG:  Well, maybe I will be.

17                Excuse me.

18                MR. MAZZEO:  Do you want to put it on your  
19 screen?

20 BY MR. STRASSBURG:

21          Q.    Mr. Mazzeo has reminded me.  Now, another  
22 aspect of Kidwell's records -- that you reviewed;  
23 right?

24          A.    Yes, sir.

25          Q.    And you don't have to call me sir.

1           A.    I'm from Texas.  That's what I do.  
2           Q.    What?  
3           A.    I'm from Texas.  That's what I do.  
4           MR. MAZZEO:  Roger, could you put it on your  
5 screen, if you don't mind?  
6           MR. STRASSBURG:  Yeah, sure.  
7           MR. MAZZEO:  Thanks.  
8           MR. STRASSBURG:  Let me get it -- get it  
9 right.  
10 BY MR. STRASSBURG:  
11          Q.    Okay.  When you reviewed Kidwell, you saw  
12 that little section in there on review of systems?  
13          A.    Yes.  
14          Q.    Now, is -- when you do medical charting, are  
15 there, like, standard approved ways to collect and  
16 chart medical information on a patient, or does  
17 everybody just kind of do their own thing and it's no  
18 big deal?  
19          A.    There's a standard approved way that is --  
20 we're all supposed to -- trained in and supposed to  
21 follow.  
22          Q.    And is review of systems analysis part of it?  
23          A.    Yes.  
24          Q.    And do doctors typically -- is there a  
25 generally accepted meaning to the terms "body systems"?

1           A.    Generally accepted.  You're looking at all  
2 organ systems or sections of the body.

3           Q.    Well, now, Kidwell, in his review of systems,  
4 he has a category for musculoskeletal.

5           A.    Yes.

6           Q.    And he had a category for neurological.  
7 Yeah?

8           A.    Yes.

9           Q.    And do you use those categories when you  
10 chart review of systems?

11          A.    I do.  I have a form in my charting that  
12 people -- that the patient fills out -- or if they  
13 haven't filled out, we'll go over it with them -- and  
14 it will go over various organ systems and body  
15 systems -- to see if they have any problems with those  
16 at the time that we're seeing them.

17          Q.    Well, are you familiar with how the term  
18 "musculoskeletal," used in the context of review of  
19 systems, what -- what that term is generally deemed to  
20 mean in the -- the medical -- in medicine?

21          A.    Generally, the physical part of your body:  
22 your legs, arms, neck, back, those kind of things.

23          Q.    And do you have an understanding of what the  
24 term "neurological" in the context of a review of  
25 systems is deemed to mean in medicine?

1           A.    It's related to -- well, the nervous system  
2 is related to that. It could be you're looking for  
3 things like numbness, tingling, burning, changes in  
4 those areas where the patient experiences.

5           Q.    Now, when a physician has somebody else put  
6 information in a medical chart, are you familiar with  
7 that practice?

8           A.    That happens in some practices if you have  
9 either a medical assistant, nurse practitioner, or  
10 physician assistant working with you sometimes.

11          Q.    Well, is the doctor supposed to check that  
12 stuff, or can the nonphysician inputters of that  
13 information just operate without adult supervision?

14          A.    Well, we're supposed to review what goes in  
15 our chart and be up to speed on what we're doing with  
16 the patient and all the information concerning  
17 complaints and objective findings. We're supposed to  
18 know what's going on in our chart and -- and review  
19 that.

20          Q.    All right. Now, if a chart -- if -- if you  
21 had to chart in review of systems under -- if you had  
22 the condition of a disk compressing upon a nerve root  
23 in the lumbar spine -- you know, if that was the  
24 condition you were going to categorize in your review  
25 of systems, would you put that condition in

1   musculoskeletal or neurological?

2           A.   Well, that's not a typical type thing that  
3 goes in review of systems.  If a patient, like, would  
4 come in and say, "Well, I have a disk pressing on a  
5 nerve," that's just not what patients do.

6           Q.   Okay.

7           A.   They're going to say, "I have back pain.  I  
8 have leg pain.  I have numbness pain in my knee."

9           Q.   Okay.  You're politely indicating I asked a  
10 stupid question.  I get it.  I get it.  You think I  
11 can't read minds.  I'm telling you.  All right.

12                   So let's say a patient comes in for the  
13 umpteenth time, right, same complaint, complains of leg  
14 pain, and you think it's because of a disk that's  
15 herniated; it's compressing on a nerve root.

16                   Do you chart that leg pain under the category  
17 of neurological, musculoskeletal, or something else?

18           A.   I would probably put that under  
19 musculoskeletal and then try to confirm or get more  
20 information about it.

21                   In Dr. Kidwell's notes, I know that I looked  
22 through those things, and there were -- they seem to  
23 have the almost same information each time the patient  
24 was seen in the charting without much variation.

25           Q.   And what significance do you assign to that

1 constancy?

2       A.    Unusual, because you're not going to have the  
3 same exact problems with review of systems or -- or --  
4 that each and every day you see a doctor.  You may have  
5 none on some and you may have some on others, but  
6 you're -- consistency on all review of systems, each  
7 and every chart note, is highly unusual.

8       Q.    Are you just being polite for "boilerplate"?

9       A.    For boilerplate?

10      Q.    Yeah.

11      A.    I -- I -- I have never had a patient, in 24  
12 years, have the same exact review of systems.  It just  
13 doesn't happen.  You -- you review these things, and  
14 they document them, and you try to confirm their  
15 documentation -- or you document when you talk to them,  
16 but you don't have the exact same review of systems all  
17 the time.

18      Q.    Well, how did that constancy in Dr. Kidwell's  
19 review of systems affect your assessment of his  
20 credibility?

21           MR. ROBERTS:  Objection.  Beyond the scope of  
22 his report.

23           THE COURT:  Come on up.

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

1 THE COURT: You withdraw the question,  
2 Mr. Strassburg?

3 MR. STRASSBURG: Do you mind?

4 THE COURT: No, I won't mind if you withdraw  
5 it.

6 MR. STRASSBURG: Thank you, sir. That's  
7 called weaseling out of it.

8 BY MR. STRASSBURG:

9 Q. Okay. Nowhere in Dr. Kidwell's review of  
10 systems, for all the constancy of charting, did he  
11 chart leg pain in the neurological category.

12 Now, what do you make out of that omission?

13 MR. ROBERTS: Objection. Beyond the scope of  
14 his report.

15 MR. MAZZEO: Judge -- Judge, it's within the  
16 scope of his review.

17 MR. STRASSBURG: Judge, he reviewed the  
18 records.

19 THE COURT: Come here, guys.

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

22 THE COURT: Objection is going to be  
23 sustained.

24 Go ahead and rephrase the question,  
25 Mr. Strassburg.



1 MR. STRASSBURG: Oh, I hate when that  
2 happens.

3 THE WITNESS: You need a quarter?

4 MR. STRASSBURG: I'll tell the jokes, Doctor.  
5 Although maybe I should leave that up to you.

6 BY MR. STRASSBURG:

7 Q. Okay. I want to talk to you about the bases  
8 that you have for the opinions you've given here on  
9 causation. All right?

10 A. Yes.

11 Q. Recollect all those opinions that you gave?

12 A. Yes.

13 Q. All right. Now, for purposes of your  
14 opinions on causation, what significance, if any, did  
15 it have for you that, in Dr. Kidwell's charting, he  
16 never charted leg pain as neurological, he only charted  
17 it as musculoskeletal?

18 A. What -- it could be significant. And, like I  
19 said, on my charts I put it as a musculoskeletal area.  
20 And then in subjective complaint that I want to  
21 objectify, it suggests that it's not coming from a  
22 nerve and not a nerve pathology-type situation, which  
23 it kind of suggests. I just want to clarify a  
24 complaint I get from a patient I'm trying to objectify.

25 MR. STRASSBURG: Thank you, sir.

1 I think that's all. Thank you, Mr. Mazzeo.

2 THE COURT: Want to go ahead and start for a  
3 little bit.

4 MR. ROBERTS: Up to you. Up to the Court.

5 THE COURT: Everybody okay? You want to keep  
6 going for a little bit? Why don't we take a break in  
7 about another half hour for maybe 10 or 15 minutes.

8 Go ahead and get started.

9 MR. ROBERTS: Thank you, Your Honor.

10 Hopefully, my voice will last through this,  
11 Doctor.

12 MR. STRASSBURG: You want me to get debris  
13 out of here?

14 MR. ROBERTS: Sure.

15 MR. STRASSBURG: Do you need this?

16 MR. ROBERTS: I do not.

17 CROSS-EXAMINATION

18 BY MR. ROBERTS:

19 Q. Okay. Doctor, let's talk about your  
20 qualifications to give the testimony you've offered to  
21 the jury.

22 You've talked about referring people to spine  
23 surgeons?

24 A. Yes.

25 Q. Are you qualified to perform spine surgery?

1           A.    No.

2           Q.    Have you ever performed spine surgery?

3           A.    No.

4           Q.    Is there any hospital in Nevada that would  
5 let you perform spine surgery?

6           A.    No.

7           Q.    You've given the jury opinions about  
8 injections, facet injections, nerve root blocks.

9                   Have you ever performed a nerve root block?

10          A.    No.

11          Q.    Have you ever performed a facet injection?

12          A.    In fact, I think I said that in -- in my  
13 testimony earlier. I have not.

14          Q.    And you've also given opinions that you've  
15 testified are within your specialty of physical  
16 medicine and rehabilitation; correct?

17          A.    Yes.

18          Q.    And that's a physiatrist, as you said?

19          A.    Yes.

20          Q.    Are you board-certified as a physiatrist?

21          A.    I think I've already gone over that also.

22 I'm board-eligible from graduating from a residency.

23 I'm board-eligible and not board-certified.

24          Q.    Okay. And you're not board-certified because  
25 you took the exam and you failed it; right?

1           A.    Many years ago I took the exam when I was  
2 getting out of residency.

3           Q.    And you failed it?

4           A.    Yes, I did.

5           Q.    And you took the exam a second time, didn't  
6 you?

7           A.    Yes.

8           Q.    And you failed it a second time; right?

9           A.    Yes.

10          Q.    Okay. Did you take it a third time and fail  
11 it?

12          A.    Um, I don't know. I think it was twice. I  
13 don't remember -- it's been many, many years since I've  
14 taken the exam.

15          Q.    Okay. So you're telling the jury that you  
16 took the boards twice in your own specialty; you failed  
17 it twice; and, as you sit here today, you can't  
18 remember if you took it a third time?

19               MR. MAZZEO: Objection. Asked and answered,  
20 Your Honor.

21               THE COURT: Overruled.

22 BY MR. ROBERTS:

23          Q.    Is that your testimony? Did I get it right?

24          A.    It is. I've already stated that. Yes. You  
25 don't have to be board-certified to practice in my

1 field or in medicine.

2 Q. And your field, you testified that about  
3 one fourth of it was medical-legal work?

4 A. Yes.

5 Q. And in your medical-legal work, 80 percent is  
6 for defense?

7 A. Approximately, yes.

8 Q. And why do you get hired so much more by  
9 defense than plaintiffs?

10 A. Again, I have stated this earlier today in my  
11 testimony. It's rehab doctors are conservative doctors  
12 and we do conservative treatments and we try to  
13 maximize the benefit of that. That's very likely why  
14 it occurs that way. I don't go out and market the  
15 business.

16 Q. You're not trying to tell the jury that all  
17 physiatrists testify mainly for defendants; right?

18 A. You didn't ask me that question.

19 Q. But your answer to why you get hired so much  
20 by defendants is that you're a physiatrist and  
21 physiatrists like conservative treatment.

22 A. In general, yes.

23 Q. And the portion of your work that's not  
24 medical-legal, is most of that in the area of workers'  
25 compensation?

1           A.    Sir, was there a question?

2           Q.    You mainly do workers' comp as part of your  
3 regular practice.

4           A.    Not mainly, no.  A lot of it but not mainly.

5           Q.    A lot of it?  What do you do more than  
6 workers' comp treatment?

7           A.    I do the whole scope of physiatry, which I  
8 kind of spelled out on two occasions earlier.  It's a  
9 wide scope of a practice.

10          Q.    Okay.  What proportion of your patients are  
11 workers' comp patients versus nonworkers' comp  
12 patients?

13          A.    Probably about 50 percent.

14          Q.    And in this case, you've told the jury a  
15 little bit about the fact that you're being paid for  
16 your time to review medical records.

17                Did you write reports?

18          A.    Yes.

19          Q.    Okay.  And you -- did you have your  
20 deposition taken?

21          A.    Yes.

22          Q.    And you're being paid for your time to come  
23 here to court today; correct?

24          A.    Yes.  That's very common among all doctors,  
25 yes.

1 Q. Okay.

2 A. I'm not unusual.

3 Q. From beginning to end, what's the total  
4 amount you've been paid for your work on this case?

5 A. I really couldn't say. I don't have those  
6 things up. My house manager takes care of it.

7 Q. Give us an estimate.

8 A. Maybe about \$8,000.

9 Q. Okay. The jury has heard from treating  
10 physicians in this case who treated on medical liens.

11 Do you sometimes treat patients on medical  
12 liens?

13 A. Yes.

14 Q. And when you treat patients on medical liens,  
15 does it change your treatment of the patients?

16 A. No, it does not.

17 Q. You're going to treat your patients on a  
18 medical lien the exact same way as someone who's paying  
19 in a different way; correct?

20 A. Why would I change my treatment for them?

21 Q. Well --

22 MR. MAZZEO: Objection, Judge. Beyond the  
23 scope of his report.

24 BY MR. ROBERTS:

25 Q. The reason I'm asking that --

1 MR. MAZZEO: I have an objection standing.

2 MR. ROBERTS: Oh, sorry.

3 THE COURT: It's not in his report. I agree.

4 Sustained.

5 MR. ROBERTS: It was asked in his deposition,

6 Judge, and these are the answers he gave in his

7 deposition.

8 THE COURT: If he was asked in his

9 deposition, then I think it's fair game. Overruled.

10 MR. ROBERTS: Thank you, Your Honor.

11 BY MR. ROBERTS:

12 Q. And the reason I'm asking you is you just

13 told the jury that you only saw treatment like

14 Ms. Garcia's in the context of a legal claim.

15 Did I get that right?

16 A. I see it very regularly in personal injuries

17 claims, yes. The extensive treatment, that's

18 unexplainable.

19 Q. You're not trying to tell the jury that you

20 never see prescriptions for narcotics outside of legal

21 claims, are you?

22 A. I wasn't asked that question.

23 Q. Okay. You're not trying to tell the jury

24 that you only see nerve root blocks in legal claims,

25 are you?



1           A.    No.

2           Q.    You're not trying to tell the jury that you  
3 never see facet injections outside of legal claims;  
4 right?

5           A.    No.

6           Q.    You're not trying to tell the jury that you  
7 don't see spine fusion except in legal claims; right?

8           A.    Correct.

9           Q.    And you've been hired by Mr. Mazzeo on other  
10 cases; is that fair?

11          A.    I'm, I think, one other case with him.

12          Q.    And one -- one thing I don't think the jury  
13 has heard -- and I apologize if I ask you a couple of  
14 questions that came out earlier -- but have you ever  
15 performed a rhizotomy?

16          A.    I have not.

17          Q.    What percentage of your private practice  
18 deals with patients who have pain in their spine?

19          A.    Probably about 80 percent.

20          Q.    Okay. And have you ever treated a patient  
21 who had pain in their spine which you determined was  
22 from a trauma but which did not have an immediate onset  
23 of pain on the same day?

24          A.    I don't remember one. It would be kind of  
25 highly unusual. I don't remember one. Oh, within 24

1 hours usually. Within 24 hours I would say it probably  
2 occurs.

3 Q. Okay. So you -- it does happen that they  
4 don't have pain immediately at the scene of an  
5 automobile collision?

6 A. Are you just talking about general pain?

7 Q. Yes, pain from their spine.

8 A. Yeah. Just general pain, yes, could happen  
9 within 24 hours.

10 Q. But you're saying that it couldn't go beyond  
11 24 hours?

12 MR. MAZZEO: Objection. Vague as to which --  
13 what spine pain, spine injury.

14 MR. ROBERTS: Let --

15 THE COURT: I don't know if it was vague in  
16 that regard, but the question was vague. So rephrase  
17 it.

18 MR. ROBERTS: I will.

19 BY MR. ROBERTS:

20 Q. Where are the -- where do the disks feel  
21 pain? Do they feel pain inside? Outside? Front?  
22 Back?

23 A. They cause pain if they're bulging onto the  
24 nerve root.

25 Q. Okay. But the disk itself -- let's assume

1 there's damage to the disk itself, the fissure, an  
2 annular tear.

3 Is the -- is the whole disk innervated?

4 A. You don't have -- you generally don't have  
5 pain from the disk when this occurs. You have pain  
6 from other structures.

7 Q. So assume for me that you've got damage to  
8 the inside of a disk.

9 It's not innervated, so the patient's not  
10 going to feel that; right?

11 A. Well, you're asking really general, general  
12 questions and general -- in general terms, if you have  
13 a damage to the disk, that's kind of a really  
14 broad-type thing.

15 If you have damage to a disk itself and  
16 there's something going on inside the disk, you may not  
17 have pain.

18 Q. Thank you, Doctor. And you testified that,  
19 in your opinion, Ms. Garcia suffered some sort of  
20 sprain/strain in this automobile collision; right?

21 A. Possibly, yes. Minimal in nature, I said,  
22 yes.

23 Q. Yes. But more likely than not, you agree  
24 with the other doctors that she was injured; correct?

25 A. With a soft tissue-type injury, yes.

1 Q. Okay. Your dispute is with the severity and  
2 permanency of the injury; correct?

3 A. There's no permanency to her injury that  
4 occurred in the accident. That's what I'm stating.

5 Q. Right. Because a sprain/strain, even if you  
6 do nothing, more likely than not is going to resolve  
7 over a short period of time, 8 to 12 weeks, a year at  
8 the longest; right?

9 A. Not usually a year. It's about three months  
10 or less in general.

11 Q. When you -- when you mentioned the word  
12 "problems and complaints from day one" -- do you  
13 remember telling that, Doc, to the jury in response to  
14 a question on direct?

15 A. Yes.

16 Q. When is day one?

17 A. Day one of the injury, of the trauma.

18 Q. Okay. So day one is January 2nd, 2011?

19 A. I can't remember the exact date. I think  
20 that's the -- if that's the day of the accident, that  
21 would be considered -- I was asked about a traumatic  
22 event to her spinal region and the listhesis.

23 Q. Okay.

24 A. That's a different -- big difference what  
25 you're trying to say in general terms and broad terms.

1 Q. Well, that's why I'm trying to get  
2 clarification.

3 When you told the jury since day one, when  
4 was day one?

5 A. The date of the accident.

6 Q. Okay. And you're not telling the jury that  
7 you've seen any evidence that Ms. Garcia had any pain  
8 from her lumbar region before the accident, are you?

9 A. Am I stating she had no pain prior to the  
10 accident?

11 Q. Let me rephrase so I'm perfectly clear.

12 You would agree that, in all the records you  
13 reviewed and all the depositions you reviewed, there's  
14 no evidence that Ms. Garcia had any lumbar pain prior  
15 to the collision of January 2nd, 2011?

16 A. I didn't see a record suggesting significant  
17 pain in her lumbar spine area.

18 Q. Tell me about the records you saw which  
19 suggested pain in the lumbar spine that you didn't feel  
20 was significant. Or did you mean to --

21 A. I think you just misstated what I said --  
22 what I was talking about.

23 Q. Okay. So what you meant to say is you didn't  
24 see any records of any pain to the lumbar spine prior  
25 to the collision; right?

1           A.    I remember records of pain to the lumbar  
2 spine -- it's unusual because the listhesis would  
3 normally cause pain.

4           Q.    What study do you rely upon for that, Doctor?

5           A.    It's my history of seeing -- dealing with  
6 problems. Usually you have some pain at some point in  
7 time in your life with listhesis. I didn't cite a  
8 study.

9           Q.    So you're not familiar with the study showing  
10 over 80 percent of people with a spondylolisthesis are  
11 completely asymptomatic?

12          A.    So the 20 percent should have pain in their  
13 spine.

14          Q.    Okay. And since we're dealing with more  
15 likely than not here, it's more likely than not someone  
16 with a spondylolisthesis is going to be completely  
17 asymptomatic; right? 80 percent.

18          A.    That's one study. I don't -- I don't see  
19 that in my practice. I've seen people with listhesis  
20 that have pain that they deal with.

21          Q.    If the accident, the collision of  
22 January 2nd, 2011, did not cause Ms. Garcia's pain that  
23 did not go away, what did cause it?

24          A.    I couldn't tell you. Pain that doesn't go  
25 away doesn't mean it's from trauma. We've already gone

1 over many things that could cause pain.

2 Q. Right. So she didn't have the pain before  
3 the collision. She has the pain after the collision,  
4 and it never goes away.

5 You can't offer this jury any other  
6 explanation for what caused it, can you?

7 A. Well, she has a listhesis, and now she has a  
8 fusion. And her pain level went up and down and had  
9 more list of symptoms.

10 Q. Did she have the pain before the fusion?

11 A. I don't know how many times I have to answer  
12 that, but I think we've already kind of covered that.

13 Q. She did.

14 A. Not that I know of. I didn't see pain in the  
15 records from prior to the accident.

16 Q. Okay. I said before the fusion.

17 So after the accident and up to the fusion,  
18 she had pain that didn't go away in her lumbar region;  
19 correct?

20 A. Correct.

21 Q. Okay. So the -- so the fusion didn't cause  
22 all of her pain; it was there before the fusion.  
23 Agreed?

24 A. Correct.

25 Q. Did you say that, even if a patient has pain,

1 if you don't see an objective finding of trauma, that  
2 you won't treat the patient?

3 A. I don't think I said that. I'd want to  
4 assess their pain and objectify it.

5 Q. Okay. And you would agree that you can't  
6 look at an MRI or an X ray or the radiological report  
7 of a MRI or an X ray and tell if a patient's in pain;  
8 right?

9 A. Correct. You don't look at that to prove  
10 pain.

11 Q. You can see age-related changes on an MRI of  
12 a patient that has no pain; right?

13 A. Correct.

14 Q. And you can have a patient in severe pain,  
15 and look at an MRI and can't find it; right?

16 MR. MAZZEO: Objection, Your Honor. Vague.

17 THE COURT: Overruled.

18 THE WITNESS: Not all pain is related to an  
19 MRI finding.

20 BY MR. ROBERTS:

21 Q. Did you state that radiating symptoms are  
22 temporary if you do not have a true radiculopathy?

23 A. In general -- I might have stated that. In  
24 general, they can be temporary, and they should clear  
25 with time.



1 Q. And more likely than not, if it's just  
2 radiating pain and there's no true radiculopathy, it's  
3 going to go away with time?

4 A. In general.

5 Q. And when you talked about the MRIs and the  
6 X rays that Ms. Garcia had taken after the collision,  
7 you just looked at the radiologist's report and not the  
8 films themselves; right?

9 A. I've seen the three MRI films also.

10 Q. When did -- did you see those after you wrote  
11 your report and after you took your deposition?

12 A. Yes.

13 Q. Is it reasonable for a physician to rely on  
14 the findings in a radiological report done by the  
15 radiologists?

16 A. Solely rely on that?

17 Q. To rely on that for part of the opinions.  
18 You relied on these things for your opinions. I'm  
19 asking if that's reasonable.

20 A. In my field of treatment, I look at lumbar  
21 spine X rays all the time. So I wouldn't solely rely  
22 on the radiologist report. I'd confirm what I see  
23 also.

24 Q. Let's talk about the process here.

25 You how many reports have you written in this

1 case?

2 A. Two.

3 Q. Okay. And when -- when did you write those  
4 reports? Do you remember the dates?

5 A. Back in 2014. One was in October, and one  
6 was in November.

7 Q. And then you had your deposition taken;  
8 right?

9 A. I don't remember the exact date of the  
10 deposition. I think it was -- I think it was after  
11 that, after the deposition.

12 Q. And you -- you understood that the purpose of  
13 those reports -- because you've done legal work before.

14 You understood that the purpose of those  
15 reports was to give us your opinions and the bases for  
16 those opinions; right?

17 A. Yes.

18 Q. Okay. And at the time you gave us the  
19 opinions, which are substantially the same at the time  
20 you wrote the reports as they are now -- at the time  
21 you gave us those opinions, you felt comfortable giving  
22 them even though you'd never reviewed the films  
23 themselves?

24 A. Correct.

25 Q. Because you just relied upon the radiology

1 reports; correct?

2 A. I did, yes.

3 Q. Counsel showed you Exhibit 19, which is a  
4 record from Dr. Hake at Las Vegas Radiology from  
5 November 19th, 2012.

6 Do you remember reviewing that with the jury?

7 A. Yes.

8 Q. Okay. There was a part that wasn't showed to  
9 you by defense counsel.

10 Audra, if you could put up page 14, right in  
11 the middle of the page, the last paragraph before the  
12 electronic signature.

13 The radiologist, Dr. Hake, said, "When  
14 compared with the prior examination, there is continued  
15 anteriospondylolisthesis of L5 upon S1. Previous  
16 slippage measures 7.5 millimeters and currently  
17 measures 1.02-centimeters" -- or -- that's  
18 10.2millimeters. "There is increasing foraminal --  
19 foraminal encroachment."

20 Did you notice that before you gave your  
21 opinions?

22 A. Yes.

23 Q. If the radiologist is correct, is that  
24 evidence that the spondylolisthesis was unstable in the  
25 period of time from the January 2011 MRI to the

1 November 2012 MRI?

2 MR. MAZZEO: Objection. Speculation.

3 THE COURT: Overruled.

4 THE WITNESS: I'm not -- I wouldn't say it's  
5 unstable. I think it's -- if that's the case -- and I  
6 looked at the films also later, and they didn't look  
7 much different when I looked at them, but that's --  
8 just means there's a change.

9 BY MR. ROBERTS:

10 Q. So if the radiologist is right, the slippage  
11 of L5 over S1 has increased by -- what's that,  
12 25 percent over two years?

13 A. If they're right. And if you look at the  
14 films, the 25 percent would be -- it doesn't look like  
15 that way at all.

16 Q. And if they're right and this rate of  
17 instability had been in existence prior to the  
18 accident, L5 would have just fallen right off S1 by  
19 this time, wouldn't it?

20 MR. MAZZEO: Objection. Foundation.  
21 Speculation.

22 THE COURT: I think I'm going to have to  
23 sustain that one. I don't know that he can testify to  
24 that.

25 /////

1 BY MR. ROBERTS:

2 Q. How many millimeters wide is an S1 vertebral  
3 body front to back?

4 A. S1 vertebral body, how many millimeter wide?

5 Q. Yes.

6 A. I don't know exactly for sure.

7 Q. Is it fair to say that the words "failed  
8 surgery syndrome" or anything like that are not in any  
9 of your reports?

10 A. I would have to look again. I don't know if  
11 it's in my report or not.

12 Q. And you didn't talk about it in your  
13 deposition when we asked you what all your opinions  
14 were; right?

15 A. No. I got asked about it here.

16 Q. Okay. By counsel?

17 A. Correct.

18 Q. Okay. Did you meet with either of the  
19 counsel for the defendants prior to testifying today?

20 A. I talked to Mr. Mazzeo on the phone, yes.

21 Q. Okay. How long did you talk to him for?

22 A. About an hour and a half.

23 Q. Okay. When did you do that?

24 A. Yesterday.

25 Q. Okay. Did you discuss failed lumbar surgery

1 syndrome or any similar term in that conversation?

2 A. I don't think so, no.

3 Q. Did you discuss whiplash or comparing spine  
4 to lumbar whiplash injuries in that conversation?

5 A. No.

6 Q. Did you discuss whether Dr. Lemper's  
7 treatment was appropriate?

8 A. I don't think we discussed that in that way,  
9 no.

10 Q. Did you discuss whether Dr. Kidwell's  
11 treatment was appropriate?

12 A. No, we did not discuss that.

13 Q. What did you talk about?

14 A. Talked about my -- my scope of my reports.  
15 I -- he was able to email me the films and the MRI  
16 scan. And we talked about time of testimony and where  
17 it was at because I didn't know where it was.

18 Q. I'd like to go over some of the things you  
19 previously testified to at your deposition compared to  
20 today.

21 Are you offering an opinion today that you  
22 believe Ms. Garcia's smoking contributed to her need  
23 for spine surgery?

24 A. I don't even know where you'd get that from.  
25 I didn't even state that.

1 Q. So you're not offering that opinion?

2 A. That her need for spine surgery was due to  
3 smoking?

4 Q. Yes.

5 A. I wasn't asked that. That's the first time  
6 I've heard that today, about the need for surgery for  
7 that.

8 Q. So you're not opining that her smoking caused  
9 her need for medical treatment following the automobile  
10 collision?

11 A. What I said earlier was that it can affect  
12 healing.

13 Q. Right. And I'm asking are you offering an  
14 opinion today -- that's fine.

15 Are you offering an opinion that her fusion  
16 didn't heal because she was a smoker?

17 A. No.

18 Q. All right. Because, in fact, her fusion did  
19 heal; right?

20 A. Yes.

21 Q. Now, we talked a little bit -- or you talked  
22 with counsel a little bit about Dr. Lemper's treatment  
23 and Dr. Kidwell's treatment.

24 Is it fair to say that you're not offering  
25 any opinions as to whether their treatment was

1 appropriate based on Ms. Garcia's complaint; you're  
2 only offering an opinion as to whether those treatments  
3 were causally related to the automobile collision?

4 A. Yes.

5 Q. And does that go beyond Dr. Lemper and  
6 Dr. Kidwell to the totality of treatment? You're only  
7 offering an opinion that the treatment, after the  
8 initial myofascial sprain/strain resolved, was not  
9 necessitated by the accident or by the collision;  
10 right?

11 A. Yes.

12 Q. Okay. You're offering no opinion as to  
13 whether or not that treatment was reasonable and  
14 appropriate for the condition, separate and aside from  
15 the accident?

16 A. I did say earlier today about the  
17 chiropractic treatments possibly not being performed on  
18 a listhesis because you could make that problem worse.

19 Q. But you never said that in your report;  
20 right?

21 A. I don't remember if it was worded that way,  
22 no.

23 Q. Okay. And you didn't say that in your  
24 deposition; right?

25 A. I don't think so, no.



1 Q. And, in fact, from your review of  
2 Dr. Gulitz's records, you've seen absolutely no  
3 indication that he performed an adjustment to her  
4 lumbar spine that could have aggravated or caused a  
5 listhesis; right?

6 A. I don't see it spelled out in the records  
7 like that, no.

8 Q. You stated that, in your view, that the  
9 success rate for lumbar fusion was low.

10 Did I get that right?

11 A. Well, it was a general question that -- it's  
12 kind of a -- the success rate I'm referring to is a  
13 person achieving a pain-free status, which is low.

14 Q. Okay. So what about a 50, 60, 70 percent  
15 reduction in pain? Do you see that sometimes?

16 A. We can, yes.

17 Q. And is the -- is that probability  
18 significantly higher than a total resolution of pain?

19 A. Yes.

20 Q. And, in fact, is it -- is it fair to say that  
21 maybe 50 percent or more of people have a 50 percent or  
22 higher reduction in pain after a lumbar fusion?

23 A. I don't see it in my practice in Las Vegas.  
24 It -- it is expected that that should occur.

25 Q. Okay. And when you say "expected," that's

1 what studies outside of Las Vegas indicate?

2 A. I've seen studies like that you would expect  
3 to have an improvement like that.

4 Q. And isn't it true that lumbar fusion on  
5 people with a spondylolisthesis have an even higher  
6 success rate than the average in causing a significant  
7 reduction in pain?

8 A. Done for the right reasons, you should expect  
9 decrease.

10 Q. Okay. You never examined Ms. Garcia, did  
11 you?

12 A. I did not.

13 Q. And you have not met Ms. Garcia?

14 A. I have not.

15 Q. And you have given the opinion -- let me make  
16 sure I'm summarizing this correctly -- that Ms. Garcia  
17 is magnifying her pain when she reports it to her  
18 physicians?

19 A. That's what it appeared to be in several  
20 records in the changing symptoms and the higher level  
21 and up-and-down symptoms, yes.

22 Q. Okay. Is this a conscious magnification?  
23 She's intentionally doing this? Is that your opinion?

24 A. I couldn't tell you.

25 Q. Okay. Is it fair to say that, in your

1 reports and in your deposition, you never offer any  
2 explanation for Ms. Garcia's palpable spasms in her  
3 back from January 12th, 2011, up until 2015? You never  
4 offer that opinion, do you? It's a yes-or-no question.

5 A. No.

6 Q. How long can Ms. Garcia stand without pain?

7 A. I don't know. I just know she was working a  
8 full day of work.

9 Q. How long can Ms. Garcia sit without pain?

10 A. I don't know.

11 Q. What's the heaviest thing Ms. Garcia can lift  
12 without pain?

13 A. I don't know.

14 Q. On a flexion-extension test, like you  
15 commented on with Dr. Cash, can a patient's  
16 flexion-extension test be influenced by guarding?

17 A. Right. And that's subjective.

18 Q. Right. And so I'm just trying to understand,  
19 when counsel was asking you about it, if this had been  
20 a valid result or a real result that she wouldn't be  
21 able to do all these other things, that didn't make  
22 sense to you; right?

23 A. Correct.

24 Q. But if a patient is in pain and having spasm,  
25 they may be guarding and not wanting to go further

1 because they're tightening up; right?

2 A. They may be.

3 Q. And -- and you're not suggesting that that  
4 only happens when a patient is faking an exam and  
5 trying to make it look like their injury is worse; a  
6 patient can be in pain and resisting that motion.

7 Right?

8 A. It occurs in both ways that you're  
9 mentioning. Our question would concern the consistency  
10 in the records.

11 Q. You -- you talked about whiplash and -- and  
12 the spine being more vulnerable because of the head;  
13 right?

14 A. Correct.

15 Q. It is possible to injure the lumbar spine in  
16 a motor vehicle accident; right?

17 A. Yes.

18 Q. And it is possible to injure a disk in the  
19 lumbar spine in a motor vehicle accident; right?

20 A. Yes.

21 Q. And it is possible for a motor vehicle  
22 accident to make an asymptomatic preexisting  
23 spondylolisthesis symptomatic; correct?

24 A. Yes.

25 MR. ROBERTS: Court's indulgence just for a

1 second. I think I can skip some of this.

2 BY MR. ROBERTS:

3 Q. You believe that Ms. Garcia should have lost  
4 weight; right?

5 A. Is that a general -- a general question?

6 Q. Yes. In -- in your reports and in your  
7 deposition, you said that Ms. Garcia should have lost  
8 weight and her pain would have gotten better?

9 A. So that's one of the things we look for in  
10 patients, to try to have them lose weight.

11 Q. How much pain should Ms. Garcia have lost --  
12 I mean, how much weight?

13 A. You can't determine it that way.

14 Q. How much did Ms. Garcia weigh at the time of  
15 the motor vehicle collision when she was asymptomatic?

16 A. I -- I'm sorry. I don't remember her weight.  
17 If you show me her record, I can tell you. But I don't  
18 remember her weight.

19 Q. You're not suggesting to the jury that her  
20 onset of pain was caused by her weight, are you?

21 A. I don't think I testified like that, no.

22 Q. And you're not testifying that, if Ms. Garcia  
23 just lost weight, she wouldn't have needed any of the  
24 treatment that she received. You're not saying that;  
25 right?

1           A.     Again, if a -- we try to get a patient to  
2 lose weight for spinal problems; that could help them.

3           MR. ROBERTS: Your Honor, Court's indulgence  
4 just for a second.

5           THE COURT: If you're at a good breaking  
6 point, maybe we can take a break now, Mr. Roberts.

7           MR. ROBERTS: Sounds good, Your Honor.

8           THE COURT: Let's go ahead and take another  
9 quick break, folks.

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

18           You are not to conduct any research on your  
19 own, which means you cannot talk with others, Tweet  
20 others, text others, Google issues, or conduct any  
21 other kind of book or computer research with regard to  
22 any issue, party, witness, or attorney involved in this  
23 case.

24           You're not to form or express any opinion on  
25 any subject connected with this trial until the case is

1 finally submitted to you.

2 Take 10 or 15 minutes.

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

5 THE COURT: We're outside the presence of the  
6 jury. Anything we need to put on the record, Counsel?

7 MR. SMITH: I would like to put one thing on  
8 the record.

9 For the second time, Mr. Strassburg violated  
10 his own Motion in Limine No. 12. The other day -- in  
11 his Motion in Limine No. 12 precludes him from  
12 attacking the credibility of a witness.

13 The other day he said he didn't trust  
14 Dr. Gross. And then today, in a passing comment, he  
15 called Select Physical Therapy a mill, which is an  
16 attack on the credibility of one of the treating  
17 physicians in this case.

18 And, you know, I don't know if we're going to  
19 get a chance to redirect or anything today or as we go  
20 on, but those type of comments are not appropriate. He  
21 shouldn't have said it to Dr. Gross and he shouldn't be  
22 attacking the credibility of the treating physicians.

23 THE COURT: Probably true.

24 MR. STRASSBURG: Dr. Gross picked a fight  
25 with me, and he got as good as he gave. The use of the

1 term "mill," I don't know what he's talking about,  
2 Judge. I meant nothing untoward by that. "Mill" is  
3 not a term from -- coming from northeastern Ohio, the  
4 land of many mills, it is not a derogatory term to me.

5 MR. MAZZEO: It didn't seem, Judge. I heard  
6 what Mr. Strassburg said. It didn't seem like a  
7 derogatory term when he said it. It could be used in a  
8 derogatory sense but not in the context in which Roger  
9 used it.

10 MR. STRASSBURG: Now, had I used it against  
11 plaintiff's law firms, that would have a derogatory  
12 connotation.

13 THE COURT: I could see how it could be  
14 considered a derogatory term. So just be careful.

15 MR. STRASSBURG: Yes, Judge. I'll abide by  
16 that caution. Thank you.

17 THE COURT: Anything else?

18 Off the record.

19 (Whereupon a short recess was taken.).

20 THE MARSHAL: Jury entering.

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

23 MR. MAZZEO: Can we approach briefly.

24 THE COURT: Sure. Come on up.

25 /////



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

3 THE MARSHAL: Jury is present, Judge.

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

6 Do the parties stipulate to the presence of  
7 the jury?

8 MR. ROBERTS: Yes, Your Honor.

9 MR. MAZZEO: Yes, Your Honor.

10 MR. STRASSBURG: Yes.

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

13 THE WITNESS: Yes, sir.

14 THE COURT: Be reminded to try to talk slow.

15 THE WITNESS: Yes, sir. Numerous times.

16 THE COURT: Go ahead, Mr. Roberts.

17 MR. ROBERTS: Thank you, Your Honor. Found  
18 my missing sheet over the break. So I appreciate the  
19 indulgence.

20 BY MR. ROBERTS:

21 Q. Doctor, is it your opinion that Ms. Garcia  
22 had a preexisting spondylolisthesis?

23 A. Yes.

24 Q. Would that make her more susceptible to  
25 injuring her lumbar spine in a motor vehicle accident?

1 MR. MAZZEO: Objection, Your Honor.

2 Foundation. Depends on mechanism of injury.

3 THE COURT: Overruled.

4 THE WITNESS: It could, depending on various  
5 factors.

6 BY MR. ROBERTS:

7 Q. And, in fact, Ms. Garcia's spine could have  
8 been injured in the automobile collision of  
9 January 2nd, 2011?

10 MR. MAZZEO: Objection, Your Honor.  
11 Speculation. Anything's possible.

12 THE COURT: Overruled.

13 THE WITNESS: It could have, but the records  
14 don't show that it -- that it did occur.

15 MR. ROBERTS: Thank you, Doctor.

16 That's all I have, Your Honor.

17 THE COURT: You go first? Yeah.

18 MR. MAZZEO: Yes, I do.

19 THE COURT: Go ahead.

20 MR. MAZZEO: Thank you.

21 REDIRECT EXAMINATION

22 BY MR. MAZZEO:

23 Q. Dr. Poindexter, on cross-examination you were  
24 asked about the -- the difference between when you're  
25 hired by the defense versus when you're hired by the

1 plaintiff in the medical-legal claims; right?

2 A. Yes.

3 Q. And -- and could it be that -- also that  
4 you're hired by the defense more often because  
5 plaintiffs have their own treating physicians to  
6 testify on their own behalf in trial?

7 MR. ROBERTS: Objection. Leading.

8 THE COURT: Sustained.

9 MR. MAZZEO: Well, it was could have, so I --

10 THE COURT: You suggested the answers.

11 MR. MAZZEO: Okay.

12 THE COURT: Objection is sustained.

13 BY MR. MAZZEO:

14 Q. What other reasons, Doctor, would -- what  
15 other reasons would there be for you being retained by  
16 the defense in medical-legal claims more -- more times  
17 than -- more -- more for the defense than for the  
18 plaintiff?

19 A. Well, as I said, conservative treatment from  
20 being a physiatrist. I don't -- I'm not a person who's  
21 involved in personal injury cases all the time. There  
22 are many doctors who are, and they're always seeing the  
23 records.

24 Q. Okay. Now, you've also -- you -- you  
25 testified also that you had reviewed -- reviewed the

1 films of the MRIs from January 2011, August 2011, and  
2 November of 2012; right?

3 A. Yes.

4 Q. And do you agree with the radiologist's  
5 finding about the continued slippage and increasing  
6 foraminal encroachment?

7 MR. ROBERTS: Objection, Your Honor. Beyond  
8 the scope of his report.

9 He can say he didn't change his opinion, but  
10 he can't disagree with it now.

11 THE COURT: Sustained.

12 BY MR. MAZZEO:

13 Q. Okay. Do you have an opinion, with regard to  
14 the finding by the radiologist that you were shown on  
15 that report by Mr. Roberts a few minutes ago, about the  
16 progression of slippage? Do you recall that  
17 questioning?

18 A. Yes, I do.

19 Q. Okay. And after having reviewed the film --  
20 I know you initially had reviewed the report, but after  
21 having reviewed the film, do you have an opinion -- are  
22 you in agreement with the radiologist's finding after  
23 reviewing the film?

24 MR. ROBERTS: Objection. Beyond the scope of  
25 the report.

1           MR. MAZZEO: Your Honor, it was brought out  
2 on cross-examination.

3           THE COURT: You can only -- we talked about  
4 the question you can ask. Come on up.

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

7           MR. MAZZEO: The question is withdrawn, Your  
8 Honor.

9           THE COURT: Thank you.

10 BY MR. MAZZEO:

11         Q. Doctor, you were -- you were asked about  
12 spasms on cross-examination?

13         A. Yes.

14         Q. All right. And can you tell the jury what --  
15 when we talk about spasms, what are we talking about?

16         MR. ROBERTS: Objection, Your Honor. Beyond  
17 the scope of his report.

18         MR. MAZZEO: It's -- this is redirect, Your  
19 Honor, based on the scope of cross-exam.

20         MR. ROBERTS: My cross-examination confirmed  
21 he had no opinions.

22         MR. MAZZEO: He opened the door. This is  
23 clearly within the scope of cross -- redirect.

24         THE COURT: If it's not in his report, it's  
25 not in his deposition, I'm not going to allow it.

1 Overruled -- or the objection is sustained, I guess.

2 Yeah.

3 BY MR. MAZZEO:

4 Q. Doctor, when do you find, with regard to  
5 spasm --

6 MR. MAZZEO: Am I not allowed to ask anything  
7 about spasms here? You going to object?

8 MR. ROBERTS: Yes.

9 MR. MAZZEO: Judge, are you going to sustain?

10 THE COURT: I don't know what's in the  
11 report, but if it's not in the report, yes.

12 MR. MAZZEO: Okay. We'll move -- we'll move  
13 on.

14 No further questions.

15 THE COURT: Mr. Strassburg.

16 THE WITNESS: My leg is starting to spasm  
17 right now.

18 THE COURT: That wasn't in your report  
19 either.

20 MR. STRASSBURG: Thank you, Judge.

21 CROSS-EXAMINATION

22 BY MR. STRASSBURG:

23 Q. Dr. Poindexter, is there anything in the wake  
24 of Mr. Roberts' cross-examination of you that makes you  
25 want to change any of the opinions that you've rendered

1 here today?

2 A. No, sir.

3 Q. Now, you recollect Mr. Roberts showing you  
4 this Hake report by the radiologists on the imaging  
5 studies done on Ms. Garcia on November 19th, 2012?

6 A. Yes.

7 Q. And you recollect that in that radiology  
8 report, Radiologist Hake said that the slippage that he  
9 observed on the films, when compared to the prior  
10 films -- I guess he meant of August 18, 2011 -- showed  
11 that the slippage at L5-S1 had increased from  
12 7.5 millimeters to a 10 point -- I'm sorry --  
13 1.02-centimeters. Recall?

14 A. Yes.

15 Q. And you know that 1.02 centimeters is  
16 10.2 millimeter, because there's 10 in each centimeter;  
17 right?

18 A. Yes, sir.

19 Q. Okay. So that would mean, then, that what  
20 the Hake report is saying is that there was an increase  
21 in slippage between August 19, 2011, and  
22 November 19th, 2012, of 2.7-millimeters in distance;  
23 true?

24 A. Yes.

25 Q. And the Hake report also said that there was

1 increasing foraminal narrowing that was also observed;  
2 right?

3 A. The term was "encroachment," but, yes, that's  
4 what it was referring to.

5 Q. And increasing foraminal narrowing is -- is  
6 this -- the notch here, right, that we talked about?

7 A. The -- the foramina is the hole where the  
8 nerves come out on the side.

9 Q. Right. And he's talking about this one down  
10 here at L5-S1?

11 A. Yes.

12 Q. All right. So if -- if we take -- convert  
13 this to percentages, like 2.7-millimeters divided by  
14 7.5 millimeters, that's about 36 percent increase;  
15 right?

16 A. I have to do the math, but it's for sure over  
17 25 percent.

18 Q. All right. And so would you be of the view  
19 that if a -- a disk -- or a vertebra moved from its  
20 position in August of 2011, 36 percent increase in  
21 displacement till its position in November of 2012,  
22 that that kind of increase from 7.5 to 10.2, that would  
23 probably cause impingement upon the nerve root. It  
24 would be large enough to do that? Right?

25 A. Very likely it could, yes.



1 Q. All right. And then that would provide --  
2 that -- that displacement of the L5 vertebra on S1,  
3 that would provide a medical mechanism that would  
4 account for a particular kind of pain, nerve pain;  
5 right?

6 A. Yes.

7 Q. All right. Now, let's say you wanted to  
8 check that from the films.

9 MR. STRASSBURG: And I know. I know. He  
10 hasn't seen the films. Okay?

11 BY MR. STRASSBURG:

12 Q. But if you were going to check that, is there  
13 any kind of comparison that you're aware of that a  
14 radiologist could perform to check Dr. Hake's report?

15 MR. ROBERTS: Objection. Beyond the scope of  
16 his expertise.

17 MR. STRASSBURG: It's not in his report, but  
18 it's in the scope of the cross-examination, and it's  
19 fair, Judge.

20 THE COURT: Well, I think he did testify  
21 about the -- the radiological studies. I'm going to  
22 allow it. Overruled.

23 BY MR. STRASSBURG:

24 Q. What would it be?

25 A. Interesting enough, in my own practice I get

1 films, and I measure those things on my own films. So  
2 I deal with this thing -- this type of problem for  
3 years in my practice. I have measured them out on  
4 films.

5 But you can assess it by examining a patient.  
6 Have them bend forward. If their symptoms get worse,  
7 they might have some translation. You could also do  
8 another test to compare. You could also get a second  
9 one to see if that really did have that much  
10 translation.

11 Q. Well, how about nerve conduction studies?  
12 Are there any nerve conduction studies that could be  
13 done to see if the -- the nerve root that should --  
14 should be impinged upon is experiencing conductive  
15 abnormality?

16 A. Yes. We talked about the term  
17 "radiculopathy" that was labeled many times on the  
18 records. It was not proven. You have to do an EMG to  
19 prove radiculopathy. If you have a concern for it,  
20 that's the test you do, is an EMG.

21 Q. And what does EMG stand for?

22 A. Electromyogram or electromyograph.

23 Q. How does it work?

24 A. You have a -- computerized units that has  
25 wires coming out of it, and you attach them to the

1 patient. You have a stimulation device -- well,  
2 there's two parts: nerve conduction velocity  
3 study --

4 Q. Give us the short version.

5 A. It works by stimulation and by a recording  
6 device also from the muscle to see if there's a nerve  
7 pathology going to that muscle. It's in that  
8 distribution.

9 Q. And what did the EMG that was performed on  
10 Ms. Garcia by Dr. Gross before he took her to surgery,  
11 what did that examination show?

12 A. I did not see an EMG performed.

13 Q. Now, you said in your practice you compare  
14 MRIs taken on different dates.

15 Do you use any kind of specialized equipment  
16 to do that, or is it just sort of a ruler and an  
17 eyeball?

18 A. I use a ruler with millimeters and  
19 centimeters on it, and I mark them and I compare them.

20 Q. All right. And have you told any radiologist  
21 what you are doing?

22 A. I am totally covert about it. I have not.

23 Q. Right. Because they'd be horrified, wouldn't  
24 they?

25 A. I don't know. They might be, but it's common

1 practice for everyone in my practice.

2 Q. Now, I could ask you, are you aware of any  
3 instances in which Ms. Garcia was not compliant with  
4 the orders for additional conservative treatment?

5 MR. ROBERTS: Objection. Beyond the scope of  
6 cross.

7 THE COURT: Seems like it is. Sustained.

8 BY MR. STRASSBURG:

9 Q. Now, on cross-examination, you were asked  
10 whether the fusion of Ms. Garcia's spine healed; right?

11 A. I was, yes.

12 Q. And you said yes. And I wanted to ask a  
13 little bit more about that as to whether you have any  
14 opinions whether nonunion of bone grafts in a spinal  
15 fusion like she had is a recognized cause of  
16 postsurgical pain.

17 A. It is, yes.

18 MR. ROBERTS: Objection. Hypothetical. Not  
19 based on facts in evidence.

20 THE COURT: Overruled.

21 BY MR. STRASSBURG:

22 Q. And is scar tissue that results from  
23 nonunion, is that a recognized cause of postfusion  
24 surgery pain?

25 A. Yes.