

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.

**APPELLANT'S APPENDIX
VOLUME XX, BATES NUMBERS 4751 TO 5000**

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1 Q. And that's because the scar tissue impinges
2 upon the nerve roots; right?

3 A. Yes.

4 Q. And there's nothing that surgeons can do to
5 prevent that scar tissue; right?

6 A. No.

7 Q. That's right, isn't it?

8 A. That is correct. There's nothing they can do
9 that I know of.

10 Q. And is there anything that rehabilitation
11 physicians, such as yourself, can do to somehow break
12 that adhesion of the scar tissue to the nerve roots in
13 patients who have undergone spinal fusion surgery
14 comparable to hers?

15 A. No. If it's established, no. We can try to
16 prevent it with exercises prior to that happening, but
17 there's nothing we can do about it once it's formed.

18 Q. Now, you were asked whether spondylolisthesis
19 can result from a collision, an automobile accident.

20 Do you remember that --

21 A. Yes.

22 Q. -- cross-examination by Mr. Roberts?

23 A. Yes.

24 Q. And I wanted to ask you, is the possibility
25 that an automobile collision makes a spondylolisthesis

1 comparable to Ms. Garcia's worse, does that not depend
2 upon the magnitude of the physical forces that are
3 brought to bear on that location of the spine by the
4 forces of the collision?

5 A. Yes.

6 Q. And if the -- if the patient is pain-free, if
7 the patient with a preexisting spondylolisthesis
8 comparable to Ms. Garcia's is pain-free for 30-odd
9 years prior to a motor vehicle accident and the
10 magnitude of the forces from the collision are less
11 than the forces that her spine was subjected to for all
12 those years before the collision, would you agree that
13 it's just pure speculation --

14 MR. ROBERTS: Objection.

15 BY MR. STRASSBURG:

16 Q. -- to blame it all on the accident?

17 MR. ROBERTS: Objection. No foundation.

18 THE COURT: Sustained.

19 BY MR. STRASSBURG:

20 Q. Well, do you have any experience in treating
21 patients who have spondylolisthesis after auto
22 accidents?

23 A. Yes.

24 Q. And in connection with your legal work, do
25 you have experience in -- in spondylolisthesis-type

1 cases?

2 A. Yes.

3 Q. And in those -- in that experience, do you
4 have experience in determining whether the accident
5 presented the kind of forces that could reasonably be
6 causative of the spondylolisthesis you're treating
7 getting worse?

8 A. I have experienced that, yes, in -- in those
9 cases, yes.

10 Q. And you had to treat patients based upon a
11 determination you made that the physical forces of the
12 collision were large enough to displace the L5-S1
13 vertebra of a spondylolisthesis in increased amount,
14 say 30 percent?

15 MR. ROBERTS: Objection. Foundation. Calls
16 for speculation.

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

18 Go ahead.

19 THE WITNESS: I might have forgotten the
20 question, but I --

21 BY MR. STRASSBURG:

22 Q. Do you have experience with those kind of
23 cases?

24 A. I do have experience with those cases, yes.
25 And I have seen those cases and I've treated those

1 cases.

2 Q. All right. And based upon your experience in
3 treating cases of spondylolisthesis and making
4 determinations that the aggravation of a
5 spondylolisthesis condition in the lumbar spine is
6 related to a motor vehicle accident, would you agree
7 that, whether the forces of a collision can make a
8 spondylolisthesis at L5-S1 worse, it depends upon the
9 magnitude, how great those physical forces are that
10 result from the collision?

11 A. Yes.

12 Q. Okay. And if you consider the condition of
13 the -- I'm sorry. Let me ask you this.

14 In those cases, do you have occasion to
15 consider the physical condition and activities that the
16 patient engaged in before they came to see you?

17 A. Yes.

18 Q. And that's because it's important to you to
19 determine what kind of daily activities the patient
20 engaged in before the pain so you can have some
21 assessment of her degree of functioning in the
22 activities she does afterwards; is that right?

23 A. Well, I want as much information as possible
24 with -- and I ask a lot of questions and try to gather
25 information to see what is going on with the patient

1 and how the pain is affecting her, when the pain
2 started, and how her level of functioning may or may
3 not have gone down and what she can and can't do.

4 Q. And based upon your training and education
5 and clinical experience in performing these kind of
6 functional assessments of the activities of daily
7 living that your own patients are engaging in, do you
8 have a familiarity with the magnitude of the forces
9 that the activities of daily living your patients
10 engage in can bring to bear upon the levels of the
11 lumbar spine?

12 A. Yes.

13 Q. Okay. And have you had occasion -- in making
14 your determinations of causation for your casework and
15 your medical-legal work, have you ever had occasion in
16 trying to figure out whether you can give an opinion
17 that the forces of an accident had the magnitude
18 necessary to aggravate or cause a spondylolisthesis at
19 L5-S1? Have you ever had occasion to compare the
20 magnitude of the forces on that spine area from the
21 patient's activities of daily living to the magnitude
22 of the forces that, based upon your history and your
23 assessment, you determined resulted directly from the
24 collision?

25 A. Yes. I have to deal with those things and

1 those situations.

2 Q. Do you have an opinion to a reasonable
3 medical probability whether the forces brought to bear
4 on Ms. Garcia's L5-S1 and lumbar spine areas, the
5 forces from her activities of daily living that she
6 conducted for 30 years without pain prior to the motor
7 vehicle accident, that those forces must have been
8 greater than the forces that this collision brought to
9 bear on that location of her lumbar spine?

10 MR. ROBERTS: Objection. No foundation as to
11 the forces involved in Ms. Garcia's collision.

12 MR. STRASSBURG: He does this all the time,
13 Judge, in his prior clinical work. It's Clinical 101
14 medicine.

15 THE COURT: Sorry. Objection sustained.

16 BY MR. STRASSBURG:

17 Q. Have you ever had to do an assessment in your
18 clinical practice to compare the history that a
19 particular patient from an automobile accident gives
20 you of how fast the vehicles were going, the nature of
21 the accident, the configuration of the vehicles
22 afterwards, whether that history is medically
23 consistent with the injuries that are presented to you
24 for therapy?

25 A. I have addressed that hundreds of thousands

1 of times.

2 Q. And -- and have you ever had to compare
3 the -- the types of injury and the types of pain
4 presented by the patient with the physical forces that
5 must have resulted from the accident described in the
6 plaintiff's history that you took and reviewed?

7 MR. ROBERTS: Objection. No foundation.
8 Calls for speculation. 48.035.

9 THE COURT: Come on up for a minute, guys.
10 (A discussion was held at the bench,
11 not reported.)

12 THE COURT: Objection sustained.

13 BY MR. STRASSBURG:

14 Q. In -- in your clinical practice, have you
15 ever had occasion to compare -- for patients of yours
16 that you are treating who have been involved in motor
17 vehicle collisions, have you ever had occasion to
18 compare the history they give you on initial
19 presentation of what happened in the accident and
20 compare that history to the symptoms that they're
21 asking you to treat?

22 A. All throughout my practice I do that. Yes,
23 I've encountered that.

24 Q. And is that an important comparison for you
25 to make clinically in deciding upon a plan of care when

1 you first assess one of your patients?

2 A. It's very important to know the degree of
3 symptoms, the type of symptoms they have, what they do
4 at home, what they do at work, if they drive a car or
5 drive a truck. Can you -- can you mow your yard? What
6 kind of job activities do you have to participate in?
7 Are they heavy? Light? Medium?

8 We have to take into account all those things
9 that might lead to a problem and/or how to treat a
10 problem and improve that situation. But we have to
11 take into account what they're able to do. And if
12 they're able to do a high level of activities, then
13 that's an objective finding that they can -- that
14 they're able to do a whole lot more even with their
15 pain.

16 Q. My question is, as part of your clinical
17 practice, have you ever had to perform a comparison in
18 devising a treatment plan as to comparing the history
19 the plaintiff gives you of the accident and how it
20 happened with the symptoms presented by the plaintiff
21 for your treatment?

22 A. Yes.

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

25 THE COURT: I'm going to allow this.

1 THE WITNESS: Yes. And it may change the
2 treatment plan depending on if things don't correlate
3 well with what occurred, what they're experiencing, or
4 how they continue to experience it.

5 BY MR. STRASSBURG:

6 Q. And why is it important for you, in your
7 clinical practice, to perform this comparison to check
8 the description by the patient of how the accident
9 happened against the symptoms that the plaintiff is
10 present -- I'm sorry -- that the patient is presenting
11 to you for treatment?

12 A. Because I strive to make sure they're
13 consistent and -- as we're going through our treatment
14 plan. And as we're making progress -- expected
15 progress or lack of expected progress, I want to make
16 sure things are consistent.

17 Q. All right. And what do you base your
18 determination of consistency on in your clinical
19 practice?

20 A. Information I've gained before -- before I
21 saw them or during the time I first see them and
22 information I gain each time when I see them either
23 from them, from an X ray, from therapy, and then when I
24 examine them if things are changing appropriately.

25 Q. Do you have any education, training,

1 experience in physics?

2 A. I have taken physics before in school. But I
3 don't have a training in physics, no.

4 Q. Okay. Fair enough. Fair enough. And did
5 you perform this comparison that you do in your
6 clinical practice that we've been talking about
7 comparing Ms. Garcia's rendition of the events of the
8 accident to, you know, Gulitz, Lemper, Kidwell, Gross
9 against the -- the symptoms that she presented for
10 treatment and that Dr. Kidwell had her chart and the
11 other physicians recorded in their records?

12 A. Did I compare that?

13 Q. Yeah.

14 A. Yes, I did look at all those issues.

15 Q. And based upon your comparison, was the
16 description of the traffic accident that Ms. Garcia
17 gave to those treaters -- was that consistent, in your
18 mind, with the symptoms that she reported throughout
19 the course of treatment?

20 A. It was not. And I point out in my report and
21 today that she's had a lot of inconsistencies comparing
22 to the date of injury, three or four days later, and
23 then the list of complaints that became longer and went
24 up and down and could not be explained objectively.

25 Q. And in offering your opinion that the

1 accident she described did not, to a reasonable medical
2 probability, cause a condition for which the spinal
3 fusion surgery and -- and the injections were
4 necessary, did that form part of the basis for your
5 conclusion that this accident didn't cause all of her
6 pain?

7 A. I stated that she -- she already had a
8 preexisting spondylolisthesis. It was not caused by
9 the accident. It was not worsened by the accident.
10 There was not a traumatic event to that level of her
11 spine. There's no evidence that -- she went for three
12 days without seeing anyone. She didn't have -- the ER
13 doctor stated that she had no pain until then. There
14 was no basis for the multiple injections. There was no
15 basis for the fusion surgery. And she should not have
16 had that in relation to even her spondylolisthesis or
17 anything related to the accident.

18 Q. And -- and was part of the basis for those
19 conclusions this comparison that we've talked about
20 between the accident that she described and the
21 symptoms she presented over and over and over?

22 MR. ROBERTS: Objection. Beyond the scope of
23 cross. Leading.

24 THE COURT: Overruled. I'm going to allow
25 it.

1 THE WITNESS: Sorry. I don't remember
2 exactly how you worded that.

3 (Record read by the reporter.)

4 THE WITNESS: Yes. And the lack of an acute
5 event that initially occurred.

6 MR. MAZZEO: I missed the last part.

7 THE WITNESS: The lack of an acute event that
8 occurred initially.

9 MR. STRASSBURG: Judge, may I have a sidebar?

10 THE COURT: Sure.

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

13 MR. STRASSBURG: Thank you for your time,
14 Doctor.

15 THE WITNESS: Thank you.

16 THE COURT: Any more, Mr. Roberts?

17 MR. ROBERTS: Yes, Your Honor.

18 CROSS-EXAMINATION

19 BY MR. ROBERTS:

20 Q. Talked to Mr. Strassburg about EMG.

21 A. Yes.

22 Q. Okay. And is that painful?

23 A. It has a little bit of pain associated with
24 it, but it's temporary.

25 Q. And would you personally perform that type of

1 a test on someone that two spine surgeons had already
2 said needed spine surgery?

3 A. If I saw the patient, yes, if they had a
4 concern for a radiculopathy.

5 Q. Counsel talked to you about nonfusion and
6 whether that could cause pain following the lumbar
7 fusion.

8 A. Yes.

9 Q. Okay. Your reports do not give the opinion
10 that there was nonfusion in this case, do they?

11 A. They do not.

12 Q. And you've reviewed all of the other expert
13 reports?

14 A. I -- yes.

15 Q. Significant number of those anyway?

16 A. Yes.

17 Q. I understand you might know if you've seen
18 all of them, but you got a bunch them?

19 A. Yes.

20 Q. And isn't it correct that not a single
21 physician opines that Ms. Garcia had nonfusion
22 following her lumbar fusion?

23 A. I did not see that, correct.

24 MR. ROBERTS: Audra, do you have the ability
25 to put up 19, page 14?

1 BY MR. ROBERTS:

2 Q. And this is the November of 2012 MRI report
3 that you reviewed with Mr. Strassburg. And if you
4 could -- let's see -- the second paragraph from the
5 bottom.

6 And Mr. Strassburg asked you about the
7 foraminal narrowing; right?

8 A. Yes.

9 Q. And you drew the -- a distinction between
10 narrowing and encroachment.

11 How do you read those terms differently when
12 you're reviewing an MRI report?

13 Could we enter the last paragraph, Audra?

14 This is just to refresh your recollection
15 here.

16 A. I just stated, when he was asking me a
17 question, there was a reference to an encroachment.

18 Q. There it is.

19 A. I thought he was referring to that.

20 Q. Okay. And -- and you said there's a
21 difference between an encroachment and a narrowing?

22 A. I did not say that.

23 Q. Okay. Can you have a narrowing without
24 encroachment?

25 A. No. They're pretty much synonymous terms.

1 Encroachment on the foramen means narrowing or
2 something making it smaller.

3 Q. Okay. Doesn't a reference to foraminal
4 encroachment means the foramen is encroaching on the
5 nerve root?

6 A. It's the same -- same synonymous terms.
7 Essentially is narrowing, something encroaching on the
8 space that's there.

9 Q. Thank you.

10 And the radiologist didn't say that there's
11 brand-new encroachment; he said there's increasing
12 encroachment; right?

13 A. He did, yes.

14 Q. And counsel suggested to you that the
15 comparison that he was making for the slippage between
16 7.5 millimeters and 1.02 centimeters was the August of
17 2011 MRI. And do you remember agreeing with him?

18 A. I don't think it was the August of 2011.
19 That was the first one.

20 Q. You think it was the first one.

21 A. I think that was -- I don't think it was
22 August 20 he was referring to. I think it was a later
23 MRI scan.

24 Q. You think it was a later MRI scan?

25 A. I think so. And I got -- on questioning.

1 Q. Okay. When -- when -- when you answered
2 Mr. Strassburg's questions, did you have any idea what
3 the prior MRI scan the radiologist was referring to?

4 A. I'm sorry. Again? Ask that question again.

5 Q. Did you have any idea of the date of the
6 prior MRI scan that the radiologist is referring to
7 when he notes an increase in the slippage and an
8 increase in the encroachment?

9 A. This is either the second or third MRI scan
10 in comparison to the first MRI scan.

11 Q. Okay. Do you know which -- if this is the
12 third, is he comparing to the second or to the first?
13 Or do you know?

14 A. I don't see a date on here. I can't remember
15 exactly which -- which one was compared as compared to
16 the prior MRI scan they obtained prior.

17 Q. So you don't know as you sit here?

18 A. I don't remember the exact date, no.

19 Q. Okay.

20 And, Audra, could you go to page 13.

21 And if you could look at "Comparison."

22 What's the prior MRI scan that Dr. Hake is referring
23 to?

24 A. 1/27/11.

25 Q. The very first one done after the collision;

1 right?

2 A. Yes, sir.

3 MR. ROBERTS: Thank you, Doctor.

4 THE COURT: Mr. Mazzeo.

5 MR. MAZZEO: Yes, Your Honor.

6 REDIRECT EXAMINATION

7 BY MR. MAZZEO:

8 Q. Dr. Poindexter, does -- with the term
9 "foraminal encroachment," is -- is -- does that mean --
10 refer narrowing of the foramen or something else?

11 A. It refers to a narrowing of the space, which
12 is the foramen. It's narrowing, encroachment, some
13 kind of making it smaller.

14 Q. Okay. Now, does that -- does that term
15 "foraminal encroachment" necessarily mean an
16 impingement on a nerve or just a -- a reduction of --
17 of the space of the foramen?

18 A. Refers to narrowing or reduction. Doesn't --
19 doesn't guarantee impingement on a nerve.

20 MR. MAZZEO: Thank you.

21 Nothing further, Judge.

22 THE COURT: Mr. Strassburg.

23 RECROSS-EXAMINATION

24 BY MR. STRASSBURG:

25 Q. Doctor, in your clinical experience, I

1 suspect you've reviewed a lot of radiological reports
2 on MRI films?

3 A. Thousands.

4 Q. Including ones by this Dr. Hake?

5 A. Um, Las Vegas Radiology where this is done,
6 I've reviewed many of them. I can't remember -- I
7 think I've seen his name before. But I can't remember
8 the names of the radiologists right now, the reports I
9 reviewed.

10 Q. Have you ever had the experience that a
11 radiological report that you've reviewed from a
12 qualified radiologist, later, upon further analysis,
13 turns out to have been inaccurate?

14 A. Yes. And that occurred recently. I just
15 called a radiologist back up to ask them to reread a
16 report because what I saw, they didn't have in their
17 report.

18 MR. STRASSBURG: Thank you, sir.

19 THE COURT: Any more?

20 RECROSS-EXAMINATION

21 BY MR. ROBERTS:

22 Q. And when you say that you've determined that
23 the report is inaccurate, is that when you got out
24 your -- your desk ruler and looked at the millimeter
25 marks on it?

1 A. Not on that particular one, no.

2 Q. Just in general, is that how you determine
3 that reports are inaccurate from radiologists?

4 A. If there's a listhesis.

5 Q. Does -- does Dr. Hake get out a ruler and lay
6 it up against a film? Or does he have specialized
7 equipment that allows him to make measurements on the
8 computer that's much more exact than what you can do
9 with a ruler?

10 MR. MAZZEO: Objection. Speculation.

11 MR. STRASSBURG: Foundation, Judge.

12 THE COURT: Sustained. I don't know that he
13 knows that.

14 BY MR. ROBERTS:

15 Q. Do you know what type of radiological
16 equipment --

17 A. They have computerized equipment. They can
18 make markers and measure, yes.

19 Q. And is that technique more accurate than a
20 school ruler?

21 A. It can be more accurate, yes. But in general
22 life, I've been very appropriate in my measurements.
23 And if I had a problem, I call somebody back.

24 MR. ROBERTS: Thank you, Doctor.

25

1 FURTHER REDIRECT EXAMINATION

2 BY MR. MAZZEO:

3 Q. Doctor, after reviewing the -- the actual
4 imaging studies -- study of November 19th of 2012, are
5 your opinions the same as they were as when -- when you
6 reviewed the findings by the impressions by Hake that
7 he put into his MRI reports with regard to the
8 progression of slippage?

9 A. I did not see a 25 --

10 MR. ROBERTS: Objection, Your Honor. He can
11 say yes or no to this question.

12 MR. MAZZEO: I think his answer was
13 appropriate, Your Honor -- Your Honor. He's not
14 limited to yes or no.

15 THE COURT: Well, based on the fact that the
16 actual imaging studies were seen later, I think he is.

17 BY MR. MAZZEO:

18 Q. Okay. Yes or no?

19 A. Please ask me the question again. I'm sorry.

20 MR. MAZZEO: No, that's fine.

21 Kristy, would you read that back.

22 (Record read by the reporter.)

23 THE WITNESS: I don't agree with that finding
24 of progression the way he described it.

25 MR. ROBERTS: Objection, Your Honor. Move to

1 strike.

2 THE COURT: It will be stricken. It's
3 inappropriate.

4 BY MR. MAZZEO:

5 Q. Okay. So -- so I guess what I'm eliciting
6 from you is a yes or a no. You had reviewed the
7 report -- in conjunction with your medical record
8 review, you reviewed the report by Hake from the
9 November 19th, 2012, MRI; correct?

10 A. Yes.

11 Q. And then after reviewing the actual film that
12 Dr. Hake had performed on Ms. Garcia on November 19th
13 of 2012, are the opinions that were expressed in the
14 report -- are the -- are the -- are your opinions with
15 regard to the findings that Dr. Hake identified in his
16 report the same or different from what you reviewed on
17 the MRI imaging study?

18 A. Different.

19 MR. ROBERTS: Objection. Move to strike,
20 Your Honor. May we --

21 THE COURT: Come on up.

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

24 THE COURT: Objection sustained. The answer
25 will be stricken.

1 MR. MAZZEO: No further questions, Judge.

2 FURTHER RECROSS-EXAMINATION

3 BY MR. STRASSBURG:

4 Q. Dr. Poindexter, this report by Dr. Hake on
5 November 19th, 2012, the MRI study, from looking at
6 that report, could you tell whether that radiologist
7 actually employed his super-duper computerized ruler to
8 measure this stuff or whether he eyeballed it?

9 A. I don't know how he did it.

10 MR. STRASSBURG: Thank you.

11 THE COURT: Any more?

12 MR. ROBERTS: Nothing further, Your Honor.

13 THE COURT: No?

14 MR. MAZZEO: No.

15 THE COURT: Any questions, ladies and
16 gentlemen?

17 Not seeing any hands.

18 Thank you, Doctor. You're excused.

19 THE WITNESS: Thank you, Your Honor.

20 THE COURT: Appreciate your time.

21 It's 1:30. Do we have something for a half
22 hour or do you want to end early?

23 MR. ROBERTS: I will leave it up to Your
24 Honor and the wedding plans. We could show video
25 clips, which we have agreed to, from Jared Awerbach.

1 THE COURT: How long are those?
2 MR. ROBERTS: 20 to 25 minutes is our --
3 THE COURT: Let's do that. So the
4 plaintiff's calling --
5 MR. MAZZEO: -- Jared Awerbach by deposition
6 testimony.
7 THE COURT: Do you guys want Kristy to report
8 it or just show that video was played?
9 MR. ROBERTS: Just show that video was
10 played.
11 THE COURT: Just make sure that a copy of
12 what is played is mark as a court exhibit.
13 MR. ROBERTS: We'll do that, Your Honor.
14 Would you like to include the video, mark it
15 as a disk?
16 THE COURT: Just whatever is played, just
17 make sure that that is either on a flash drive or a
18 disk or something.
19 (Whereupon video deposition was played.)
20 THE COURT: That it on this one?
21 MR. ROBERTS: Does that complete the
22 designations?
23 MS. BONNEY: Yes. Yes, it does.
24 THE COURT: Want to end here?
25 MR. ROBERTS: Yes, Your Honor. That would be

1 good with us.

2 THE COURT: All right, folks. This is really
3 going to hurt your feelings, I'm sure. We don't have
4 any witnesses on Monday. So I'm going to give you a
5 three-day weekend, have you come back on Tuesday at
6 10:00 o'clock. Okay? Hopefully, we still get through
7 the trial this next week. But be here Tuesday at
8 10:00.

9 During our break over the weekend, you're
10 instructed not to talk with each other or with anyone
11 else about any subject or issue connected with this
12 trial. You are not to read, watch, or listen to any
13 report of or commentary on the trial by any person
14 connected with this case or by any medium of
15 information, including, without limitation, newspapers,
16 television, the Internet, or radio.

17 You are not to conduct any research on your
18 own, which means you cannot talk with others, Tweet
19 others, text others, Google issues, or conduct any
20 other kind of book or computer research with regard to
21 any issue, party, witness, or attorney involved in this
22 case.

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

1 See you Tuesday at 10:00.

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

4 THE COURT: All right. We're outside the
5 presence. Anything you guys want to put on the record?

6 MR. MAZZEO: Yes, Your Honor. Just briefly.

7 When I was redirecting Dr. Poindexter on the
8 stand, I -- I went to ask him about spasms.

9 Mr. Roberts, in cross-examination, elicited that
10 testimony, opened the door for me to question him about
11 the nature -- the nature of spasms. And I was
12 precluded, and I think that I was wrongfully precluded
13 because the door was opened and that was a topic that
14 was brought out on cross-examination.

15 MR. ROBERTS: And --

16 THE COURT: Go ahead.

17 MR. ROBERTS: Thank you, Your Honor.

18 I tried to be very careful when I asked him
19 about it. The only thing I asked him to confirm was
20 that he did not mention spasms in either his reports or
21 his deposition, just to confirm that he hadn't
22 addressed that issue. I did not ask him -- open the
23 door, ask him to go beyond his reports.

24 THE COURT: I don't recall the issue had been
25 opened. That's why I didn't let -- let you get into it

1 because the objection was it was beyond the scope of
2 his reports and his deposition. I think it was.

3 MR. MAZZEO: You think it was open?

4 THE COURT: No, I think it was beyond the
5 scope of what -- what had been opened and what had been
6 disclosed.

7 MR. MAZZEO: Okay.

8 MR. ROBERTS: Your Honor, just because so
9 much of the objections were with regard to the scope of
10 his reports and deposition, I would just like to offer
11 his report dated October 13th, 2014; his report dated
12 November 10th, 2014; and both volumes of his deposition
13 as court exhibits.

14 THE COURT: That's fine.

15 MR. MAZZEO: What's the basis for that?

16 MR. ROBERTS: As court's exhibits?

17 MR. MAZZEO: No, I know. Your explanation as
18 to you're offering it as court exhibits.

19 MR. ROBERTS: In case you appeal the judge's
20 rulings.

21 MR. MAZZEO: Oh.

22 MR. ROBERTS: So the appellate court can
23 determine what was beyond the scope of his reports.

24 THE CLERK: They're going to be listed under
25 the deposition list and not the court exhibit list --

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MR. ROBERTS: That's fine.

THE CLERK: -- just to let you know.

MR. ROBERTS: As long as they're part of the
record, I'm good with it. Thank you so much.

THE COURT: Anything else, guys?

MR. MAZZEO: No, Judge.

THE COURT: All right. Off the record.
We'll see you Tuesday.

(Thereupon, the proceedings
concluded at 1:47 p.m.)

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CERTIFICATE OF REPORTER

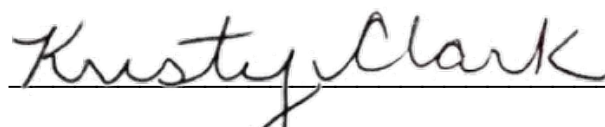
STATE OF NEVADA)
COUNTY OF CLARK) ss:

I, Kristy L. Clark, a duly commissioned
Notary Public, Clark County, State of Nevada, do hereby
certify: That I reported the proceedings commencing on
Friday, February 26, 2016, at 8:34 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
26th day of February, 2016.


KRISTY L. CLARK, CCR #708

<p>BY MR. MAZZEO: [26] 9/15 17/22 23/10 26/12 28/20 34/8 44/25 46/4 48/2 49/24 53/5 54/17 61/24 65/21 71/24 74/13 77/7 154/21 155/12 156/11 157/9 158/2 181/6 184/1 184/16 185/3 BY MR. ROBERTS: [15] 122/17 124/21 127/23 128/10 130/18 136/19 140/8 140/24 149/1 153/19 154/5 176/18 177/25 182/20 183/13 BY MR. STRASSBURG: [26] 89/21 93/24 95/20 98/13 100/2 100/16 104/13 105/1 113/1 114/19 115/9 120/7 121/5 158/21 161/10 161/22 164/7 164/20 166/14 166/18 167/20 170/15 171/12 173/4 181/23 186/2 JUROR NO. 1: [1] 98/8 MR. MAZZEO: [82] 6/14 7/13 8/2 8/20 9/11 17/7 17/15 17/20 22/17 22/21 44/24 45/23 46/1 46/3 47/23 48/1 49/17 49/21 49/23 52/5 54/16 56/11 58/5 60/16 60/22 60/25 61/3 61/18 61/23 65/2 65/7 71/23 77/6 89/13 99/22 104/6 104/9 104/20 114/14 114/17 115/3 115/6 120/14 124/18 127/21 127/25 130/11 136/15 140/1 140/19 152/4 152/22 153/8 153/25 154/9 154/17 154/19 155/8 155/10 156/25 157/6 157/17 157/21 158/5 158/8 158/11 176/5 181/4 181/19 183/9 184/11 184/19 185/25 186/13 187/4 189/5 190/2 190/6 190/14 190/16 190/20 191/5 MR. MOTT: [2] 6/23 7/11 MR. ROBERTS: [90] 8/1 17/11 22/16 25/19 28/13 34/4 44/21 45/22 47/21 49/11 52/1 52/21 54/13 56/8 59/2 59/8 60/8 61/4 61/17 64/25 71/19 71/22 74/5 77/2 89/17 93/16 93/19 95/16 99/19 100/8 103/18 103/21 104/3 112/16 112/20 119/20 120/12 122/3 122/8 122/13 122/15 128/1 128/4 128/9 130/13 130/17 148/24 150/2 150/6 153/7 153/16 154/14 155/6 156/6</p>	<p>156/23 157/15 157/19 158/7 161/14 164/4 164/17 166/13 166/16 167/14 170/9 171/6 172/22 175/21 176/16 177/23 181/2 183/23 184/9 184/24 185/18 186/11 186/22 187/1 187/8 187/12 187/20 187/24 189/14 189/16 190/7 190/15 190/18 190/21 190/25 191/2 MR. SMITH: [3] 4/17 59/7 151/6 MR. STRASSBURG: [37] 4/10 8/3 58/9 89/15 89/18 93/18 93/20 98/9 99/25 100/12 103/20 103/24 104/22 114/15 115/5 115/7 120/2 120/5 120/16 120/25 121/3 121/24 122/11 122/14 151/23 152/9 152/14 153/9 158/19 161/8 161/16 170/11 176/8 176/12 182/17 183/10 186/9 MS. BONNEY: [1] 187/22 THE CLERK: [4] 9/2 9/7 190/23 191/1 THE COURT: [133] 4/4 4/14 6/13 6/20 7/10 7/12 7/14 7/20 8/4 8/22 9/12 17/10 17/13 17/18 22/19 25/21 28/14 34/6 44/22 45/24 46/2 47/25 49/16 49/20 49/22 52/3 52/23 53/2 54/15 56/13 56/16 57/16 58/8 60/15 60/17 60/23 61/1 61/6 61/12 61/19 61/22 65/5 71/21 74/7 77/4 89/14 95/18 99/21 100/1 100/10 100/13 104/8 104/12 112/18 112/23 119/22 119/25 120/3 120/18 120/21 122/1 122/4 124/20 128/2 128/7 130/14 136/16 140/2 140/21 150/4 150/7 151/4 151/22 152/12 152/16 152/23 153/3 153/10 153/13 153/15 154/2 154/11 154/16 154/18 155/7 155/9 155/11 156/10 157/2 157/8 157/23 158/9 158/14 158/17 161/19 164/6 164/19 166/17 167/16 170/14 171/8 171/11 172/24 175/23 176/9 176/15 181/3 181/21 182/18 183/11 184/14 185/1 185/20 185/23 186/10 186/12 186/14 186/19 186/25 187/2 187/6 187/10 187/15</p>	<p>187/19 187/23 188/1 189/3 189/15 189/23 190/3 190/13 191/4 191/6 THE MARSHAL: [6] 7/16 7/19 61/8 61/11 152/19 153/2 THE WITNESS: [30] 9/1 9/6 9/9 17/16 17/19 22/22 25/23 28/16 52/6 61/21 65/6 65/8 74/9 98/12 121/2 136/17 140/3 153/12 153/14 154/3 154/12 158/15 167/18 172/25 175/25 176/3 176/6 176/14 184/22 186/18</p> <hr/> <p>\$</p> <p>\$2,000 [1] 20/15 \$3,500 [1] 20/25 \$700 [1] 20/17 \$8,000 [1] 127/8 \$800 [1] 20/17</p> <hr/> <p>'</p> <p>'11 [1] 30/11 '90s [2] 13/3 13/9</p> <hr/> <p>1</p> <p>1.02 [2] 159/15 179/16 1.02-centimeters [2] 139/17 159/13 1/26 [1] 30/11 1/27/11 [1] 180/24 10 [11] 4/13 57/11 103/4 103/9 103/9 105/6 105/7 122/7 151/2 159/12 159/16 10 degrees [6] 42/23 43/5 43/19 44/3 44/20 45/18 10-degree [1] 47/3 10.2 [1] 160/22 10.2 millimeter [1] 159/16 10.2millimeters [1] 139/18 100 [1] 58/10 101 [1] 170/13 10:00 [2] 188/8 189/1 10:00 o'clock [1] 188/6 10th [2] 2/15 190/12 11 [2] 4/13 180/24 11/19 [1] 30/12 12 [3] 132/7 151/10 151/11 12/26/2012 [1] 72/16 122 [1] 3/6 12th [4] 39/15 66/16 99/1 147/3 13 [2] 33/12 180/20 13529 [1] 1/24 13th [4] 18/14 76/9 76/17 190/11 14 [2] 139/10 177/25 15 [5] 39/19 57/11 99/11 122/7 151/2</p>
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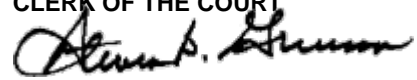
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1 CASE NO. A-11-637772-C
2 DEPT. NO. 30
3 DOCKET U
4

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 PROCEEDINGS
20 BEFORE THE HONORABLE JERRY A. WIESE, II
21 DEPARTMENT XXX
22 DATED TUESDAY, MARCH 1, 2016
23

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

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1 LAS VEGAS, NEVADA, TUESDAY, MARCH 1, 2016;

2 10:00 A.M.

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

5 * * * * *

6
7 THE COURT: All right. We are back on the
8 record, Case No. A63772. We're outside the presence.

9 What do you got?

10 MR. SMITH: So before Dr. Klein takes the
11 stand, we were going to address some foundation
12 questions while he was on the stand, but we got -- or
13 some -- his experience essentially.

14 But we got 58 slides from the defense last
15 night that leads us to believe that he is going to
16 testify outside the scope of his experience and outside
17 the scope of his report. And I'd like to address those
18 before he takes the stand to try and see if we can
19 streamline things today.

20 And I want to address the experience first.
21 And after we talk about the experience, depending on
22 what you say, we can talk about the scope of his
23 opinions outside his report. But that may become moot,
24 so I'm going to leave that alone until I hear from you
25 on the experience.

1 In terms of his experience, there are a few
2 things he's going -- or I think the defense intends for
3 him to testify about that he's not qualified to talk
4 about.

5 The first is his qualifications as a spine
6 surgeon. The second is pain management opinions. And
7 the last is radiology opinions.

8 As far as qualifications as a spine
9 surgeon -- and this is all undisputed and from
10 Dr. Klein's testimony in this case -- he has
11 essentially no experience in the last 30 years as a
12 spine surgeon. The last spine surgery that he was a
13 part of was in the late '80s. Prior to that, he was
14 really a hip, knee, and shoulder doctor. He was never
15 really a spine surgeon.

16 He has been involved in five or less -- he
17 said less than five fusion surgeries. Those were in
18 the late '80s. He's never placed a cage in a person;
19 he's never placed a pedicle screw. In the less than
20 five fusion surgeries that he was involved in, those
21 were not as the primary surgeon.

22 He's only been the primary surgeon to fix a
23 spondylolisthesis 10 to 12 times. And, again, the last
24 time was in the late '80s. He has agreed that his
25 experience in the '70s and '80s doing the limited

1 amount of spine work that he did -- because, like I
2 said, he was a hip, knee, and shoulder doctor. He's
3 agreed that that experience was with equipment and
4 techniques that are very different from what was done
5 in this case.

6 In other words, when he was actually acting
7 as a surgeon, the hardware that Dr. Gross implanted in
8 Ms. Garcia did not exist and had not been invented yet.

9 For those reasons and given the length of
10 time since he's even done that with very different
11 hardware, he should not be permitted to testify as a
12 spine surgeon or about the spine surgery and
13 complications and any -- any of the other things that
14 they intend to talk about.

15 And there are any number of qualified spine
16 surgeons in Nevada or in California, where Dr. Klein is
17 from, that could have been hired by the defense in this
18 case. And instead they chose to hire a hip, knee, and
19 shoulder doctor who's not qualified to testify.

20 And, in fact, in this case, they previously
21 had Dr. Elkanich, who is a spine surgeon. And they
22 withdrew him in favor -- in favor of this orthopedic
23 surgeon who has very little experience in spine surgery
24 and no pertinent experience.

25 He also intends to give opinions on pain

1 management. He's not a pain management physician. He
2 doesn't hold himself out as a pain management
3 physician. He's never administered pain management
4 injections like were administered to Ms. Garcia. So he
5 shouldn't be allowed to testify about the techniques
6 and the specifics of those injections either.

7 The last thing is MRI films. Now, last
8 night, we got -- what they gave me this morning was 14
9 slides on MRI films. I didn't check all the ones last
10 night to count them, but there's at least 14 slides
11 they want him to testify about for MRIs. He is not
12 qualified to read an MRI film or testify about it.

13 MRIs were not invented when he went to
14 medical school. He has had very little experience and
15 training in MRIs since then. He's taken a few half-day
16 courses. As he has explained it, he is self-taught by
17 talking to another -- or to a radiologist, and that
18 radiologist admits that MRIs weren't invented when he
19 went to medical school either.

20 Dr. Klein is not a radiologist. He doesn't
21 hold himself out as a radiologist or a
22 neuroradiologist. And, in fact, in this case, when he
23 said he looked at a couple of the -- of the spine films
24 for Ms. Garcia -- and his reports only talk about him
25 looking at two of them -- he said he actually had to go

1 and speak to a neuroradiologist in order to verify
2 whether what he was thinking is correct or not. And he
3 can't come into court and parrot the opinions of
4 another neuroradiologist. Again, the defense -- or of
5 a neuroradiologist.

6 The defense could have hired any number of
7 qualified radiologists or neuroradiologists from Nevada
8 or any state, and they chose not to do that. And they
9 want to have a surgeon -- a former surgeon who had
10 never dealt with these types of MRIs in his clinical
11 practice and is not qualified to read them or to
12 present them to the jury.

13 So I can talk about some of the specific
14 opinions encompassed in these that are outside the
15 scope of the report. But I think if Your Honor would
16 agree with us on these three topics, then we don't have
17 to get to the specific opinions in these areas.

18 THE COURT: I think, as far as the orthopedic
19 spine surgeon opinions, if he's an orthopedic doctor
20 and he's done spine surgeries, the fact that it was
21 30 years ago, I think, goes to weight. So I'm not
22 going to exclude him as it relates to spine surgery or
23 his testimony as an orthopedic surgeon.

24 As far as the pain management, that's a -- a
25 bigger question. And I don't know what he's going to

1 be expected to testify to about that. As an orthopedic
2 surgeon, I know a lot of these doctors will refer
3 people out to pain management, and they know what pain
4 management doctors do as it relates to epidural
5 injections and things like that that are necessary
6 before a spine surgery because it's diagnostic and
7 therapeutic.

8 So I don't know what the -- the scope of the
9 testimony is there. You're going to have to maybe give
10 me some more.

11 As far as the MRI films, I guess I'm -- at
12 this point, I need to hear a little bit more about what
13 he thinks his qualifications are to look at films.

14 MR. MAZZEO: And I can tell you, Judge,
15 he's -- he did testify. Mr. Smith took his deposition.
16 So Mr. Smith actually knows his experience. And why
17 he's -- why he's stating contrary is -- is odd to me
18 because he's fully aware of his deposition testimony.

19 In his deposition on December 18th of 2014,
20 pages 41 through 44, Dr. Klein does talk about his
21 ability to read CT scans and MRIs and that he reads
22 approximately 200 MRIs per year since 1995.

23 Dr. Gross is not a radiologist, but he was
24 able to testify and say that he reads an MRI scan.
25 Dr. Kidwell -- not Dr. Kidwell -- but Dr. Cash also

1 read an MRI scan. Dr. Oliveri, who's a physiatrist,
2 read an MRI scan.

3 You do not have to be a radiologist to be
4 qualified to read MRI imaging studies, certainly not
5 to -- to be able to testify in court either. So he
6 does it all the time in his practice. He does it with
7 regard to the hundreds of forensic evaluations that he
8 performs.

9 He's a forensic medical examiner. So this is
10 in the course and scope of his work to not just read
11 MRIs but to read all of the medical records and then
12 offer opinions as to the relatedness to an event. So
13 he's done that.

14 He has the experience. He's a member of the
15 North American Spine Society and -- as well as other
16 societies. He's a professor that teaches at UC --
17 UC Davis. He's a clinical professor of orthopedic
18 surgery at UC Davis.

19 So Mr. Smith, giving you half the picture,
20 is -- is wholly inaccurate. So he's qualified to
21 testify as an orthopedic surgeon.

22 And, in addition, Judge --

23 THE COURT: What are the pain management
24 issues that he's going to testify about?

25 MR. MAZZEO: Pain management has been -- to

1 the extent that he testified to it, it's reflected in
2 his reports and testified to in his -- in his
3 deposition because Mr. Smith asked him about it.

4 So, of course, he has a working knowledge of
5 pain medicine. And he's not going to testify to
6 anything that would be beyond the scope of his
7 expertise or -- or knowledge concerning that.

8 With regard to -- so he will certainly
9 testify to the -- with regard to -- to the
10 interventional injections, he's going to testify that
11 they were not diagnostic. And so he has a
12 familiarity -- although he didn't perform it, he has a
13 familiarity, as does Dr. Poindexter, with the workings
14 of -- of these procedures and the local anesthetic
15 and -- and the response by patients.

16 So in that limited fashion, that's what he's
17 going to testify to.

18 So he's -- he's reviewed the records. It's
19 in his report. They brought a motion in limine to
20 exclude Dr. Klein on December 8th of 2014, and that was
21 denied.

22 So why we're bringing this up on -- not on
23 the day -- first day of trial but on the -- at a time
24 when Dr. Klein is ready to testify is odd to me. So
25 I -- I would say that everything I -- I anticipate

1 Dr. Klein testifying today is clearly within the scope
2 of his experience, knowledge, training, what have you.

3 THE COURT: Okay.

4 MR. SMITH: First off, the reason we're
5 bringing it up is because we got slides last night that
6 show us he's going to greatly attempt to expand his
7 opinions beyond what the original scope was.

8 As far as the motion that was previously
9 filed, that motion was regarding bias because, prior to
10 the Rule 35 exam, Dr. Klein had made up his opinions
11 about Emilia's physicians, specifically Dr. Lemper,
12 Dr. Kidwell, and Dr. Gross, and Dr. Cash. And he had
13 made up his opinions about our firm allegedly doing a
14 bunch of things regarding her care that didn't have to
15 do with these issues. It was -- it was to exclude his
16 Rule 35 exam for not being independent. So that issue
17 is separate and apart from what we're talking about.

18 And briefly I'll address a couple of things
19 that Mr. Mazzeo said. With respect to the MRI films,
20 Dr. Klein hasn't reviewed those in his clinical
21 practice. He decided in the '90s to become an expert.
22 And he decided when he wanted to become an expert, he
23 was going to do spine work, even though that wasn't his
24 expertise, because that's where the expert work is.

25 So he hasn't reviewed 200 MRIs per year in a

1 clinical practice. And he hasn't done, for example,
2 what Dr. Gross and Dr. Cash do, which is review those
3 MRIs and use them to do a spine surgery. He never did
4 that.

5 In addition -- and we can talk about this
6 more in a moment when we get to the specifics of his
7 opinions. But he didn't review most of these MRIs
8 until -- I don't know when, because he has a
9 January 6th, 2016, report that doesn't reference any of
10 these, and none of his prior ones do either.

11 With respect to the pain management
12 injections, he's going to testify about how they were
13 done. So Mr. Mazzeo said that he's going to testify
14 they're not diagnostic. Well, that's because of how
15 he's claiming Dr. Lemper and/or Dr. Kidwell did them
16 wrong.

17 And he's not qualified to talk about whether
18 they did the pain management injections wrong. He
19 might be qualified -- I mean, I disagree with this.
20 But what Your Honor's saying is he might be qualified
21 to testify about ordering a pain management injection
22 or interpreting the results of a pain management
23 injection to determine whether surgery is appropriate
24 at a particular level or the diagnostic nature of an
25 injection. But that's not the limits of what he's

1 going to testify about.

2 He's going to testify about where Dr. Lemper
3 placed the needle, how he did the specific injections.
4 And those are opinions that are specifically within the
5 purview of a pain management doctor and somebody who's
6 actually done these type of injections.

7 MR. MAZZEO: Your Honor, if I can respond to
8 that. So how Dr. Lemper and Kidwell did the procedure
9 and that they did it wrong, he's not going to testify
10 to that. I don't know where Mr. Smith is getting his
11 information from.

12 But he's not going to testify how it was
13 wrong or how he placed the needle. I don't understand
14 where Mr. Smith is coming up with that.

15 And then he gets some slides that are slides
16 of images that are in evidence. And he reviewed the
17 actual imaging studies, so I don't know what he's
18 referring to about not reviewing the imaging studies.
19 He's reviewed those all along. It's in his report.

20 And he wants to greatly expand, Mr. Smith
21 says, greatly expand on -- on his opinions. I -- I
22 have a copy of the MRI -- the MRIs that are in
23 evidence.

24 Greatly expand from looking at the MRIs? How
25 does he -- how does he jump -- make that mental leap?

1 This is -- this is nonsense. This -- I don't know why
2 he's -- he's putting forth this -- this motion to -- to
3 try to exclude Klein.

4 I think they had luck last week with
5 Dr. Scher. So they figured, "Hey, let's push it.
6 Let's see if we can get Klein out." This is absurd,
7 and it's wasting our time.

8 THE COURT: From what I'm hearing so far, I
9 think you're going to have to make objections with
10 regard to the specifics as it comes up. So far,
11 everything you've said seems to go to weight and not
12 admissibility.

13 MR. SMITH: And we will do that. Then I also
14 want to talk about some specific opinions that will be
15 outside the scope of reports, and one of them is what
16 Mr. Mazzeo was just talking about.

17 If you look at Dr. Klein's reports, he
18 started with an October 9th, 2014, report. And all he
19 reviewed in this report in terms of films are a
20 January 2011 film and an August 2011 film.

21 He then issued a report on November 15th,
22 2014, where he says he did not receive any additional
23 films and then another report on January 6th, 2016, of
24 this year, where he again says, "I was not provided any
25 additional diagnostic studies to review."

1 The slides that we received last night and
2 this morning talk about many other MRIs in addition to
3 the ones that he says he reviewed as of January 6th of
4 this year. That includes pre- and postsurgical MRIs.
5 He's never offered any opinions about any of those MRIs
6 and cannot expand upon the opinions that he gave in his
7 reports.

8 In addition, many of the slides talk about
9 something called modic changes. And -- and I don't
10 know where they're going with those slides, but none of
11 his reports talk about modic changes or whether there
12 are modic changes on the -- on the two MRIs that he
13 says that he reviewed.

14 There's a number of other slides that I think
15 we can address as they come up. And -- and, you know,
16 counsel will have to let us know what ones they're
17 going to use because we've gotten conflicting
18 information this morning about which they will or they
19 won't use out of the 58 new slides.

20 But specifically with respect to the MRIs, he
21 needs to be limited to the two that he reviewed as of
22 January 16th -- or January 6th, 2016.

23 MR. MAZZEO: Your Honor, Dr. Klein has -- oh,
24 with regard to modic changes, that's been testimony
25 that came up during the course of trial from

1 Plaintiff's treating physicians. So that's certainly
2 open and out there. So I can certainly ask him about
3 modic changes.

4 Regarding the review of the films, yes, it's
5 my understanding he did review the January 26th, '11,
6 film; the August -- what is it? -- August 12th, 2011,
7 film; and the November 19th, 2012, film. He's reviewed
8 all of these -- these films way before January of this
9 year.

10 So there may have been -- oh, during the
11 course of the trial, Plaintiff put forth postoperative
12 X rays showing the hardware that was placed inside. So
13 that's -- that's something that's in evidence. And so
14 that -- I believe that's one of the slides that we have
15 as one of the 14 that we'll be showing Dr. Klein on
16 direct examination.

17 So -- and that's -- so that's something that
18 he reviewed in the context of -- for -- for trial
19 purposes.

20 I -- I don't know as I stand here -- and
21 maybe Roger can -- can help me on this -- but I believe
22 that that was -- that may have been reviewed prior, but
23 in any event, it's in evidence. It was discussed by
24 Plaintiff's treating physicians. So it's -- it's
25 something that Dr. Klein will be discussing during his

1 direct examination.

2 THE COURT: Well, just because somebody else
3 said something during trial doesn't mean that your
4 expert gets to offer a bunch of new opinions. So ...

5 MR. MAZZEO: Well, no, it's -- I'm sorry,
6 Judge.

7 THE COURT: He can offer opinions based on
8 the films that he saw and evaluated prior to his
9 reports or in his deposition, if he was questioned
10 about it. That's fine. But, I mean, you can't have
11 shown him new films and he has new opinions that --
12 that weren't previously disclosed.

13 MR. MAZZEO: Absolutely, Judge. And -- and,
14 as a matter of fact, I just need a moment to find out
15 where he did talk about -- at his deposition, he did
16 testify that he had reviewed both the -- the
17 January 2011 film and the November 2012 film.

18 So this was back in -- at least by February
19 of 2015. And Mr. Smith was asking him about this, and
20 he offered an opinion that -- with regard to this
21 alleged progression of the alleged slippage that
22 occurred between the two films. And, in his opinion,
23 after reviewing the film, there was no additional
24 slippage. So he can certainly testify to that on
25 direct examination.

1 If Mr. Smith wants to cross-examine him about
2 that, he certainly can. But he's within his right to
3 testify about that addition.

4 THE COURT: If it's an opinion that was
5 previously disclosed in the report or deposition, I'm
6 going to allow it.

7 MR. MAZZEO: Thank you.

8 THE COURT: If there's -- if there's
9 additional stuff, just object when we need to.

10 MR. SMITH: We will.

11 MR. MAZZEO: Yeah. We would just ask that --
12 I mean, as long as they're legitimate objections, not
13 to the point where it's obstructionist, and -- and
14 interfering with the presentation of the defendants'
15 case.

16 If -- if there's a legitimate basis for it, I
17 have no problem with any objections from the other
18 side. But if it's just to annoy, harass, and -- and --
19 and impede the -- the presentation of evidence, I would
20 certainly ask the Court to --

21 THE COURT: I would hope that neither side
22 would be doing that.

23 MR. MAZZEO: Absolutely, Judge. Thank you.

24 THE COURT: You ready to go?

25 MR. SMITH: Yes.

1 MR. MAZZEO: Yes, Judge.

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

3 THE MARSHAL: All rise for the presence of
4 the jury.

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

7 THE COURT: Go ahead and be seated.

8 Welcome back, folks. We're back on the
9 record, Case No. A637772.

10 Do the parties stipulate to the presence of
11 the jury?

12 MR. MAZZEO: Yes, Your Honor.

13 MR. SMITH: Yes, Your Honor.

14 THE COURT: Hopefully, you guys didn't mind
15 having a three-day weekend. I was sick all weekend, so
16 excuse my coughing and sniffing today. Hopefully,
17 Kristy won't have to have people repeat stuff too many
18 times because I coughed over the testimony. That'll
19 happen some, I'm sure.

20 You folks have met Curt now. He's -- Curt's
21 our regular marshal. Tom was our marshal filling in
22 while Curt was gone. So hopefully you get to know
23 Curt.

24 You got a little bit longer in the trial. So
25 glad that you all made it back. We are still -- we

1 still have not completed the plaintiff's case, but we
2 have another defense witness that was scheduled for
3 this morning. So it's going to be taken out of order.

4 This is just kind of the way the trial works.
5 You folks have figured that out by now.

6 Mr. Mazzeo, who are you calling?

7 MR. MAZZEO: Going to call Dr. Michael Klein,
8 Judge.

9 THE COURT: Good morning, Doctor.

10 THE WITNESS: Good morning, Your Honor.

11 THE COURT: I'm going to ask you to step all
12 the way up on the witness stand. And once you get
13 there, can you please remain standing and raise your
14 right hand to be sworn.

15 THE MARSHAL: Watch your step.

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

20 THE WITNESS: I do.

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

23 THE WITNESS: Michael Robert Klein Jr.,
24 K-l-e-i-n.

25

1 THE COURT: Go ahead, Counsel.

2 MR. MAZZEO: Thank you, Judge.

3

4 DIRECT EXAMINATION

5 BY MR. MAZZEO:

6 Q. Dr. Klein, thank you for rearranging your
7 schedule and making yourself available to testify in
8 court on this trial today.

9 A. You're welcome.

10 Q. Doctor, would you tell the jury what is your
11 profession.

12 A. I'm an orthopedic surgeon.

13 Q. And what does the field of orthopedic surgery
14 entail?

15 A. Orthopedics is a surgical specialty that
16 deals with all aspects of the skeleton, the muscles,
17 the ligaments, the tendons, with the exception of the
18 skull. We don't get training in the skull, the
19 mandible.

20 We deal with congenital problems -- so from
21 the time a child is born -- such as hip dysplasia,
22 clubbed feet, other deformities.

23 A large part of orthopedics is trauma,
24 fractures: fractures of the spine, fractures of the
25 arms, the legs.

1 There's a subspecialty of orthopedics called
2 upper extremity or hand, where you do an extra year of
3 training to learn how to take care of congenital
4 problems, traumatic problems, and things as simple as
5 carpal tunnel syndrome or lumps and bumps like
6 ganglions.

7 Some orthopedic surgeons deal with tumors, so
8 they're called orthopedic oncologists. Primary tumors
9 of bone fortunately are very, very rare. But we
10 unfortunately see a lot of patients who have metastatic
11 disease to bones, from prostate, from the lung, from
12 the GI tract.

13 Some orthopedic surgeons choose to do sports
14 medicine, dealing with athletes and weekend warriors.
15 So we do a lot of arthroscopy of the shoulder, the hip,
16 and the knee.

17 As the skeleton ages, we develop degenerative
18 problems. So that requires replacement of joints, like
19 total hips and total knees.

20 Another small subspecialty is called foot and
21 ankle, dealing just with problems like bunions or
22 deformation posttrauma or problems, again, of an ankle
23 that wears out either after aging or simply from an
24 injury.

25 So we deal with all aspects of the skeleton

1 from birth through the aging process.

2 Q. Thank you.

3 And would you tell the jury about your
4 educational background after high school.

5 A. I graduated from the University of Missouri
6 in 1959 with a bachelor's in biology. My intention at
7 that time was to become a teacher. So I went on to
8 Drexel University where I obtained my master's in
9 anatomy and neuroanatomy. I started my PhD training
10 and decided to go to medical school. I became
11 interested in clinical medicine.

12 Because I had been teaching anatomy and
13 neuroanatomy and had the whole first-year course
14 schedule, I started as a sophomore in medical school.
15 I finished in 1966 from the University of Miami School
16 of Medicine.

17 Vietnam was heating up at that time, and all
18 of us ended up in the military. I -- I interned at
19 Scott Air Force Base, which is just north of St. Louis.
20 I finished that in 1967, and I was sent to Germany as a
21 general medical officer, like a primary care physician.

22 In 1971, I came back to the continental
23 United States and began four years of training in
24 orthopedic surgery at Wilford Hall Medical School --
25 Medical Center -- excuse me.

1 I finished that in 1975, and I was sent to
2 Mather Air Force Base, which is on the outskirts of
3 Sacramento, where I was a staff orthopedic surgeon for
4 two years. I separated from active duty as lieutenant
5 colonel and stayed in the reserves, went into private
6 practice, and remained in full-time private practice
7 till 1991 when I got activated for Desert Storm. So I
8 was gone for about five months, then returned and
9 resumed my practice.

10 Q. Thank you.

11 And would you tell the jury some of the
12 training and experience that you have received in the
13 area of orthopedic surgery since graduating from
14 medical school.

15 A. Well, my interest has been primarily general
16 orthopedics. When I first started my practice, I did a
17 lot of trauma work, including skeletal trauma, meaning
18 the spine.

19 And then, because of my interest in teaching,
20 for the past 20 years I've been a professor of
21 orthopedics at the University of California, Davis,
22 where I do clinics on Fridays, seeing general
23 orthopedic problems.

24 And my surgery now is just limited to upper
25 extremity. I'm no longer acting as primary surgeon on

1 the spine or total joints or even arthroscopy. I still
2 assist in the operating room to two of my colleagues
3 who do primarily reconstructive total hips and total
4 knees.

5 I'm the facilitator for the resident journal
6 club. We meet monthly. We pick a topic, and I just
7 sort of guide them along. One of my big fears when I
8 finished training was how to stay current, and
9 residents are very stimulating. They force me to read.
10 And then just the environment is educational.

11 Q. Thank you.

12 And are you board-certified?

13 A. Yes. Since 1976.

14 Q. In what area?

15 A. In orthopedic surgery.

16 Q. What does it mean to be board-certified?

17 A. After you finish your training, two years
18 after, after you have been in practice, either private
19 practice or academic environment, you submit all the
20 operations you have done to the board. Your professor
21 signs off that you have the training and background to
22 sit for the exam. And the exam is written and oral.
23 And it's written -- it's accumulated -- the questions
24 are compiled by a group of orthopedic surgeons who feel
25 that you need a certain body of knowledge, after all

1 this training. And you take the exam, and if you're
2 successful, then you call yourself board-certified.
3 About 75 percent of those who take the exam are
4 successful in passing it.

5 Q. And do you have to be board-certified to
6 practice medicine?

7 A. You do not.

8 Q. Thank you.

9 And what academic appointments have you had
10 or currently have?

11 A. Well, I have been -- I started off as an
12 instructor at UCD, University of California, Davis. I
13 taught courses called Applied Medical Principles. And
14 then I do the clinical work where I am interacting with
15 medical students, residents, some fellows. And over
16 the years, I -- it's a volunteer; I'm not paid
17 anything. But they -- I'm finally elevated to full
18 professor. So I'm called clinical professor --
19 volunteer clinical professor.

20 Q. Thank you.

21 Can you tell the jurors what, if any,
22 presentations you've given in your area of specialty?

23 A. I have discussed how to examine the shoulder,
24 how to examine the knee, how to examine the spine, both
25 to professional groups and lay groups. I have talked

1 to individual -- groups about indications for total
2 hips. The group in Sacramento calls themselves The
3 Hipsters. I talk about evaluating an individual to
4 physical therapists.

5 So usually I'm receptive to talking about
6 almost anything, depending on the interest of the
7 group, as well as how to do an evaluation in the
8 medical-legal arena.

9 Q. Thank you.

10 And what academic awards have you received?

11 A. My most recent was the residents honored me
12 as the teacher of the year, 2012.

13 Q. Okay. And do you have any consultant
14 positions?

15 A. I act as consultant primarily for two
16 entities, one here in Las Vegas called Consultants
17 Medical Group and the other in Sacramento called MRK
18 Medical Consultants. MRK are my initials.

19 Q. Okay. And you mentioned, briefly, a few
20 minutes ago about your continuing medical education.

21 Is that something that's required for
22 doctors?

23 A. It is. The main licensure, both in
24 California and Nevada, you have to take what we call
25 continuing medical education or CMEs.

1 So I attend courses, specialty courses. I go
2 to the American Academy of Orthopedic Surgeons. I
3 go -- I'm a member of the North American Spine Society
4 here in Las Vegas. From February 4th to the 6th, I
5 attended the Cedar Sinai -- it's called Current
6 Concepts of Spine Care put on by the Cedar Sinai
7 Medical Center in Los Angeles. It's the 15th annual.
8 And then, in May, I'll attend the University of
9 San Francisco, three-day conference on the spine.

10 I'm sort of a voracious reader. I read Spine
11 Journal and the Journal of Bone and Joint Surgery, and
12 I'm a reviewer for the Journal of Bone and Joint
13 Surgery.

14 Q. Thank you.

15 And what professional affiliations or
16 associations do you belong to?

17 A. Well, I'm a member of the American Academy of
18 Orthopedic Surgeons. I'm a fellow of the American
19 College of Surgeons. I'm a member of the California
20 Orthopedic Association and the Western Orthopedic
21 Association. Active in my local medical society, which
22 is called the Sacramento Sierra Valley. One time, when
23 I was in active duty, I was active and gave
24 presentations, at the Society of Military Orthopedic
25 Surgeons.

1 Q. Okay. And do you have any association with
2 the North American Spine Society?

3 A. I do. I'm on the evidence-based medicine
4 committee, one of probably 200 members of that
5 committee.

6 Q. Can you explain to the jury what that
7 committee involves?

8 A. The evidence-based medicine committee picks a
9 topic, like what's the best way to evaluate arthritis
10 of the neck? What's the best way to treat it?

11 So we start doing what's called meta
12 analysis, which is looking at articles from around the
13 world, and they -- then you decide where do you want --
14 when they ask you which -- where your interest is:
15 diagnostics, treatment, interventional, surgery.

16 So they send all this out. It's about a
17 two-and-a-half to three-year process. And then they
18 start coming up with questions. What's the best way to
19 do this? What's the data that supports this? What is
20 your criticism? And you start reading articles. And
21 we start compiling the information, determining is
22 it -- is there good evidence? Is there insufficient
23 evidence? Is it something we could recommend to
24 develop guidelines? Not as standard, as a guideline.

25 And we have done it for the neck, for what's

1 called myopathy and radiculopathy. We've done it -- we
2 published, in 2014, the treatment of spondylolisthesis,
3 the topic of issue in this case. So it takes about
4 two-and-a-half to three years. It's an
5 ultraconservative organization. And we keep sifting
6 and filtering until we come up with what we think some
7 good, salient recommendations.

8 Q. And how long have you been practicing
9 full-time orthopedics for?

10 A. 45 years.

11 Q. Okay. Since 1971?

12 A. Yes.

13 Q. And during the 40 year -- 45 years that you
14 have been a full-time orthopedic surgeon, can you tell
15 the jury how often you've dealt with trauma in your
16 practice?

17 A. The first five years of my private practice,
18 I was in the emergency room every other night. That --
19 that's sort of the way we make a living, initially,
20 until the other physicians develop some confidence in
21 you and start wanting to refer you elective cases. You
22 know, like elective spine cases, arthritic cases that
23 need total joints.

24 You deal with trauma from the first day
25 you're in training. Just to see -- the professors are

1 going to learn -- and I do the same thing with my
2 residents -- are you analytical? Can you figure out
3 the problem? Can you narrow down the issues in taking
4 care of the whole patient in severe trauma? And that
5 begins with taking care of broken wrists in kids, open
6 fractures from motorcycle riders, severe polytrauma
7 where there's fractures of the spine and upper and
8 lower extremities from falls off cliffs or falls off
9 ladders. And you develop a philosophy about how to
10 best manage those type of patients.

11 And, in addition, there's a subspecialty
12 called trauma. An extra year of training for those of
13 us who just are interested in doing that. And a lot of
14 it is taking care of pelvic fractures, a very special
15 area in orthopedics.

16 So I have been exposed to all of that, and I
17 did it up through 1999. I was chief of surgery at
18 Mercy San Juan Medical Center, and we became a Level II
19 trauma center. But, you know, I did it from '71 to
20 '99, and I think I sort of paid my dues. It was
21 enough -- it's a young man's work. It's hard.

22 Q. And in your years of practice, approximately
23 how many surgeries would you perform per year?

24 A. I would say, as primary, around 300.
25 Anywhere from a carpal tunnel decompression, a broken

1 wrist, or a major reconstructive procedure of a hip or
2 a knee, but each one of those is an elective or
3 emergent procedure. So at least -- some years more
4 than -- but about at least 300 a year.

5 Q. Okay. So we're talking about several
6 thousand operations during the 45-year career; correct?

7 A. Well, I also assist on a lot. In other
8 words, there's a lot of major trauma cases or some
9 total joints where there's another orthopedic surgeon.
10 So I would say I probably did another 100, 150 a year
11 or so. I would think it would be 20,000 operations
12 where I was either primary or first assistant.

13 Q. Thank you.

14 And during your lengthy career, did you also
15 take care of patients with spinal problems, both
16 traumatic and degenerative in nature?

17 A. I did.

18 Q. Okay. And --

19 A. I still do.

20 Q. And you still -- sure.

21 And -- and you've also acted as primary
22 surgeon on spinal cases, both degenerative and
23 traumatic?

24 A. Correct.

25 Q. Have you seen and treated patients, such as

1 the plaintiff in this case, who had congenital
2 spondylolisthesis?

3 A. Yes.

4 Q. Okay. And what experience do you have in
5 correcting spinal deformities surgically?

6 A. During the second year of my training, I
7 became very interested in scoliosis, curvature of the
8 spine in mostly teenagers but in some adults. So after
9 the second year of training, you have some latitude.
10 You can sort of move into some of the rotations where
11 you get more experience or more exposure to spine.

12 So my interest then was reconstructive
13 surgery and scoliosis. Every Friday, we would do two
14 scoliosis cases. Where I trained was the scoliosis
15 center for the Air Force. Then I became interested in
16 traumatic spine. And at that time we did not have the
17 instrumentation that's available today.

18 Once I got into private practice, I teamed up
19 with other orthopedic surgeons and some neurosurgeons,
20 and we did traumatic surgery. Fractures, dislocations
21 of the neck, thoracic spine, and also the lumbar spine.
22 We also did major operations for cancer that had
23 metastasized to the spine. And many times those are
24 what we call a pathologic fracture. So that's a form
25 of a trauma as a result of a tumor.

1 So I have -- my background and knowledge
2 in -- as an anatomist and neuroanatomist was a familiar
3 area for me, anatomically.

4 Q. Do you have experience in performing spinal
5 fusions for spondylolisthesis?

6 A. I do.

7 Q. And when you performed spinal fusions for
8 spondylolisthesis, did you have available to you the
9 current devices that Dr. Gross used in his surgery?

10 A. No. Those had not yet been invented.

11 Q. Have you ever assisted or acted as co-surgeon
12 on cases involving fusions with pedicle screws,
13 connecting rods, interbody spacers -- also referred to
14 as cages -- such as that used by Dr. Gross?

15 A. Yes.

16 Q. And tell the jury, what is the nature of your
17 clinical practice?

18 A. On Fridays, at UCD, I'm one of about six
19 orthopedic surgeons who volunteer. So it's called VCF,
20 volunteer clinical faculty. It's a -- depending on the
21 interest or the background of the orthopedic surgeon,
22 they tailor the type of patients.

23 Some orthopedic surgeons, they do hand
24 surgeries, so they don't want to see other problems.
25 Some are sports medicine. They don't particularly want

1 to see other than sports medicine issues. I take an
2 egalitarian approach; I see everybody, whether it's a
3 hand or a spine. And I see patients such as
4 Ms. Garcia. I see patients who have very arthritic
5 joints.

6 The patients come into the clinic from five
7 outlying primary care physicians called the PCM,
8 primary care network. The university has five large
9 clinics in the Sacramento area. And those patients are
10 seen by their primary care, and then they're sent to
11 our department. And I see them on Fridays.

12 And I evaluate them, and the most -- I had a
13 patient a few clinics ago like Ms. Garcia, and I take
14 care of that patient, do all the evaluations. If they
15 need interventional treatment, I send them to our
16 interventionalist to the point they have exhausted all
17 conservative treatment, including therapy. And then we
18 send them to our spine team.

19 That's the way the university training
20 department is -- is set up. So if you have a shoulder
21 problem, you go to the shoulder team; an elbow problem,
22 go to the elbow team; or a spine problem, to our spine
23 team.

24 Q. Okay. Thank you.

25 And what percentage of your time is spent

1 doing clinical orthopedics involving teaching and
2 performing -- and/or performing operations?

3 A. About 20 percent of my time.

4 Q. Is -- is done teaching and/or --

5 A. Or seeing patients.

6 Q. Okay.

7 A. Most of the time, I have a resident with me,
8 but sometimes the residents aren't available. They're
9 in the operating room, they're spread thin. So I see
10 the patients by myself, and I'm willing to do the
11 dictation and all the paperwork through the
12 electronic -- the electronic medical record format we
13 use at UCD.

14 Q. How do you spend the remainder of your time?

15 A. The other 80 percent of my time is doing
16 med-legal or forensic orthopedics.

17 Q. Okay. And when -- just so the jury knows,
18 when you talk about med-legal or forensic orthopedics,
19 what are we talking about? If you can describe that
20 for the jury.

21 A. I receive a call from an attorney who wants
22 to discuss a case or wants to get educated. What's the
23 best way to proceed? Or if he feels he needs a
24 specialist, what's the best type of specialist for
25 that? It would be an orthopedic surgeon, maybe a

1 physical medicine specialist, maybe a neurologist. So
2 just give them -- educate and send them in the right
3 direction.

4 I then review records, such as these that I
5 have brought with me today, and just do the record
6 review and, again, discuss -- give my opinion.
7 Sometimes I dictate a report at the request of the
8 attorney. And other times I will examine the patient
9 and give opinions as to, in severe trauma cases,
10 what -- has anything been overlooked? What do I see as
11 the need for future surgery? What can be expected
12 based upon the natural history of the disease process?

13 And then I spend time -- some of those cases,
14 I -- I get deposed, and about 2 percent go to trial.
15 So I end up in a courtroom, as I am today.

16 Q. Okay. Thank you.

17 And would you consider yourself well versed
18 in the anatomy of the spine?

19 A. Yes.

20 Q. And, by the way, you mentioned -- you told
21 the jury about the corrective spinal deformity surgery
22 that you performed.

23 How would you characterize the degree of
24 difficulty between performing a fusion laminectomy, as
25 was done in this case, versus correcting spinal

1 deformities?

2 A. Do you mean in terms of the technical
3 difficulty or the approach?

4 Q. The technical difficulty.

5 MR. SMITH: Object to the foundation.

6 THE COURT: I'm going to sustain that. You
7 need to lay a little bit more, I think.

8 BY MR. MAZZEO:

9 Q. Doctor, have you -- in the course of your
10 practice, have you performed fusion surgeries and
11 laminectomies?

12 A. I have.

13 Q. Okay. And also you -- and you've performed
14 surgeries in correcting spinal deformities?

15 A. Correct.

16 Q. Are you -- are you aware or familiar with the
17 degree of difficulty -- technical -- technical
18 difficulty in performing both of these surgeries?

19 A. Yes. I have in-depth knowledge of the -- the
20 technical difficulties, but the more important thing is
21 the preoperative planning.

22 Q. Okay. And just tell us what -- in terms of
23 technical difficulty, can you distinguish between -- or
24 explain to the jury the technical difficulty with
25 performing a fusion laminectomy versus a -- correcting

1 a spinal deformity?

2 A. Yes. Spinal deformities, such as a teenager
3 with scoliosis or even an adult with scoliosis, is
4 usually an individual who is otherwise healthy.
5 There's no cardiac problems, there's no pulmonary
6 problems, they're neurologically intact, and we know
7 that they're going to have an expected outcome because
8 of their ability to heal.

9 So we do extensive preoperative planning,
10 including pulmonary function tests, depending on the
11 severity of the curve. And the last time that I do the
12 surgery is when I'm scrubbing my hands at the sink and
13 anticipating all the problems that can occur. Have I
14 planned all the instruments I'm going to need? Do we
15 have adequate amount of blood available? Am I going to
16 do intraoperative neuromonitoring? Anticipating every
17 possible scenario.

18 And then, the fun part actually is doing the
19 surgery. In some cases, in patients over the age of 50
20 or postmenopausal females or a severe deformity with
21 slippage, which can occur in either plane -- can I use
22 this?

23 Q. Certainly. Sure.

24 A. Sometimes the vertebral bodies develop --

25 Q. Doctor, I'm sorry. If it would help, because

1 you are quite a distance away, if you want to walk up
2 to the bar right here so you can show it to the jury.

3 A. Sure. Maybe this would be better.

4 As the spine ages, we develop conditions
5 similar to what Ms. Garcia had, which is a congenital
6 spondylolisthesis, but you can also acquire it. And
7 you can acquire it in this area, where the vertebral
8 body goes forward, it can rotate, or it can go
9 laterally. So this vertebral body goes this way.

10 The most difficult is when it slips, and then
11 you get this deformity, a spondylolytic scoliosis. And
12 that's the biggest challenge for us is to do this in
13 the postmenopausal female whose bone is not of the same
14 quality as a teenager. And the advent of the pedicle
15 screws and the rods has been a terrific boon to us,
16 although there are still occasions where we use
17 something similar to what used to be called the
18 Harrington rods or the Dubousset system.

19 D-u-b-o-s-s-e-t [sic].

20 The Dubousset system, which is the metal
21 construct that holds things together until the bone
22 fuses. So the adult spine is more challenging than
23 the -- a growing spine or the skeleton of a mature
24 female teenager. Because it occurs mostly in girls,
25 about 8.2 times to boys.

1 The technical part is all the planning we do
2 ahead of time of what we can expect. And are we going
3 high enough above the area of the curve? What is our
4 anticipated curvature? Is the spinal cord at risk,
5 such as in the thoracic region? And we then do all of
6 the preoperative planning and have an idea of what we
7 want at the end.

8 Q. So in terms of degree of difficulty, which is
9 more challenging, doing a laminectomy or correcting a
10 spinal --

11 A. Correcting a spinal deformity.

12 Q. Okay.

13 A. The laminectomy and fusion is not as
14 challenging because you are dealing with a much shorter
15 segment of the spine, and the spinal cord is not at
16 risk because you're working below the terminus, the end
17 of the spinal cord.

18 Q. Okay. Thank you.

19 What percentage of your medical-legal work is
20 performed or done for the defense as opposed to the
21 plaintiffs bar?

22 A. 85 to 90 percent is defense work.

23 Q. And how do you account for that discrepancy?

24 A. The plaintiff attorneys have the advantage of
25 speaking to the treating physicians. I get a call once

1 per week, and I'll talk to a plaintiff attorney, and
2 I'll ask who the treaters are. And I'll say those
3 fellows will handle themselves very nicely. They're at
4 depo, at trial. Why do you want to spend a moderate
5 amount of money -- in the thousands -- in order to get
6 me involved? And sometimes the answer is, I want
7 someone who's experienced, I need an apportionment, or,
8 in some cases, the treating physician doesn't want to
9 be involved. They don't want to get involved in the
10 legal aspect of it.

11 So that's how it's -- it's been that way for
12 many years. The defense doesn't have access to the
13 treater other than through the deposition or
14 person-to-person -- you know, face-to-face meeting.

15 Q. Thank you, Dr. Klein.

16 MR. MAZZEO: Your Honor, at this time, I move
17 the Court to recognize Dr. Klein as an expert in the
18 field of orthopedic surgery.

19 MR. SMITH: We would object to his
20 recognition as spine surgeon and a -- and an expert in
21 spinal fusion, but we would not object to his
22 recognition as a general orthopedic surgeon.

23 THE COURT: Based on our discussion outside
24 the presence, I'm going to recognize him as requested
25 by defense counsel.

1 MR. MAZZEO: Thank you, Judge.

2 BY MR. MAZZEO:

3 Q. Now, with respect to this case, Dr. Klein,
4 what were you asked to do?

5 A. Initially, your office asked for review, and
6 then I was asked to evaluate Ms. Garcia in the office
7 here in Las Vegas.

8 Q. Okay. And -- and then you were -- I believe
9 you were provided records of Ms. Garcia's -- pertaining
10 to Ms. Garcia's medical treatment in this case as well
11 as diagnostic imaging studies for review?

12 A. Yes. They didn't all come at once. They
13 came incrementally, which is the routine. So I got
14 some of these records -- and I can give you the dates
15 when they arrived -- but I received records, and then I
16 received additional records. And I started looking at
17 them, getting an idea of what the issues were, the
18 treatment. And then Ms. Garcia appeared for the exam.
19 I obtained a -- a history of her symptoms.

20 Q. And Doctor, we'll get into the --

21 A. Sure.

22 Q. -- examination in -- in a minute.

23 What -- tell the jury, what is the purpose
24 for a forensic medical examination?

25 A. Ms. Garcia's accident happened on 1/2/11. I

1 saw her on 9/24/14. Many of the original problems,
2 symptoms, the injuries that occurred, are no longer
3 present. Or sometimes the original -- a group of
4 symptoms were masked.

5 So the purpose is to determine what are the
6 ongoing symptoms, if any; has the treatment that's been
7 provided appropriate; has something been overlooked or
8 missed, which happens occasionally. What's the
9 patient's current status? In other words, how are they
10 responding in terms of returning to their preinjury
11 functional level? How are they doing, based on the
12 recommendations and treatment to date? And do I agree
13 with that? And do I see -- could I make
14 recommendations of future care, or has there been
15 something significantly overlooked that simply got
16 missed?

17 And so I look at all this. I don't come with
18 any type of -- I come with an open mind, just to look
19 and determine how can I give an objective opinion based
20 on what we call evidence-based medicine?

21 Q. And what assumptions do you make prior to
22 doing a medical record review and/or, as you did in
23 this case, also a medical examination and evaluation?

24 A. I make no assumptions. I -- I'm sometimes
25 given really good records. Sometimes I get records

1 from -- as -- some physician, we have really bad
2 handwriting. And sometimes I have to try and figure
3 out what it says.

4 With the advent of electronic medical
5 records, it really has been helpful because at least I
6 don't have to decipher illegible, you know,
7 handwriting. So depending on the quality of the record
8 and the patient's symptoms, is it heading somewhere?
9 Is it making sense? Is it what would be expected,
10 depending on the original diagnosis?

11 And having that as a basis, then I have the
12 opportunity -- not always, but in this case -- to
13 interview and examine Ms. Garcia and get her opinion.
14 How's she doing? And I always ask, share with me how
15 you're doing the last three or four months. And,
16 actually, that's what's important. What happened a
17 year ago usually is not very significant.

18 Q. Okay. Now, when you're asked to do an
19 evaluation, do you come with any sort of bias, whether
20 it's for the defense or the plaintiff?

21 A. No, not at all. It's -- my job is to be
22 honest and objective and, based on the information and
23 the data, to just give an opinion.

24 Q. What steps do you take to ensure that you're
25 performing an objective evaluation?

1 A. Utilizing evidence-based medicine guidelines,
2 looking at the medical records. And then I have what I
3 call a 4-C rule.

4 The first C is credibility. In other words,
5 is -- and I -- part of that is some just subjectivity
6 when I interview and examine, as I did Ms. Garcia. In
7 other words, is she believable? Is she making sense as
8 to what she's saying to me and to others?

9 The second is consistency. Has there been a
10 change along the way? Are things being added in?
11 Taken out? Embellished upon?

12 The third is chronicity. Is there evidence
13 this is going on now, in this case, for months and
14 months? Usually things that go on for more than three
15 months, we use the term "chronic" or "chronic pain."

16 And then the fourth is corroboration, meaning
17 are the objective findings, that which we find on the
18 exam -- measuring, bending, testing -- does it fit with
19 the subjective complaints?

20 We have the advantage of looking at
21 diagnostic studies -- X rays, MRIs, CT scans -- and
22 then looking at all that data. And does it come to a
23 sensible diagnosis?

24 And also outcome, in terms of what was done
25 initially, the treatment, did it improve things? Make

1 it worse? Or did -- at some point did they plateau?

2 Q. Thank you, Doctor. And, by the way, how much
3 are you being paid for your time to testify here today?

4 A. Consultants Medical charges \$6,000 per half
5 day.

6 Q. And for a full day?

7 A. Twice that.

8 Q. 12,000. Okay.

9 And are all of the opinions you'll express
10 today to a reasonable degree of medical probability?

11 A. Yes.

12 Q. And would you tell the jury what percentage
13 of spinal care is provided by nonsurgeons?

14 A. In the United States, 95 percent of spinal
15 care is by nonsurgeons: chiropractors, physical
16 medicine, rehab specialists, physical therapists,
17 acupuncturists, primary care physicians directing care
18 to treaters like physical therapists, therapists who
19 are specialists in things like Pilates, specialized
20 strengthening exercises. Only 5 percent is by
21 surgeons.

22 Q. And what percentage of people with axial
23 skeletal problems submit to elective reconstructive
24 surgery?

25 A. For those that are indicated, that fail

1 conservative treatment, at the most, 5 percent and
2 sometimes 7 percent ever require any type of
3 reconstructive surgery other than trauma.

4 Q. Okay. And in performing an evaluation,
5 whether of a patient, let's say, in a clinical setting,
6 what is the most critical step in making a diagnosis?

7 A. The most important is the history.

8 Q. Why is that?

9 A. With the proper set of questions -- and the
10 way we're trained is to listen -- or at least hopefully
11 we should -- is -- depending upon the precipitating
12 event, is to ask a series of questions, such as, where
13 is the location of the pain? What's the frequency of
14 the pain? Does it occur on a daily basis? Is it
15 constant? Is it two days out of seven? If you're not
16 moving and you're not weight-bearing, do you have the
17 pain when you're at rest? The quality of the pain, is
18 it -- is it sharp? Dull? Throbbing? Burning? Achy?
19 If you have the sharp pain, does it last for seconds,
20 minutes, or hours?

21 And then the famous 0 to 10, what we call the
22 visual acuity scale. On your worst day, your best
23 day -- when I say -- the day I'm seeing the patient,
24 what is it today? Does it stay in one area? Does it
25 radiate? Does it go from your back into your buttock

1 or your leg in terms of spine issues? What makes it
2 better? What makes it worse? What are the aggravating
3 factors?

4 And as I begin that -- and taking notes. And
5 then I go back again, and -- and sometimes I'll ask a
6 question to remind the patient of something else. How
7 is it affected by just activities of daily living --
8 vacuuming, sweeping, bending, lifting children,
9 grocery shopping -- all the things we do in our lives?

10 And then does it cause sleep disturbance?
11 Pain that causes sleep disturbance is of concern
12 because sleep is a semicomatose state. And if it wakes
13 you up, we're concerned.

14 And then, as in Ms. Garcia's case, of all the
15 treatment you've had since the accident, I'm always
16 interested, what seems to have given you some relief?
17 What has worked?

18 So the history part gives me -- tells me the
19 anatomic area, it tells me the structures that may have
20 been injured, and what would be expected. Because
21 every disease has a history.

22 Q. Now, in the scope of an evaluation, what is
23 meant by the term "suggestive" and "objective"?

24 A. Subjective is what you tell us, similar to
25 what I just shared with you. Where is the location of

1 the pain? How severe is the pain? Does it stay in one
2 area? It's all information I glean from you.

3 Objective is what I can measure. Measuring
4 how far you can bend. If I lift your leg, check your
5 reflexes, measure circumference of your arms, your
6 thighs, have you lost muscle mass. If you have, that's
7 called atrophy. So objective is measurable things and
8 how do they correlate, how do they mesh with the
9 subjective?

10 Q. And when a patient comes into your office for
11 an evaluation, what is the most important aspect of
12 evaluating a patient with a complaint?

13 A. The history.

14 Q. Okay.

15 A. Without a doubt, the history.

16 Q. Okay. And after obtaining a thorough history
17 from a patient, what's the next step in the evaluation?

18 A. The next step is to watch the patient walk.
19 I ask the patient to walk in the -- there's a long
20 hallway adjacent to the exam room. How does the
21 patient carry themselves? Is there decreased core
22 strength? Watching you turn, how do you handle that?
23 Are you hesitant when you turn? Are you limping?

24 Ask you to walk forwards and backwards on
25 your toes and heels. That changes weight-bearing

1 characteristics on the spine as well as on the
2 weight-bearing joints.

3 Then, depending on many times the weight of
4 the patient or the age of the patient, I'll ask the
5 patient to hop. Some patients are very reluctant.
6 They say, "I'm afraid I'm going to fall."

7 Well, that gives me more history when I then
8 do another thing, which is called -- it's called
9 abasia-astasia. But basically it's like the highway
10 patrol asks you to do, walk the white line. In other
11 words, how can you walk tandem, heel-toe, and maintain
12 your balance. So that's the first part.

13 And then just having the patient sit down and
14 look -- have I fatigued the muscles when they're just
15 walking up and down the hall or walking on their heels?
16 Are their muscles quivering, arms or legs?

17 Like when you get very tired and you get that
18 little twitching around your eye, that's called a
19 fasciculation. Have I irritated a nerve root by asking
20 them to do all those things when they're walking?

21 And I know some of that because I've already
22 taken the history and the patient's told me, "If I walk
23 for a long time, it really aggravates my low back" or
24 "if I go grocery shopping or driving."

25 And then after just observing, I start doing

1 range of motion of the neck, look at the tone of the
2 muscle, measure the thighs and the calves, see if
3 there's a muscle loss. I check the reflexes. Are the
4 reflexes diminished, or are they hyperactive?

5 In other words, like when the doctor taps
6 your knee with the little rubber hammer, if it's very
7 fast and brisk, that can be a very abnormal sign. That
8 means a nerve root or the cord is irritated.

9 Then check sensation, check the ability to
10 feel the tuning fork. Loss of vibratory sensation is
11 very abnormal. We see it a lot in diabetics. But in
12 an individual who doesn't have diabetes or a spinal
13 thoracic cord injury, we're really concerned about loss
14 of sensation.

15 And how does the patient move in the exam
16 room? Getting on and off the exam table, do they need
17 hand assistance? And then when they're standing,
18 bending, turning, rotating. And then looking at things
19 that could irritate based on the history.

20 Q. And did you use this methodology on
21 Ms. Garcia when you interviewed and examined her --

22 A. Yes.

23 Q. -- on 9/24/14?

24 A. I did.

25 Q. Okay. During the -- during the course of

1 your evaluation, part of your -- actually, part of your
2 evaluation included an interview of Ms. Garcia; is that
3 correct?

4 A. That's correct.

5 Q. And did Ms. Garcia share with you anything
6 regarding the motor vehicle accident? And, if so,
7 what?

8 A. I'm just going to refer to my record.

9 Q. Just let the Court know so that you can
10 refresh your recollection.

11 A. Sure.

12 Q. Let us know after you've read it.

13 A. As an overview, Ms. Garcia shared with me she
14 was the restrained driver of her Hyundai Santa Fe.

15 Q. And, Doctor, if you've refreshed your
16 recollection, try not to read from it.

17 A. Okay.

18 Q. Yep.

19 A. She was -- had no preknowledge she was going
20 to get hit. And she got hit on the passenger side of
21 her vehicle.

22 And so the next thing that I always ask is,
23 did you have enough preknowledge that you could take
24 some evasive action or prepare for the impact?

25 And as many patients do, they don't always

1 remember. She said, "I just remember that my body got
2 jerked from side to side." And I didn't pursue it any
3 more than that. And I didn't -- one thing in my
4 evaluation, it's not supposed to be another deposition.
5 I had the deposition. And that was -- had been asked
6 in detail. So I just -- that's all I needed to know,
7 affirming that she was the driver and what happened to
8 her at the time of impact.

9 Q. And what did Ms. Garcia tell you about her
10 ability to exit her vehicle?

11 A. I asked her sort of, you know, "As the dust
12 settled, as you were able to regain your composure,
13 could you get out yourself?" And she said yes.

14 And I said, "I'm going to ask you three
15 questions before you got out. And the answers are
16 'yes,' 'no,' or 'I don't remember.' Did you have any
17 blurred vision or double vision? 'Yes,' 'no,' 'I don't
18 remember.' Do you have any nausea or vomiting, lose
19 control of your bowel or your bladder?"

20 If you're concussed, if you're knocked out or
21 even have a mild head injury, you're going to have some
22 of those symptoms. And she -- and the answers were no.

23 So she then was able to get out. She knew
24 where she was. She wasn't necessarily confused or
25 disoriented spatially.

1 And I then said, "Knowing that things change
2 with time" -- the common thing is to get adrenalized.
3 That's very normal when you get in an accident. I
4 said, "Did you have any localized pain anyplace?" And
5 she didn't remember having any then at the scene of the
6 accident.

7 And then I said, "What happened?"

8 She said, "Well, I exchanged information with
9 the investigating officer." And then because her car
10 was not -- she couldn't drive it, she got home -- the
11 tow truck driver gave her a ride to her house.

12 Q. During the course of your evaluation, did
13 you -- and record review, did you -- were you provided
14 and did you review the traffic accident report
15 pertaining to this case?

16 A. I was provided, and I reviewed it. Yes.

17 Q. Okay. What relevant information did you
18 glean from that report with respect to your evaluation?

19 A. Just -- it basically, in police terminology,
20 sort of referred to Vehicle 1, Vehicle 2, and from
21 the -- where the impact had been on the passenger side.

22 Q. Did Ms. Garcia share with you that -- whether
23 she had any localized symptoms in her spine by that
24 evening?

25 A. My habit is always, after you get home, sort

1 of do another reassessment. So I said about
2 10:00 o'clock that night, the accident -- because I
3 remember it happened in the afternoon. Did you have
4 any symptoms anyplace, localized symptoms, onset of a
5 headache, neck pain, mid back pain, low back pain? And
6 she said, "My mind was racing. I was really most
7 concerned about getting my daughters ready for school
8 the next day."

9 Q. Okay. And did Ms. Garcia represent to you
10 how she felt the following morning on January 3rd of
11 2011?

12 A. Yes. And I proceeded after, you know -- you
13 know, I said -- I remember also asking, "How did the
14 night progress? Did you -- you know, was it a fitful
15 night? Were you able to sleep?" She just didn't
16 remember.

17 And then I said, "Well, how about when you
18 woke up in the morning? Did you have any localized
19 pain that prevented you from doing what you had to do
20 to get your kids ready for school?"

21 She said, "No, I had no localized symptoms,"
22 that she could remember.

23 Q. And what, if any -- what, if anything, did
24 Ms. Garcia -- actually, withdrawn.

25 What did Ms. Garcia report to you as to when

1 the onset of symptoms started?

2 A. After taking her children to school, she went
3 to her job at the Alicante [sic] Casino.

4 Q. Aliante?

5 A. Aliante.

6 And she -- it's a job where she stands.

7 It's, I think, a cashier's cage, as I remember.

8 And she had onset. That's when she first
9 noticed that she had some onset of what she returned as
10 numbness and like a shooting, stabbing pain in the
11 center of her low back. That was sometime on the day
12 of the 3rd.

13 Q. I'm sorry. Go ahead.

14 A. And I said, "Were those -- did those symptoms
15 persist all that day at work?" She said they did. And
16 then they continued the same on the 4th. And then on
17 January 5th, which would have been the third day after
18 the accident, she decided to get some professional
19 advice.

20 Q. Okay. And did you review any records that
21 indicated that the onset of symptoms did not occur
22 until after January 3rd of 2011?

23 A. She presented to the emergency room at
24 MountainView Hospital, was seen by the emergency room
25 doctor. And that progress note identifies that she

1 said her symptoms began that day, so a little bit
2 different than what she had told me.

3 Q. Okay. By the way, did Ms. Garcia, when she
4 met with you, did she know that she was appearing for
5 you in the context of a medical-legal evaluation with
6 respect to her claim?

7 A. Yes. I explained that your office had asked
8 me to do an evaluation regarding this accident. And
9 then -- in fact, I asked her was she going to be joined
10 by her attorneys. Sometimes the plaintiff attorney
11 will, you know, join the plaintiff for the eval.

12 Q. Okay. What did Ms. Garcia tell you with
13 respect to whether she lost any time from work
14 following this incident?

15 A. Other than her physician visits, like the ER
16 or when she started her chiropractic care with
17 Dr. Gulitz, she had not lost any time from work.

18 Q. And did Ms. Garcia tell you what her current
19 symptoms were as -- at the time of your evaluation on
20 9/24 of '14?

21 A. Yes.

22 Q. What -- what -- what did she tell you?

23 A. At the time of the evaluation, her symptoms
24 were localized to her low back and her right leg. And
25 I asked her, "Had these areas bothered you prior to the

1 incident?" She said no, that she had never had any low
2 back pain or the right leg pain prior to January 2nd of
3 2011.

4 Q. And what's your understanding as to whether
5 Ms. Garcia was doing any exercises for her low back at
6 the time of your evaluation?

7 A. She wasn't doing any exercises then. In
8 other words, I -- I said, "I notice that you've been
9 seen by Dr. Gulitz and had seen a therapist." At that
10 time she was not doing any active exercise program.

11 Q. Did you -- during the course of your
12 interview and evaluation, did you ask Ms. Garcia
13 whether -- of all the treatment that she had received,
14 which had been most helpful to her?

15 A. Yes.

16 Q. What did she tell you?

17 A. I prefaced it by saying, "Of all the
18 treatment you've had since the day of injury," which
19 would be 1/2/11, I said -- we went over it. I said,
20 "You've had chiropractic treatment. You'd had therapy,
21 and you'd had some injections. And then you had the
22 surgery."

23 And her response was that -- she said, "The
24 injections provided absolutely no help." That was her
25 terms. The therapy provided no help. The surgical

1 fusion that she had had on 12/26/12 by Dr. Gross gave
2 her one year of relief.

3 Q. Okay. And what did she share with you with
4 regard to her right leg symptoms which you mentioned a
5 moment ago?

6 A. I mentioned to her, I said, "You shared with
7 me you were having low back pain and right leg pain."

8 And she -- without a proposed question, she
9 says -- she said, "Well, the leg pain wasn't there
10 before I had the surgery." In other words, that was
11 something she noted after she had the surgery.

12 And I said, "Well, what's the right leg pain
13 feel like?"

14 She says, "It's sort of a throbbing. It
15 feels sort of like when you hit your funny bone, when
16 you hit your elbow." And she said, "Most of the time,
17 the symptoms really -- they're sort of more annoying,
18 but they really" -- they didn't go below her knee.
19 They sort of went down the front of the thigh, towards
20 the knee. And sometimes, if she stands too long,
21 they'll go into the calf -- into the back of the calf.
22 And she still had some numbness and tingling in the
23 right foot.

24 Q. What did she indicate with -- whether the
25 symptoms radiated or not?

1 A. Well, that was her description. She -- there
2 was -- the radiating pain in the right leg was what we
3 call somewhat atypical and asymmetrical. Sometimes it
4 would start in her groin, go down the front of the
5 thigh. Other times she'd be more noticeable it was in
6 the calf. Sometimes it would go down into the foot.

7 So it wasn't always the same each time, and
8 it appeared to be somewhat related to her activities.

9 Q. Did you ask Ms. Garcia whether she was having
10 ongoing neck symptoms as of the time of your
11 evaluation?

12 A. I did. Because she had been treated for
13 that. And she said no. She says, "My neck hasn't
14 bothered me in a long time."

15 Q. Okay. And did there come a time when you
16 examined Ms. Garcia during the course of your
17 evaluation?

18 A. Yes. After -- I went back over the symptoms
19 she shared with me just to make sure it was as thorough
20 as possible. Then I asked -- I said, "I'd like to
21 examine you." And I said, "Before I examine you, I'd
22 like you to just walk in the hallway and" -- which we
23 did.

24 I wanted to see, did she have a nice, smooth
25 gait? Was she unstable? Any evidence of ataxia? She

1 walked forwards and backwards on her heels. I left and
2 asked her to change into a paper gown and paper shorts.
3 And then I brought a female chaperone back with me.

4 Q. Okay. Now tell the jury -- just give a
5 summary of the examination that you performed on
6 Ms. Garcia. And if -- if you have to refresh your
7 memory, you can look at your record --

8 A. Sure.

9 Q. -- but then testify without it.

10 A. After I came back with the chaperone, I said,
11 "Please sit on the exam room table." And I again
12 looked at her arms and legs. Was there any evidence of
13 shaking, quivering? Had I fatigued any of her muscles?
14 Had I irritated any of the nerve roots by asking her to
15 walk in the hall on her heels and her toes, forwards
16 and backwards? Then I did what's called a seated
17 straight leg raise test where I ask her to sit --

18 Can I demonstrate?

19 Q. Yeah, please. Certainly.

20 A. One of the things that is important is,
21 because of her telling me she had the pain in the leg,
22 was there any evidence of irritation of the nerve
23 roots, the lumbar nerve roots.

24 So I asked her to sit like this (witness
25 indicating) with her hands -- palms flat so that she's

1 at a 90-degree angle. And then I brought her knees out
2 straight, which is the same as if she's laying on her
3 back. It's called the straight leg test. It's the
4 most sensitive test we do for the lumbar nerve roots.

5 And when you have those symptoms -- and you
6 heard the term -- you may have heard the term
7 "sciatica." So that's the first thing I did.

8 Then I looked at just her body habitus. I
9 look -- checked the reflexes with the rubber hammer
10 that we use. I checked her pulses. I checked the
11 temperature of her skin. I looked at her nail beds.
12 How's the blood supply? I asked her to stand. I asked
13 her to then bend. I noted that she did not have good
14 muscle tone on her back, her tummy area, or her
15 muscles -- spinal muscles. Some of that was apparent
16 when I was watching her walking.

17 I asked her to bend to the right, to the
18 left, backwards. Attempting -- I was attempting to
19 reproduce the symptoms that she had told me -- in other
20 words, during the examination. I asked her one -- one
21 thing I asked her to do was to -- we call it the
22 simulated axial rotation. I had her put her palms
23 against her upper outer thighs, and I rotated her
24 15 degrees to the left and 15 degrees right on her hip
25 joints. That motion, which is called simulated, does

1 not put any motion here at the lumbosacral or at the
2 thoracal lumbar, that 15 degrees each way. There's no
3 motion in the spine. That's why we call it simulated.

4 And I asked her, "Did that bother you?" She
5 said no, that didn't cause her any pain at all. Then I
6 asked her to put her arms out like this. And I said,
7 as I always do, "Pretend you're ten years old and
8 you're playing airplane. These are the wings of your
9 airplane. Dive your airplane to the right. Dive your
10 airplane to the left. Rotate."

11 So I can look now at the entire spine. Is
12 there any evidence of a scoliosis, a curvature? Does
13 having her do those motions cause a spasm? Does it --
14 is it irritating a nerve root? And she -- she did it
15 very smoothly and she had a very nice, straight spine.

16 Then I had her lay down on the table, and I
17 did the straight leg raising test again when she's
18 laying down. Then I measured her thigh
19 circumference -- or I looked at her thigh circumference
20 to see if there's any atrophy. And I looked at the
21 scar she had from the previous surgery.

22 And then I asked her to push my hand away.
23 She's laying flat. I asked her, "Push your hand away.
24 Push against my hand. Pull your toes towards your
25 nose. Does that bother you?"

1 Anatomically, that can't cause back pain.
2 And then with her hips and knees flexed, "Pull your big
3 toe up in the air. Did that cause back pain?" And
4 none of those things caused back pain at all.

5 So then I -- after doing all this, did I
6 irritate anything? I had her stand again. Could I
7 feel spasm? Did I create a spasm by doing any of this?
8 And that was the end of the exam.

9 Q. Okay. What did you note with respect to
10 Ms. Garcia's height and weight and visual inspection?

11 A. As that -- on that date in -- September 24th
12 of 2014, Ms. Garcia's 5 feet, 1 inch; and she weighed
13 186 pounds. Unfortunately, she was at least 40 pounds
14 above an ideal body weight for her age and height. But
15 she didn't have good muscle tone. She was wearing a
16 garment that sort of -- like -- I think the women
17 called it a Spanx, something to hold in the tummy.
18 And, I mean, that's -- I think it was something she had
19 figured out.

20 She did -- the records -- I asked her if she
21 had a corset to wear. Because at one time, one of her
22 doctors had recommended a brace, but she never did get
23 that brace initially. But she didn't have a -- and
24 sometimes they wear a post-op brace, but she didn't
25 bring that with her to the exam.

1 Q. Okay. And did you perform a range-of-motion
2 testing of her lumbar spine?

3 A. Yes, in the standing position.

4 Q. Okay. And what did you observe or note with
5 respect to her reflexes, whether they were normal or
6 abnormal?

7 A. She had very smooth, symmetrical reflexes.
8 They were normal reflexes.

9 Q. And when you say "reflexes," what -- what
10 part of the body are we looking at here?

11 A. We're looking at the lower extremities. So
12 the two reflexes we check is -- in a non-weight-bearing
13 posture is I touch the front of her knee to see if her
14 knee moved, knee jerked, and then her ankle. The knee
15 reflex tells us about two major nerve roots, L4 and L5.
16 The ankle reflex, where we tap behind your Achilles
17 tendon, tells us about L5 and S1 primarily.

18 Q. Okay. And what, if anything, did you note
19 with respect to weakness of the muscles of the lower
20 extremities?

21 A. I would -- I would say that there was no
22 major weakness, but it wasn't good muscle tone in the
23 thighs and the calves.

24 Q. Okay.

25 A. In other words, nothing to suggest she'd

1 been -- at one point -- let's see. Let me just review.

2 At this point of the exam, she began
3 grunting, so it was -- I think she was getting a little
4 bit tired. Sometimes I'll ask the patients to lift
5 their heels off the exam table just to check their
6 abdominal muscle tone. But I -- I didn't want to do
7 that because I didn't want to cause any more pain.

8 Q. Okay. And if she did have major weakness of
9 the muscles of the lower extremities, what would that
10 be indicative of?

11 A. Well, it could be indicative of nerve root
12 irritation with atrophy, but she didn't have any. Her
13 thighs were 19 3/4 inches bilaterally. We measure
14 above and below the kneecap. And the calves were the
15 same at 14 inches. So fortunately she didn't have
16 muscle loss; she just didn't have good muscle tone.

17 Q. Okay. And what, if any, part of your
18 evaluation included testing her for sensation, and
19 what's the purpose for doing that?

20 A. Nerve roots -- nerves have two types of
21 fibers: sensory fibers that send information back to
22 your brain and the motor fibers that you send
23 information. If I want to make a fist, I just sent
24 information to the muscles in my forearm to make a
25 fist. Those are called motor fibers.

1 Most of the sensory fibers are on the outside
2 part of the nerve. So we use a -- either a pinwheel or
3 just a stroking to see if there's any temperature
4 change, sweating change, or loss of sensation. And
5 there wasn't.

6 Q. Okay. Thank you.

7 With respect to -- oh.

8 During your evaluation, you were also
9 provided diagnostic studies for review; is that
10 correct?

11 A. Many. Yes.

12 Q. Okay. Well, we'll get to those in a little
13 while.

14 With respect -- I'm going to go over some of
15 the medical record you reviewed specifically, and if
16 you have the records, you can certainly look at those.
17 Those are in evidence. I want to start with the
18 MountainView record from the emergency room.

19 A. All right.

20 Q. I just want to ask you some questions about
21 that.

22 Can you share with the Court the history
23 of -- that the emergency room physician was told by
24 Ms. Garcia?

25 A. When -- on the 5th, three days postaccident,

1 when she was seen by the emergency room doctor, she was
2 complaining of head, neck, and lower back pain. And
3 the word "sacral" is in parenthesis. The doctor
4 said -- asked her, did you have a blow to the head?
5 There wasn't any airbag -- did the airbags deploy?
6 Common questions.

7 Were you -- did you get out yourself? Yes.
8 Were you ambulatory at the scene? Yes. Did you have
9 any pain immediately after the accident? No. And it
10 says "pain-free after accident. Symptoms started
11 today."

12 The emergency room doctor did an exam,
13 looking for spasm. Spasm is a protective phenomenon.
14 If you have an early whiplash, you'll protect your
15 neck. And usually it starts peaking 12 to 24 hours
16 after the event. And he noted no spasm, painless range
17 of motion. And it says, "no back tenderness." In
18 other words, where we palpate, where we touch you and
19 say, "Does it hurt to touch?" And no motor or sensory
20 deficit. In other words, the structure that we worry
21 about, the structure at risk, even with a whiplash, is
22 nerve roots.

23 So the doctor said no motor or sensory
24 deficit based upon the symptoms, the evaluation, at --
25 this is not quite 72 hours after the accident. Low

1 back strain, secondary to her motor vehicle accident.
2 The doctor ordered a CT of the head, because she
3 complained of some head symptoms, and a chest X ray.
4 There were no X rays done of the neck or the mid back
5 or the low back. And she was given a drug called
6 Lortab, which is a -- has hydrocodone; it's an
7 analgesic. An anti-inflammatory called Naproxen. And
8 a drug named Valium, which is a muscle relaxant.

9 And then she was advised to go see your
10 primary care physician for follow-up.

11 Q. And just -- yeah. And, Doctor, with regard
12 to those -- the studies that were ordered, I think
13 there were studies or -- or references to another
14 individual's name in her file.

15 But, in any event, you -- you weren't given
16 any of -- any reports -- were you given the reports of
17 the diagnostic studies or you just saw reference to the
18 fact that a diagnostic study was performed?

19 A. I only had the reference.

20 Q. The reference.

21 A. Excuse me. The report.

22 Q. Okay.

23 A. Not the diagnostic study.

24 Q. Okay. All right. Well, with respect to the
25 primary findings from the physical examination, what

1 was the significance of that -- the primary findings
2 from the physical examination that was performed with
3 respect to Ms. Garcia?

4 MR. SMITH: Objection. Cumulative.

5 THE COURT: I'm going to allow it for now.

6 THE WITNESS: Can you --

7 THE COURT: Don't get into too much.

8 THE WITNESS: Repeat the question.

9 BY MR. MAZZEO:

10 Q. Sure. What was the significance of the
11 primary findings from the physical examination that was
12 performed?

13 A. In the emergency room?

14 Q. Right. Correct.

15 A. The best -- the most important thing was that
16 she's neurologically intact in both lower extremities.
17 And at that time the emergency room physician, nor did
18 anybody else, including Ms. Garcia, know that she had a
19 spondylolisthesis. So she -- she didn't have any
20 symptoms subjective of nerve root irritation, the
21 structure at risk. She had symptoms of a low back,
22 soft tissue injury. Low back strain.

23 Q. And what, if any, medications were prescribed
24 for Ms. Garcia prior to her being released from the
25 hospital?

1 A. A muscle relaxant, the Valium; and an
2 anti-inflammatory called Naproxen, which is, you know,
3 a -- a form of Ibuprofen; and an opiate called Lortab.

4 Q. Did -- and then Ms. Garcia, she subsequently
5 went to see her next primary -- or her next treatment
6 provider was Dr. Gulitz, a chiropractor --

7 A. Yes.

8 Q. -- is that correct?

9 And what were Dr. Gulitz's diagnoses?

10 MR. SMITH: Objection. Cumulative.

11 THE COURT: I'm going to allow it for
12 foundational purposes.

13 THE WITNESS: Dr. Gulitz obtained a history.
14 He did an examination. Found out she works as a
15 cashier in a cage at a casino. Noted that she had
16 spasm, at that time, in the neck and also in the mid
17 back and then in the low back.

18 The -- she had positive straight leg raising.
19 I mentioned earlier about lifting the leg, but it was
20 radiating pain. It wasn't radicular pain. There was
21 some limited range of motion in all three areas. And
22 Dr. Gulitz's opinions were those of -- he added in a
23 diagnosis that hadn't been -- was abdominal contusion,
24 which may well have been from the lower portion of the
25 seat belt; muscle spasm; and then cervical, thoracic,

1 and lumbar sprain/strains, which were causing some
2 dysfunction and some posttraumatic headaches, somewhat
3 corroborating the emergency room physician's
4 evaluation, which had been done nine days -- seven days
5 earlier, on the 5th. This is on the 12th of January.

6 And -- but there had been some increase in
7 the symptoms. This is a normal history you would
8 expect.

9 Q. A normal history of -- when you -- in respect
10 of --

11 A. In terms of soft tissue complaints.
12 Cervical, thoracic, and lumbar.

13 Q. Okay. And -- and then did Dr. Gulitz order
14 diagnostic imaging studies?

15 A. He ordered X rays of her neck, her mid back,
16 and her low back, but those weren't done until five
17 days later.

18 Q. Okay. Now, before we review the diagnostic
19 studies that you reviewed in this case, in following
20 your interview -- your examination -- your review of
21 the -- the diagnostic studies, your extensive review of
22 all the medical records, including deposition
23 testimony, were you able to arrive at a -- a diagnosis
24 for the injuries that Ms. Garcia sustained --

25 A. Yes.

1 Q. -- from the motor vehicle accident?

2 A. Based upon my evaluation that day, interview,
3 looking at these plethora of medical records, and some
4 but not all the diagnostic studies up to that point in
5 time, my opinion was that she had sustained acute
6 cervical, thoracic, and lumbar myofascial
7 sprain/strains. Soft tissue events. And then she had
8 come under the care of Dr. Gulitz, had completed about
9 26 visits through May 20th, and was slowly getting
10 better.

11 In terms of the treatment, the soft tissue
12 modalities, she wasn't particularly getting any
13 manipulation. In other words, that wasn't a big part
14 of it. But the best part, in my -- in looking at the
15 records, no progressive neurologic deficit. That's
16 paramount that she's not having pressure on nerve
17 roots.

18 Q. Okay. Thank you.

19 And in the records that you reviewed -- we're
20 not going through each one. The jurors heard about
21 these records numerously --

22 A. Yes.

23 Q. -- repeatedly.

24 But specifically I just want to call your
25 attention and direct your attention to the MountainView

1 record. Dr. Cash's record of 2/16 of 2011,
2 Dr. Gulitz's record of 1/12 of 2011, and then
3 Dr. Gross's report of May 25th or May 31st of 2011.

4 And what did you note with regard to
5 Ms. Garcia's -- and you did review those records that I
6 just mentioned; right?

7 A. They were provided. I reviewed Dr. Cash,
8 Dr. Gross, and while she was under Dr. Gulitz's care,
9 she saw a physician assistant named McGauran as well.

10 Q. Okay. Now, specifically, what did you note
11 with respect to Ms. Garcia's reporting of the onset of
12 symptoms to these various medical providers?

13 MR. SMITH: Objection. Cumulative.

14 THE COURT: I'm going to allow it.
15 Overruled.

16 THE WITNESS: There was a discrepancy between
17 the onset of symptoms with -- with the presentations.
18 In other words, with Dr. Gulitz -- and you asked me
19 that earlier. When she saw Dr. Gulitz, which was seven
20 days afterwards, she had said that the pain began
21 immediately after the collision, a little bit different
22 than seven days earlier when she told the emergency
23 room physician it started that day. A little bit
24 different than when I saw her, when it began when she
25 was in the -- the next day, when she went to work on

1 the 3rd.

2 So -- but each one was a little bit different
3 in terms of when the symptoms began. By the time she
4 saw Dr. Gross on -- on the 25th of May, the -- that
5 wasn't an issue. It was because of the -- the -- the
6 symptoms she was having. And when she saw Dr. Cash,
7 which was 2/16, which is about six weeks after the
8 accident, she shared with Dr. Cash the pain -- she said
9 she fought through the pain four days after work
10 because she didn't -- for four days because she didn't
11 want to miss work. So there's a discrepancy between
12 each of those.

13 Q. And what importance do you make of the -- the
14 inconsistencies in her reporting of the onset of
15 symptoms postaccident to these different medical
16 providers?

17 A. The importance, by the time I'm involved in
18 the case, is none of the symptoms are consistent with
19 an acute slip at L5-S1.

20 Q. Okay.

21 A. That's the most important, but it's the best
22 of all, that, fortunately, she did not sustain an acute
23 slip, because it's so painful. So severely painful.

24 Q. Okay. We'll talk about that in a little
25 while.

1 THE COURT: Mr. Mazzeo.

2 MR. MAZZEO: Yes.

3 THE COURT: One of our jurors needs a break.
4 I'm going to suggest that maybe we take -- just take an
5 early lunch and go from 11:45 to 12:45 if everybody is
6 okay with that.

7 Anybody have a problem?

8 MR. MAZZEO: No, Judge.

9 THE COURT: All right. During our break,
10 folks, you're instructed not to talk with each other or
11 with anyone else about any subject or issue connected
12 with this trial. You are not to read, watch, or listen
13 to any report or other commentary on the trial by any
14 person connected with this case or by any medium of
15 information, including -- without limitation --
16 newspapers, television, the Internet, or radio.

17 You are not to conduct any research on your
18 own, which means you cannot talk with others, Tweet
19 others, text others, Google issues, or conduct any
20 other kind of book or computer research with regard to
21 any issue, party, witness, or attorney involved in this
22 case.

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

1 Why don't you go ahead and take till
2 1:00 o'clock. See you back at 1:00.

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

5 THE COURT: Sorry to interrupt you during
6 that. I know Curt texted me that one of our jurors had
7 made contact with him.

8 MR. MAZZEO: I was moving on to a new area,
9 so it was perfect.

10 THE COURT: Okay. Anything we need to put on
11 the record?

12 MR. MAZZEO: No, Judge.

13 MR. ROBERTS: No.

14 THE COURT: Off the record.

15 (Whereupon a short recess was taken.).

16 THE COURT: All right. We are we're record
17 on the Case No. A637772. We are outside the presence
18 of the jury.

19 Go ahead, Mr. Mazzeo.

20 MR. MAZZEO: Thank you, Judge.

21 So during the morning, Mr. Smith had made
22 several objections on the grounds of cumulative, and
23 I -- what he's referring to -- and I will just direct
24 the Court's attention it -- he's referring to
25 plaintiff's motion in limine No. 35 to exclude

1 defendant's expert witness, Dr. Poindexter. And -- and
2 that was -- that motion concerned Dr. Poindexter.
3 Seeking to exclude him because the defense also had
4 Dr. Robert Odell who was an anesthesiologist and pain
5 medicine physician.

6 It didn't have anything to do with Dr. Klein
7 from my recollection. It was just one or the other
8 plaintiff was seeking -- or asking the Court to allow
9 the defense just to call either Dr. Poindexter, or
10 Dr. Odell. So -- and the -- that was denied by the
11 Court. And -- and then, in the ruling, the Court said
12 that cumulative testimony will not be allowed at trial
13 nor will two physicians be permitted to testify to the
14 same subject matter at trial.

15 It was referring to two physicians.
16 Mr. Smith, at the time, was arguing that they were
17 essentially the same, the physiatrist and the pain
18 medicine doctor. I argue that they're not. They're
19 actually two different disciplines. So the fact that
20 I'm asking Dr. Poindexter -- Dr. Klein, obviously, is a
21 different specialty. We need to lay foundation for his
22 testimony, with respect to the opinions he's offering,
23 different than Dr. Poindexter's last week, and I would
24 argue that this order does not pertain -- and there's
25 no intent that it pertained to -- to doctors of

1 different disciplines, such as Dr. Klein and
2 Dr. Poindexter.

3 So he can keep making that -- that objection,
4 but I would -- I just want to bring this to the Court's
5 attention so that the -- the Court is aware of why --
6 of why he's making this objection and that this motion
7 didn't pertain to Dr. Klein, it pertained to
8 Drs. Poindexter and Odell. So I would continue to ask
9 the Court to sustain or -- or to overrule any
10 objections made by Mr. Smith and continue to allow me
11 to lay the foundation for Dr. Klein's testimony.

12 MR. SMITH: Well, I wasn't referencing that
13 motion, although the order in that motion is relevant.
14 It says, cumulative testimony will not be allowed at
15 trial nor will two expert physicians be permitted to
16 testify at trial to the same subject matter. And
17 Mr. Mazzeo left out the expert part.

18 What I'm referring to is just the general
19 rule that the defense can't out on expert after expert
20 to testify about the same thing. Whether he's in a
21 different specialty or not. They cannot put
22 Dr. Poindexter on and have him testify about a subject
23 and then put an expert in a different specialty and
24 have him testify about the same subject. That is
25 cumulative, and that's what the objection is based

1 upon.

2 Your Honor has overruled a few of those to
3 allow him to lay some foundation, should he have any
4 opinions that are different than Dr. Poindexter, but to
5 the extent that they continue to go over the same
6 medical records and the same opinions, they cannot
7 bombard the jury with cumulative testimony from
8 different experts.

9 MR. LASSART: And the Court can see that I'm
10 not going through -- over the same testimony in detail
11 as I did with Dr. Poindexter -- or as I did with
12 plaintiff's treating physicians and experts in
13 cross-examination. So I -- I -- I -- I abbreviated my
14 questions with Dr. Poindexter. I'm doing the same with
15 Dr. Klein; however, part of his role as a -- performing
16 a comprehensive medical evaluation, is to review the
17 relevant medical records. And if I -- if I'm not
18 allowed to elicit that from Dr. Klein, then the jury
19 will assume that he hasn't laid, and they'll --
20 plaintiff will probably argue in closing arguments that
21 Mr. Mazzeo didn't lay the foundation for -- for
22 Dr. Klein's opinions.

23 We're moving to strike his testimony, after
24 he -- after we rest or during closing arguments. I
25 mean, he can make any argument he wants. So to lay the

1 foundation, I have to discuss records that Dr. Klein
2 reviewed, I have to discuss records that Dr. Poindexter
3 reviewed. I'm just a little perplexed by Mr. Smith's
4 argument that he can make this objection that I can't
5 ask him questions about the work that he did in this
6 case.

7 It's not -- and I would argue that it's not
8 cumulative, but it is a foundation for his testimony
9 regarding the opinions he's offering. And also --
10 sorry, Judge. We heard from Drs. Cash, Gross, Lemper,
11 Kidwell, Oliveri, who have all offered cumulative-type
12 testimony with regard to accident-related injuries,
13 causation, mechanism of injury. So we've heard that
14 from plaintiff, and now plaintiff wants to turn around
15 and say, with my second medical expert, cumulative. He
16 can't talk about record. He can't talk about reviewing
17 MountainView or this record or that record. It's
18 hypocritical.

19 THE COURT: Well, he -- he is a different
20 expert than Dr. Poindexter was. I think he can offer
21 different opinions than Dr. Poindexter's qualified to
22 offer, so as far as the -- the objections so far, I
23 have allowed the things that he said because I think
24 that, primarily, they were foundational in nature for
25 the ultimate opinions that he has.

1 If there are ultimate opinions that he offers
2 that are the same as another expert has offered, then
3 you can object. I'll rule on them at the time.

4 MR. MAZZEO: Thank you, Judge. That's it.

5 THE COURT: Okay.

6 Bring our jury back and get going. Are we
7 going to get done with Dr. Klein today, do you think?

8 MR. MAZZEO: I -- that's -- I hope so. You
9 know, there's only so many hours in the day, Judge.
10 So -- and I know you're sick, so I hope --

11 THE COURT: I'm pushing through. I'm fine.

12 MR. MAZZEO: Yeah. Okay. I mean, that's
13 the -- that's the plan.

14 MR. SMITH: I would say not likely.

15 THE MARSHAL: All rise for the presence of
16 the jury.

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

19 THE COURT: Go ahead and be seated. Welcome
20 back, folks. We're back on the record in Case
21 No. A63772.

22 Do the parties stipulate to the presence of
23 the jury?

24 MR. MAZZEO: Yes, Your Honor.

25 MR. SMITH: Yes, Your Honor.

1 THE COURT: Go ahead, Mr. Mazzeo.

2 MR. MAZZEO: Thank you, Your Honor.

3 BY MR. MAZZEO:

4 Q. All right. Dr. Klein, continuing, there's
5 been references and you've made references to radiating
6 pain and radicular pain.

7 Are these things -- are these two terms the
8 same thing?

9 A. No, they're not.

10 Q. Okay. Tell the jury what radiating pain is,
11 and then tell them what is meant by radiculopathy.

12 A. Pain radiating, like the branches of a tree
13 or the roots of a tree, means there's an origin of the
14 pain. You could have sprained your neck, slept wrong,
15 wake up, the pain isn't just localized to the side of
16 your neck. It radiates like sunrays to another area.
17 To the top of your shoulder, maybe the top of your
18 shoulder blade. That's very common if you have an
19 inflammatory process around a nerve. So it radiates
20 down the branches of the nerve.

21 The term "radiculopathy," the suffix "opathy"
22 means an abnormality of. And the word -- the first
23 part of the word, "radical", means the nerve root
24 supplying in this particular area, either the skin or
25 the motor -- the muscles. Radiculopathy, by

1 definition, means extrinsic pressure. Something is
2 pushing on the outside part of this nerve root causing
3 pain to follow the radical, where that nerve is going
4 to. The sensory fibers or the motor fibers.

5 So it's an entirely -- but the two terms --
6 in fact, there's three terms that get interposed or
7 used. Radiating pain, radiculitis -- which is -- means
8 inflammation of the nerve, "itis" -- and radiculopathy.
9 But anatomically, they're all different.

10 Q. Okay. Thank you.

11 And with respect to -- or following your
12 evaluation of Ms. Garcia in this case, did you -- did
13 you come to any conclusions as to injuries that
14 Ms. Garcia sustained as a result of this accident?

15 A. Yes.

16 Q. And what are those opinions?

17 A. In my opinion, as a result of the accident,
18 Ms. Garcia sustained primarily soft tissue injuries,
19 which we call myofascial, meaning muscle and fascia.
20 The -- I just want to -- just so I don't misquote
21 myself ...

22 Q. Okay. And you're refreshing your
23 recollection from your report, Doctor?

24 A. I'm just looking. All three areas of the
25 spine -- the neck, the cervical; the mid back, the

1 thoracic; and the low back, the lumbar, which is the
2 anatomic terms used: neck, mid back, and low back,
3 or cervical, thoracic, and lumbar. Soft tissue
4 sprain/strains as a result of this accident.

5 Q. Okay. And also could you clarify for the
6 jury the difference between what's referred to as
7 "acute" and "chronic" when referencing an evaluation in
8 a plaintiff's constellation of symptoms?

9 A. We reserve the word "acute" when you, as the
10 patient, can identify a specific precipitating event.
11 "I was walking along. I slipped on the ice. I landed
12 on my butt. And I had acute onset of pain
13 immediately." You can relate it to an event.

14 "Chronic" means, "I don't know, Doctor. It's
15 been going on for a long period of time, maybe three or
16 four months. I'm not sure what caused it. Maybe
17 because I was cleaning the garage, I picked up
18 something heavy. But I've been having this low back
19 pain now for at least three months, maybe four months.
20 It comes and goes."

21 So "chronicity" means -- term from the Greek
22 "chronos," long term --

23 Q. Okay.

24 A. -- time.

25 Q. Thank you.

1 What are your responsibilities with the
2 evidence-based committee of the North American Spine
3 Society?

4 A. They ask me -- first of all, you have to take
5 this 12-hour online course after you -- they give you
6 all this material. You have to answer questions and
7 turn in your answers. And then on the -- we -- it's
8 done through -- you know, on the -- on the Internet.

9 And you go through -- so it's interactive.
10 You go through each one of the cases. You -- they know
11 who you are. You identify yourself, the questions.
12 And they sort of explain to you where you -- where you
13 made a mistake in terms of is it Evidence 1, 2, or 3
14 leading to how you come to Evidence Levels 1, 2, 3, 4,
15 and 5.

16 And then they then ask you to review this.
17 No one reviewer is going to review 2,000 articles. So
18 they sort of get an area which you're interested in.
19 They may send you, over a period of time, 50 articles
20 to read in one particular area, answering a posit, a
21 question they proposed.

22 For example -- this was the material I handed
23 out in my deposition -- what's the best diagnostic test
24 to prove or prove [sic] instability for
25 spondylolisthesis? That's the question.

1 You look at the data, and everyone agreed the
2 best test is flexion-extension X rays. Is there
3 evidence to prove that? Is there sufficient or
4 insufficient? So that's how we get there.

5 And you're assigned one little area. It's
6 too much work for 10 or 20. There's at least probably
7 200 guys. We all don't get our name on a document that
8 says you were a reviewer. There's guys that are, you
9 know, responsible. So that's -- that's how the
10 committee works.

11 Q. Okay. Thank you. And has the committee
12 published its findings and recommendations regarding
13 the treatment of the condition of spondylolisthesis in
14 adults?

15 A. Yes.

16 Q. Okay. And when was the data first made
17 available to the North American Spine Society as well
18 as to the world of orthopedic surgeons?

19 A. In 2014.

20 Q. Okay. By the way, Dr. Cash testified in this
21 case. Dr. Cash testified that he had performed flexion
22 and extension X rays in both the neck and the lumbar
23 spine.

24 Are you aware whether Dr. Cash noted any
25 instability to the lumbar spine based on his X rays

1 that he performed on the lumbar spine?

2 A. Yes. I've never seen those studies -- those
3 X rays, but I know that he testified there was no
4 evidence of instability.

5 Q. Okay. And, in your opinion, did Ms. Garcia
6 sustain an acute Grade II spondylolisthesis at the
7 L5-S1 level of her lumbar spine as a result of the
8 accident on 1/2 of 2011?

9 A. In my opinion, she did not.

10 Q. And can you tell the jury why that is your
11 opinion.

12 A. As I shared with you in the morning session,
13 the most important thing is the history. An acute
14 movement of L5 on S1, this vertebral body moving
15 forward, is very similar to a fracture. Moving it --

16 Q. Doctor, if it would help, because you're kind
17 of a distance away from the jurors --

18 A. Oh, I'm sorry. I apologize.

19 Q. That's fine. You can move right up to the
20 bar.

21 A. For this lumbar segment, L5, to move forward
22 to a Grade I or II position, it's graded -- we draw a
23 line through the middle of the lumbar vertebra. So
24 anything one fourth is Grade I. Grade II is halfway.
25 Grade III is a Grade III. Grade IV, it's very rare.

1 They almost always call it "occur with fracture
2 dislocations."

3 So if you have an acute movement of this
4 lumbar vertebra, the pain is so severe because of the
5 contiguous structures. The nerve root's at risk.
6 It's -- the -- the ligament, the fat that moves with
7 it, the vessels, that patients immediately know,
8 "Something's wrong with me."

9 It's the pain into the -- the buttocks, the
10 legs, which is about 80 percent, 20 percent low back.
11 And patients become fearful because the pain will go
12 around the anus. It'll go to the base of the testicles
13 in men and the severe onset of pain in the lower
14 extremities.

15 Many patients will not move for fear of
16 what's happened. They don't know what it is
17 anatomically, but it is so severe.

18 Q. And, Doctor, earlier you've testified that
19 you've treated and cared for patients with this
20 condition, the spondylolisthesis; correct?

21 A. Both acute and chronic, yes.

22 Q. Okay. And, in your opinion, do the records
23 that you've reviewed in this case of the treatment
24 that's been provided to Ms. Garcia support the
25 constellation of symptoms that go along with an acute

1 Grade II spondylolisthesis?

2 A. No. Those symptoms fortunately are not in
3 the records as an acute event.

4 Q. And do you have any -- do any cases come to
5 mind of -- of the particular set of symptoms that have
6 occurred regarding evaluations that you've performed as
7 part of your medical-legal practice?

8 MR. SMITH: Object to the form and
9 foundation.

10 What cases?

11 THE COURT: Yeah, sustained. Why don't you
12 rephrase that.

13 BY MR. MAZZEO:

14 Q. Can you describe for the jury the -- the
15 patients that you've evaluated and -- and cases that --
16 that you've evaluated who have suffered a, let's say,
17 an acute Grade II spondylolisthesis.

18 MR. SMITH: Objection. Outside the scope of
19 his opinions.

20 MR. MAZZEO: Can we approach, Judge?

21 THE COURT: Sure.

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

24 THE COURT: All right. I'm going to overrule
25 the objection, but the testimony about any other

1 specific cases are only offered for purposes of
2 establishing foundation for Dr. Klein's ability to
3 testify in this case.

4 MR. MAZZEO: Thank you, Judge.

5 BY MR. MAZZEO:

6 Q. So, Doctor, you can answer that question with
7 regard to your experience with other cases.

8 A. Two cases come to mind. Three years ago, I
9 evaluated a gentleman in Oakland. The name was Ray
10 Mario Lee, and he drove a garbage truck. And he was
11 headed to -- it was one that had a front-end loader.
12 He was headed to the bins on Livermore Airport. He was
13 approaching the bins, and the hub broke on the left
14 axle and the truck stopped immediately. And he -- he
15 had no symptoms. He felt fine and called the
16 supervisor, got a tow truck, took him back.

17 Thirty days later, to the date, same truck,
18 the hub on the right axle broke. The truck was heavy
19 or laden that day, and the axle dug into the tarmac.
20 And he moved forward, even though he was in a seat
21 belt, and had immediate pain in his low back that went
22 in towards his anus, around his testicles, and into his
23 legs.

24 He didn't know he had a Grade II
25 spondylolisthesis -- asymptomatic, active guy -- and

1 called his supervisor and said, "There's something
2 wrong with me. Come get me. I'm not moving out of the
3 truck." They came to take him to a medical center.

4 I examined him. And he had unstable Grade II
5 spondylolisthesis. And I opined that he needed a
6 fusion as a result of that. And I was the defense
7 expert. He had the surgery, but it wasn't the fusion.

8 He had another surgery to relieve some
9 pressure around the nerve roots, and his dura was torn.
10 So he had that complication. I saw him again. He was
11 worse.

12 So he had sustained an acute grade
13 subluxation Grade II. He had the classical symptoms.
14 And subsequently he had the operation he needed, which
15 was the fusion.

16 Last year, I reviewed records here -- a case
17 here in -- in Las Vegas of a gentleman that was coming
18 up the street by the fashion mall where the valet is.
19 And a taxicab made a U-turn right into the side of his
20 car, an acute injury. And he immediately had similar
21 symptoms. Couldn't get out of the vehicle, taken to an
22 emergency room. And his symptoms persisted. And he
23 subsequently already has had a fusion, and he's doing
24 very well.

25 In each of those cases, the symptoms were

1 consistent with an acute injury, acute movement.
2 And -- and I opined that the surgery was related to the
3 accident. Those are the two that recently come to
4 mind.

5 MR. SMITH: I move to strike.

6 Can we approach, please?

7 THE COURT: Sure.

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

10 THE COURT: Objection's overruled.

11 MR. MAZZEO: Thank you, Judge.

12 BY MR. MAZZEO:

13 Q. Doctor, in what way -- and you may have
14 touched upon this earlier -- in what way does a
15 traumatic injury to a preexisting Grade II
16 spondylolisthesis affect one's functionality?

17 A. With an acute slip and contusion of the nerve
18 roots --

19 May I approach?

20 Q. Oh, please do. Yeah.

21 A. The structure at risk with an acute slip of
22 the nerve roots, any type of spinal injury -- fracture,
23 dislocation, large disk herniation -- it's the nerve
24 root that supplies the muscles, the tissue, the skin.
25 So the thing that has to be protected is the nerve

1 root.

2 When the acute slip occurs, in addition to
3 the localized severe spasm, which is a protective
4 mechanism -- and there's no model here. But from these
5 major nerve roots, there's thousands of fibers that are
6 going into the muscles that sit in front and behind
7 this area.

8 With the nerve root being irritated, being
9 bruised -- just appreciate when you hit your funny bone
10 the severe pain in your hand. Imagine that ten times
11 as bad. It causes spasm in this big group of muscles
12 called the hamstrings (witness indicating). So
13 patients have difficulty even standing because of the
14 spasm, the severe pain.

15 And if you injure both nerve roots severely,
16 you can get what's called a cauda equina syndrome.
17 Because as the nerve roots all come down, it looks like
18 a horse's tail. That's the term we use, cauda equina.

19 So the cauda equina syndrome, the acute,
20 which tends to usually go away over the next 72 hours,
21 is severe spasm, severe pain, in some cases
22 incontinence of urine and feces. It's a very severe
23 injury.

24 Patients immediately will present to an
25 urgent care center or emergency room because of the

1 pain and just the inherent knowledge "something's wrong
2 with a part of me, but I don't know what." That's how
3 it affects function.

4 Q. Okay. Thank you. And what's your
5 understanding as to how Ms. Garcia's functionality was
6 affected as of this -- or as a result of this accident?

7 A. Based upon the records I was provided and my
8 opportunity to interview and examine Ms. Garcia, she
9 did not have the symptoms that comport to an acute
10 slip.

11 She was ambulatory at the scene. She got a
12 ride home with the tow truck driver. Her concern that
13 evening was getting her three daughters ready for
14 school, just the busy things a mom does. And the next
15 morning, getting the kids ready to school and taking
16 them to school.

17 During the day, as she shared with me, she
18 had some pain and some numbness down into her foot
19 while in the cage -- the cashier's cage. In my
20 opinion, that was radiating pain, not radicular pain.

21 Q. But also what Ms. Garcia shared with you was
22 in a scope of a medical-legal evaluation, which you had
23 testified was inconsistent with her prior reporting to
24 other providers; is that correct?

25 A. Yes. That's my -- I noticed those

1 inconsistencies, and I put that in my report. I'm
2 talking about what -- the records and what she -- she
3 remembered.

4 Q. Well, what she remembered is what she's
5 reporting to you at the time of your evaluation?

6 A. Yes. But that's -- you know, this is three
7 years and eight months later.

8 Q. Right.

9 A. So -- so my memory can get a little bit
10 blurry, but I -- I reminded her, you know, of what she
11 had reported. I had the records.

12 Q. Oh, okay. What she reported at MountainView
13 Hospital?

14 A. Yes. Yes.

15 Q. Sure.

16 A. So what she had reported. And then with an
17 acute slip, she would have presented to emergency room,
18 urgent care center that afternoon. So -- and -- and
19 certainly during the night. Some patients have greater
20 tolerance for pain. It would have been difficult to
21 get through the night. So it just doesn't -- the
22 symptoms of an acute slip aren't there.

23 Q. Okay. And what diagnostic tests are used to
24 confirm whether a patient sustained an acute trauma to
25 a preexisting Grade II spondylolisthesis?

1 A. With the complaint of severe low back pain
2 and buttock pain, the initial -- the physician might
3 think you've got an acute disk, not a subluxation or a
4 slippage. So the -- it's -- normally, the first X ray
5 is lumbar spine films. Depending upon the neurologic
6 examination, if the physician is concerned, he's not
7 sure what's going on, if there's hamstring spasm, some
8 change in reflexes, either hyperactive or hypoactive,
9 the next would be an MRI study --

10 Q. Okay.

11 A. -- of the lumbar spine to look at both bony
12 detail and subtissue.

13 Q. Thank you.

14 And in what way do core-strengthening
15 exercises and weight loss assist with a stable -- let
16 me distinguish stable from an unstable --
17 spondylolisthesis?

18 A. For the patient who has a stable -- meaning
19 it's not moving -- a stable spondylolisthesis, the core
20 strengthening of the deep muscles down inside in front
21 of here -- this -- it's called the iliopsoas. It's
22 actually the muscle that filet mignons are made from.

23 But the big group of muscles are the ones in
24 the back that you can feel, the ones that you pull when
25 you overexercise or heavy lift or lift wrong or overuse

1 syndrome.

2 In addition, it's the abdominal muscles. The
3 spine depends upon the strength of the muscles in
4 front, the muscles in the back, and the deep core
5 muscles working together to maintain good, erect
6 posture.

7 Q. Okay. Now, what's your opinion with regard
8 to whether Ms. Garcia's -- Ms. Garcia's preexisting
9 Grade II spondylolisthesis was stable or unstable
10 following this motor vehicle accident, and why?

11 A. Number 1, she's -- as the records affirm,
12 she's testified she had no symptoms. People that have
13 instability, progressive movement, whether -- and it
14 reduces on its own have symptoms of low back pain.
15 They may not have any radicular pain or radiating pain,
16 but they have localized low back pain.

17 The other is her X rays and her MRIs clearly
18 show what we refer to as buttressing. The slippage is
19 taking place over a period seven to nine years, maybe
20 longer, since she was skeleton mature. And you can see
21 the buildup of the bone.

22 Bone cells respond to pressure, in other
23 words, weight-bearing pressure. We call it Wolff's
24 law. And the body knows it's slipping. And you can
25 surely see on her X rays and her MRI that she's

1 building up bone at the bottom of L5 and the top of the
2 sacrum, buttressing to keep it from slipping any
3 further. And that takes a long time for that to become
4 mature that you see on the X rays and the MRIs.

5 So this has been going on. And it's very
6 slow. It's moving less than a millimeter per year
7 probably.

8 And then, depending on what she does -- and
9 it'll have periods of where it doesn't move, and then
10 it'll move a little. And it's part of -- things that
11 we know aggravate it is pregnancy. During the third
12 trimester of pregnancy, there's a hormone called
13 relaxin that relaxes all these ligaments that are in
14 the pelvis. We know that that's a period where a
15 spondylolisthesis will move forward.

16 But when patients are pregnant and have low
17 back pain, we don't X ray them because of the fetus.
18 So the diagnosis never gets established. And it's
19 assumed, "Well, you just are pregnant, and you got low
20 back pain." And then you have this large, you know,
21 swollen uterus.

22 Q. And so based on all of the -- the reports,
23 the treatment records, and the imaging studies and
24 reports that you've reviewed in this case, your
25 determination -- what was your determination as to the

1 stability or instability of Ms. Garcia's spine?

2 A. She had a very stable chronic slip -- we use
3 the term "chronic" because over time -- and the fact
4 that she subsequently had flexion-extension X rays
5 performed by Dr. Cash that showed it was stable.

6 That's the other set of X rays. Can we
7 demonstrate on flexion, when we ask the patient to
8 bend, and to extend movement?

9 Q. Thank you. Okay. Thank you, Doctor. Okay.
10 Let's move on now.

11 In your report, you had cited various
12 articles regarding the treatment of spondylolisthesis,
13 and I wanted to ask you some questions about those
14 articles.

15 A. Sure.

16 Q. First I will ask you, what was your purpose
17 in referencing certain articles?

18 A. The treatment of spondylolisthesis was, is,
19 and continues to remain controversial.

20 You have a group of surgeons, treaters who
21 feel it needs to be treated even if it's stable,
22 assuming it's going to progress.

23 You have another group that says,
24 conservative treatment works adequate, weight loss,
25 exercise.

1 I thought that by referencing the report from
2 Dr. Spratt, from Dr. Moller, from Ekman, Donaldson,
3 they give a balance that -- there isn't any particular
4 cookbook that works all the time. One of the articles
5 was a 45-year follow-up. They had followed kids --
6 children that had spondylolisthesis through their adult
7 years.

8 So my point was to give some balance and to
9 show there isn't just one way to do it. And, in fact,
10 Mr. Smith asked me those. We went through those in
11 detail in my deposition, what -- what -- the purpose
12 and what --

13 Q. Sure.

14 A. -- and -- and that was the whole point of it,
15 putting them in there.

16 Q. Now, in the Moller article that discussed
17 surgical versus conservative treatment for
18 spondylolisthesis.

19 What was the gist of that article by Moller?

20 A. The article shows some patients respond very
21 nicely just to conservative treatment. The article
22 also shows that -- and, in fact, one of the things you
23 mentioned earlier, the NASS study, that patients who
24 have surgery early on get more immediate relief. Then
25 they do crossovers, people that were treated

1 conservatively then had surgery.

2 So you compare those groups at five and ten
3 years. And coming -- trying to come to a consensus, it
4 sometimes is successful. It depends upon the
5 follow-up. It's very difficult to -- to keep one group
6 of people in one area to get the follow-up as the years
7 go by. We tend to be a transient society.

8 The Spratt article was, how does it work just
9 to do exercises, flexion-extension, and use bracing?
10 The -- I mentioned the Ekman article, long-term effects
11 of the surgery. So that -- my own purpose was balance,
12 not to show any bias.

13 Q. Okay. All right. Let's move on to -- to the
14 MRI studies.

15 As you know from your review of the records
16 in this case, multiple diagnostic studies have been
17 performed on Ms. Garcia since January of 2011; right?

18 A. That's correct.

19 Q. Okay. And would this be a good opportunity
20 to review those and share those with the jury?

21 A. I think so, yes.

22 Q. Okay. But before we go into the studies
23 specifically, why don't you tell the jury, you know,
24 the part of your clinical practice and medical-legal
25 practice, what your -- the nature and scope of -- your

1 work entails involving reviewing films, diagnostic
2 imaging studies?

3 A. In my practice as an orthopedic surgeon and
4 before that as a physician, we were trained to read
5 X rays. And as I shared with you, just from the -- my
6 training -- the years of training, my training began
7 before the MRI or the CT was even available.

8 So we are trained to look at X rays, know
9 what is normal, a variant, and markedly abnormal, like
10 a severe fracture of a leg, an arm, or the spine.
11 Because we're trained in what normal anatomy is.

12 With the advent of the MRI, then I started
13 taking classes and took my first class here in
14 Las Vegas with Dr. David Stoller, who teaches MRI
15 studies. I took the opportunity to sit with a fellow
16 named Dr. Al White, who was interested. He was
17 learning too -- he's a radiologist -- to -- to keep
18 adding to my knowledge base of interpreting MRI studies
19 as the technique got better and better.

20 On a weekly basis, I teach residents X rays.
21 I teach them how to interpret MRIs because you have to
22 know cross-sectional anatomy and coronal anatomy.

23 So as part of my med-legal, I'm looking at 2
24 to 300 MRIs of the spine every year. They're
25 repetitive ones, as Ms. Garcia's had; people that have

1 just had one.

2 So -- and my background and knowledge as a
3 anatomist, a neuroanatomist, I know -- I can see --
4 sort of like Superman. I have X ray vision. I know
5 what it's supposed to look like in a three-dimensional
6 format. So it's an area of extreme comfort for me.

7 And the other thing is, as the techniques
8 improve, the -- which we have to thank our engineers
9 for -- the computer programmers keep improving the way
10 that the -- that they're formatted through the
11 computer.

12 Q. Okay. Now, what's the value of magnetic
13 resonance imaging studies, MRIs, in terms of looking at
14 the structures of the vertebrae, disks, and tissues?

15 A. The big advantage of MRIs is there's no
16 X ray. There's no radiation. They're using a big
17 magnet that lines up a hydrogen ion, and then you throw
18 an electrical beam through it, the energy. And you
19 then are able to come up with a image, and then it's
20 reformatted through a computer. Okay. That's -- in
21 simplification.

22 It really is best for looking at soft
23 tissue -- that's what it originally was for -- more so
24 than looking at bone. Bone imaging is best done
25 through a CT scan, which is X ray. But there's X ray

1 radiation. So they both have some limitation.

2 The MRI gives you a great deal of
3 information. We typically say they are highly -- they
4 have a high degree of specificity but -- a high degree
5 of sensitivity but a low degree of specificity. They
6 give us almost too much information.

7 So you have to correlate what you see in the
8 MR, the patient's symptoms and histories, and the exam.
9 There has to be a clinical correlation, and that's a
10 common last sentence in radiology reports, "clinical
11 correlation necessary."

12 Q. Okay. Thank you.

13 MR. MAZZEO: So let's go ahead and take a
14 look at this. Judge, if we can turn the monitor on. I
15 think it --

16 MR. SMITH: Can we approach, Your Honor?

17 THE COURT: Sure.

18 MR. SMITH: I'll be brief.

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

21 MR. MAZZEO: I don't know if that went on.

22 THE COURT: I'm not seeing anything on my
23 screen yet, which means it's not going through the
24 system yet.

25 MR. MAZZEO: Oh, okay.

1 THE COURT: You have it going through the
2 ELMO, not through the table; right?

3 MR. MAZZEO: Correct. Right through the
4 ELMO.

5 No RGB signal, Judge. Whatever that means.
6 Regional --

7 THE COURT: I pushed all the right buttons on
8 my screen.

9 MR. MAZZEO: Okay. And I think that the
10 monitor went off, Judge.

11 THE COURT: It's still not showing on the
12 little monitors, so it's not going to show up up
13 there --

14 MR. MAZZEO: Okay.

15 THE COURT: -- unless you get it on everybody
16 else's screens.

17 MR. MAZZEO: Well, is there -- yeah. Sure.
18 Yeah, let's do it this way. Actually, I mean -- Roger,
19 I can keep this at the table if you just want to go
20 from slide to slide.

21 Yeah. Oh, there we go. Got it, Judge. Just
22 wasn't a tight connection. I think I have it. So I --
23 but I think it has to be switched. No? I'm on --
24 let's see here.

25 THE COURT: Whatever you're seeing is what

1 everybody else is seeing.

2 MR. MAZZEO: Okay. Slide show. Oh. We're
3 up. Here we go.

4 BY MR. MAZZEO:

5 Q. And, Doctor, what I'll -- yeah. Thank you.
6 You -- that's what I wanted to ask you. I know you
7 have it come up on your screen, but I wanted you to
8 come down so you can actually show -- point to the
9 structures as you look at these slides.

10 A. Is there a laser pointer --

11 Q. So --

12 A. -- available?

13 Q. I don't know if the laser pointer will pick
14 up on that -- on the monitor. So --

15 A. Is there a pen pointer?

16 Q. That is a point on the -- at the end of the
17 cap, so ...

18 A. Serious budgeting issues.

19 Q. To use that. Okay. So and --

20 A. I just don't want to block this --

21 MR. MAZZEO: Yeah. Can everyone see this
22 screen fine? Okay.

23 THE WITNESS: Sometimes there's these long
24 pointers in courtrooms.

25 MR. MAZZEO: This is -- Mr. Bailiff, is this

1 the laser pointer?

2 THE WITNESS: No.

3 THE COURT: That's the remote control.

4 THE WITNESS: Oh. I'm very sorry.

5 MR. MAZZEO: I mean, if you can make do with
6 using your finger or using the pen, we can --

7 THE WITNESS: Can you lower the lights a
8 little bit, just for some contrast?

9 MR. MAZZEO: We might get better -- better
10 contrast if we can lower the lights in the front,
11 Judge.

12 THE COURT: I don't know how to do that.

13 MR. MAZZEO: Oh, here it is. Curt, do you
14 have control over the lights? We want to make -- we
15 want to -- it will make the images clearer for the
16 jurors if we can lower the rights in this area.

17 THE MARSHAL: Well, the answer is, it's
18 complicated.

19 MR. MAZZEO: Okay.

20 THE MARSHAL: I do better from over here.

21 MR. MAZZEO: Okay.

22 THE CLERK: Do you want me to get it? Is it
23 over here?

24 MR. MAZZEO: There we go. That works.

25 THE WITNESS: Thank you.

1 MR. MAZZEO: Great. That's good? Better?

2 THE WITNESS: What I'm sharing with you, I
3 was provided three sets of MRIs that were preoperative.
4 This is 1/26/11, 24 days after the accident. And this,
5 as you can see, I'll just mention if you can't --
6 11/19/12. So we have a -- about a 22-month hiatus
7 between this and this.

8 And whenever you do magnification, you're
9 going to see Lowe's resolution. This is the L5
10 vertebral body. You have heard about that before.
11 This is the sacrum. And the point that I put on here,
12 bone spur, this is the bone spur that has developed at
13 the lower part of L5, the top part of the sacrum. As
14 L5 is slowly been moving forward, this is -- the dark
15 thing is the disk, but this is the spur. We sometimes
16 call it the top of the sacrum or the sacral promontory.

17 The reason it's whiter is, as I testified
18 earlier, bone responds to pressure, the bone cells. We
19 call this buttressing. The body knows that this is
20 slipping, and it responds by building up bone and
21 remodeling. And you can see that it's here, at S1.
22 I'm telling you, this is a long-term, chronic problem.

23 Next?

24 Q. Sure.

25 A. The other thing that we look at is the

1 structures at risk. And I keep talking about -- I
2 sound like a -- a --

3 Go back one.

4 Q. Yeah.

5 A. -- a broken record, but it's the nerve root.
6 Can we demonstrate that this nerve root, the one that I
7 showed you on the model, is at risk? What's it look
8 like? So we don't just look at the nerve root. We
9 also look at the fat -- the peri -- there's fat around
10 it -- and the accompanying vessels. One's here, one's
11 here. Because when it moves forward in an acute slip,
12 the pressure makes this go away, and the vessels get
13 contorted. So this is the nerve root, and this is the
14 sacrum. Here's L1. And you can -- and in my opinion,
15 there hasn't been any change.

16 We also look at the shape of the neural
17 foramen. Has it changed in its configuration? So we
18 see that these all are what we would expected to see.

19 Go ahead?

20 Q. Sure.

21 MR. SMITH: Your Honor, is there a question
22 here, or are we just going to get a presentation?

23 THE COURT: Good point. Let's have a
24 question.

25 /////

1 BY MR. MAZZEO:

2 Q. So, Doctor, what I -- my question would have
3 been please explain what -- what you're showing to the
4 jury on this -- on this slide. And you did.

5 A. That's the information that we can glean from
6 that slide.

7 Next one.

8 Q. Okay. All right. Doctor, tell us what
9 slides we're looking at -- tell the jury what slides
10 we're looking at --

11 A. All right.

12 Q. -- the dates, and tell us the findings that
13 are significant with respect to this case.

14 A. So then I took the opportunity to do what's
15 called sagittal -- right down the center of the MRI --
16 from 1/26/11, 8/19/11, eight months later, and
17 11/19/12. Three MRIs. What I'm looking for is
18 evidence of change -- anatomic change of is this moving
19 forward at all, L5 on S1? I'm looking at the -- this
20 white area, which is actually the fluid, and looking to
21 see has there been any change between the three.

22 In my opinion, there hasn't been. This is
23 the dural sac where the nerves roots are. Here's the
24 vertebral body. This is L4-5. The configuration at
25 this level -- L5-S1, L4-5 -- hasn't changed between

1 January 26th of '11 and 11/19/12.

2 Q. And was this an opinion that you arrived at
3 independently, based on your own evaluation?

4 A. Yes. And I thought it would be helpful from
5 an instructional standpoint to just put these three
6 together.

7 Q. Sure. Now, in addition to you arriving at
8 this assessment regarding these three films, did you
9 also have an opportunity to speak with a
10 neuroradiologist, Dr. David Seidenwurm?

11 MR. SMITH: Objection. Outside the scope of
12 his report. Testifying outside the scope of his
13 expertise.

14 MR. MAZZEO: Your Honor, the expert can rely
15 on hearsay evidence, which is what he has done as well.

16 THE COURT: The question that he was asked so
17 far, I'm going to allow.

18 MR. MAZZEO: Thank you.

19 THE COURT: Once he gets into the next
20 question, make the objection.

21 MR. MAZZEO: Okay.

22 THE WITNESS: I did. And -- and, in fact, I
23 mentioned that in my deposition.

24 BY MR. MAZZEO:

25 Q. Correct.

1 A. That because of the issues --

2 MR. SMITH: Your Honor, objection. He's
3 going to testify as to what you thought the next
4 question would be, and he can't parrot the opinions of
5 another expert if it's outside the scope of his
6 expertise.

7 THE COURT: He answered the question. Ask
8 another question.

9 MR. MAZZEO: Yes. Thank you, Judge.

10 BY MR. MAZZEO:

11 Q. All right. And what -- in conferring with --
12 after arriving at your own independent opinions, and
13 after -- and secondly, in conferring with Dr. David
14 Seidenwurm, a neuroradiologist, what discussion did
15 both of you have with regard to these specific findings
16 at the L5-S1?

17 MR. SMITH: Objection. Same objection I just
18 laid out.

19 THE COURT: Sustained.

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

21 THE COURT: Sure.

22 MR. MAZZEO: Thank you.

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

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

1 THE COURT: You may.

2 BY MR. MAZZEO:

3 Q. So, Dr. Klein, after speaking with Dr. David
4 Seidenwurm, did your discussion with him change any of
5 the opinions you arrived at independently with regard
6 to there being no change between the three studies that
7 were performed?

8 A. He concurred with my assessment.

9 Q. Okay. And --

10 MR. SMITH: Objection. Move to strike.

11 THE COURT: It will be stricken.

12 MR. MAZZEO: Okay.

13 THE COURT: The question that was asked.

14 BY MR. MAZZEO:

15 Q. Okay. And if I can -- did -- rather than
16 what Dr. Seidenwurm said, my question was: Did that
17 change any of your opinions after speaking with the
18 neuroradiologist, Dr. David Seidenwurm?

19 A. It did not change my opinion.

20 Q. Thank you.

21 Okay. Anything else with regard to this
22 slide, or should I move on?

23 A. Move on.

24 Q. Okay. All right. So tell us what these
25 three slides -- what the dates on these three slides

1 and what they represent.

2 A. These are the same three dates, 1/26/11,
3 8/19/11, and 11/19/12. These are the T1 weighted
4 images. If you go back to the other slide, you'll see
5 that the spinal canal, the structures are dark. Here
6 they're white. And, again, each image of the
7 formatting gives us other information. The disks are
8 dark, so you can see that, on each one of these, with
9 some minimal technical changes, L5 is in the same
10 position it was on 1/26/11, the same place it was on
11 this 11/19/12. There's been no change. This even
12 clearly shows the buttressing and the building up at
13 the top of sacrum, and even better over there.

14 Every time you do an MR, you're going to get
15 a little different finding. That's just the way they
16 are. You do -- the same person in the morning and the
17 afternoon, you're never going to get same identical
18 image. The point being, it demonstrates stability.

19 Q. Now, if you recall, at the time of your
20 deposition, you were asked about the third one on
21 November 19th of 2012, performed by radiologist
22 Dr. Hake. H-a-k-e.

23 A. Yes.

24 Q. And who noted on the report that there -- he
25 noted a progressive worsening of the -- of the slip --

1 slippage, the T1 -- the L5 on top of the S1?

2 A. Yes. I have that on the slide. He reported
3 that it went from, I think, 7.2 millimeters to 10.3, in
4 that range. In terms of millimeters, yes.

5 Q. Okay. And so -- and what was your -- having
6 reviewed these films, have you -- have you -- are you
7 in agreement with Dr. Hake or -- or do you have your
8 own independent opinions with regard to whether there
9 was a progressive change?

10 A. I have my own independent opinion.

11 Q. Which is based on what you've said?

12 A. Yes. There is no change. And the variation
13 with MRs from one to the other over this period of
14 time, you don't have that quality of resolution.
15 There's at least a 10 percent error of measurement,
16 with -- you say from 10 -- 3 millimeters is less than
17 an eighth of an inch, but it could be the other way as
18 well.

19 There just -- we don't -- it would be nice if
20 we had that finite measurement, but none of these --
21 there's no MR right now -- the biggest magnets that you
22 can measure things in millimeters, you have to
23 correlate it to the clinical symptoms. That's what's
24 lacking here.

25 Q. And for the jurors' own edification, how can

1 you assist them in -- in showing points of reference
2 which might -- to indicate there's been no progressive
3 change from one to the next?

4 A. You focus on the back of L5 at this point.
5 It looks a little different here, but look at its
6 relationship here to the back of the sacrum. Look at
7 it -- its relationship from the bottom of L5 here to
8 the back of the sacrum. And the same when we get to 19
9 November of 2012.

10 Look at the tissue here, which is the
11 posterior longitudinal ligament, in this area, and this
12 is fibrous tissue. This goes along with the chronic
13 slip. It all looks the same. This whiteness, as we
14 call hyperintensity. This is based upon that beam,
15 that day, and the -- the problems that we deal with in
16 terms of MRI studies.

17 Q. Okay. I'm going to back up to the first
18 slide again. Sorry. The second slide. The -- on the
19 left side -- the left -- the image on the left side.

20 A. Yes.

21 Q. And you have two boxes circled or outlined in
22 red. And you pointed that out to the jurors.

23 That -- that depicts what, specifically?

24 A. That's the --

25 MR. SMITH: Objection. Outside the scope of

1 his report and testimony.

2 MR. MAZZEO: It doesn't, Your Honor --

3 THE COURT: Come on up, guys.

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

6 THE COURT: Based on the representation of
7 what the testimony will be, I'm going to overrule the
8 objection. Go ahead.

9 MR. MAZZEO: Thank you, Judge.

10 BY MR. MAZZEO:

11 Q. All right. Doctor, the -- I went back to the
12 slide. This was the second slide in the presentation.
13 You talked about this a few minutes ago.

14 What I want you to talk about, does this
15 slide, particularly the one on the left -- well, the
16 left and right -- do they show the nerve root?

17 A. Yes, they do. It was -- I just took red to
18 show the size of the foramen. And it's -- it's --
19 there's a magnification here. This is the nerve root,
20 the dark structure. It's surrounded by what we call
21 perineural fat. Every nerve has fat around it. And
22 these are the accompanying vessels. One here and one
23 there.

24 If the nerve root had been moved at the time
25 of an acute slip, the contour of the foramen would be

1 different because the vertebral body had moved forward,
2 and the vessels would not be in the normal position.
3 That's what this demonstrates quite clearly.

4 Q. And so how do you characterize the condition
5 of the -- that would be the L5 nerve root, the one on
6 top?

7 A. Yes. But, see, if L5 moves, it's going to
8 take the L5 nerve root with it. And L5-S1 is the S1
9 nerve root. You see how -- mentioned it here?

10 Q. And how -- so how would you characterize the
11 condition and -- and --

12 A. It's stable.

13 Q. Okay.

14 A. The condition is stable. It doesn't depict
15 movement of the nerve roots.

16 Q. Okay.

17 A. The structure's at risk.

18 Q. Okay. And also, from looking at these two
19 films, what, if any, indication is there of any --
20 what's referred to as impingement or pressure on -- or
21 compression of either the L5 or S1 nerve roots?

22 A. Doesn't exist.

23 Q. And that can be seen in -- on these two
24 films?

25 A. If -- if L5 had moved forward as a result of

1 an acute event, you would not see a normal-appearing
2 contour of the foramen. It would be changed. You
3 can -- usually, in this situation, it would look like
4 this because, as the body moves forward, it's going to
5 pull nerve root and vessels with it. The configuration
6 would be different.

7 The same on the S1 nerve root. You would see
8 it -- it doesn't have the elasticity, and it would be
9 draped over the back of the S1 -- the top of S1.

10 Q. And -- and as an orthopedic surgeon who's
11 evaluating and looking at this film, what does that
12 tell you in terms of the potential for symptomatology
13 to emanate from the L5 or S1 nerve roots?

14 A. It correlates directly with her clinic --
15 lack of clinical symptoms of an acute stretch injury or
16 contusion to the L5 and S1 nerve roots. The lack of
17 those immediate symptoms, I shared with the jury
18 earlier. The severe pain and lack of pain
19 radiculopathy into the buttocks, the hamstrings, and
20 down into the lower extremities.

21 Q. Thank you. We're going to move on. I think
22 we were up to Slide 5. Right? We already talked about
23 the sagittal T2; right?

24 A. Yes.

25 Q. So now we're up to Slide 5.

1 A. Yes.

2 Q. And would you please --

3 A. This is --

4 Q. -- discuss with the jury what this slide --
5 what these two films represent and the dates.

6 A. Okay. This is 1/26/11. Both the same. And
7 what -- you changed it.

8 Q. Sorry. Slid back. There we go.

9 A. I said, the two words here -- you may have
10 heard it earlier, during the course of the trial -- T1
11 and T2. This is, as you can see on the T1, it's white.
12 Over here, it looks a little bit different. It's dark.
13 But the point being, this is the area we're talking
14 about. This is now looking -- it's a loaf of bread.
15 We're looking down on top of the vertebral body, the
16 canal, over where the nerve roots are coming out.
17 That's the importance of this slide.

18 This is -- the abdomen is up in the front.
19 This is the back. In other words, Ms. Garcia's laying
20 on her back, as all patients are, in an MRI unit. This
21 demonstrates normal-appearing nerve roots. This is
22 what the nerve root looks like. Since she's lying on
23 her back, the other nerve roots pull down.

24 If you get over to this side over here on the
25 T2, you can see, quite nicely, that the nerve root is

1 beginning its transverse, moving along to go out
2 through the foramen. This round thing that's dark here
3 is the same thing that's over here. It just appears
4 dark. The muscle, everything is the same.

5 Q. And when -- when you're looking at this --
6 this nerve root --

7 A. Yes.

8 Q. -- is coming down from the -- this is what
9 level?

10 A. Well, this is -- this is just a represent --
11 doesn't show here, but this is a lumbar. There's
12 the -- the ganglion. This is the nerve root as it
13 comes through the foramen, the contour of the foramen.
14 And the slice is through this area. (Witness
15 indicating.) So we're looked straight down to see, has
16 this nerve root been drug along? Because there's no
17 slippage here. This is a normal level.

18 Q. Sure.

19 A. Okay?

20 Q. But this is Ms. Garcia's actual study?

21 A. Yes.

22 Q. Okay.

23 A. Exactly.

24 Q. And this -- this nerve root that you pointed
25 out is -- is which nerve root?

1 A. That's the L5.

2 Q. Thank you. Is there any indication of any
3 impingement, pressure, compression of that L5 nerve
4 root?

5 A. No. It's a beautifully round,
6 normal-appearing nerve root.

7 Q. Okay. Moving on. We're on Slide 6.

8 Tell the jury what these slides represent,
9 and identify each of these films that we're looking at.

10 A. Again, this is -- the yellow line shows
11 through -- this is L4-5. Vertebral body 5, vertebral
12 4. This is S1. You can see the 5, where it's moved
13 forward. This demonstrates -- this very small bulge
14 here we call a normal physiologic bulge at the back of
15 the vertebral body of the annulus. You can see it
16 there and here. (Witness indicating.)

17 And just showing you -- this clearly depicts,
18 as the nerve's moving up, appreciate each one of these
19 is 4 millimeters in thickness. You can see the
20 configuration of the nerve root here, here as it goes
21 out. You don't see it as far in this side. It's never
22 symmetrical, but you can see it on the right side here.

23 This means left and right. You can see R and
24 H. It's always reversed on the MR. These are the
25 other nerve roots. The lower sacral nerves, as

1 they're -- because she's lying on her back. So L5 --
2 L4-5 is a beautifully looking -- appearing nerve root.
3 There's nothing wrong with that nerve root.

4 Q. Okay. All right.

5 A. Had -- had the vertebral body moved forward,
6 it would look abnormal.

7 Q. Okay. We are -- now, this is the next slide.
8 Slide 7.

9 A. Again, the first one, done 24 days later,
10 that there's no pressure on the nerve roots. These are
11 the nerve roots moving through the foramen. This is
12 1/26/11. It did -- you can see the difference, T1 and
13 T2. And then the sagittal picture, just to show you
14 where the cut is through.

15 Q. Now, in looking at these slides that are
16 taken -- what did we -- what is it? 24 days after the
17 accident?

18 A. Yes.

19 Q. Because all of these slides are from
20 January 26th of 2011?

21 A. Correct.

22 Q. So what does this tell you in terms of
23 Ms. Garcia's complaints with respect to her lumbar
24 spine or -- and low back?

25 A. This affirms to me that her complaints are

1 not emanating from injuries to nerve roots. That's
2 really good because that's the structure at risk. Her
3 back pain is from the soft tissue component. The
4 lumbar -- the muscles, of which there are
5 significance -- appreciate, in terms of the anatomy,
6 90 percent of the tissue is muscle and soft tissue.
7 The nerve roots make up maybe 1 percent of the total
8 tissue.

9 So this affirms -- in the absence of
10 deformity of the nerve roots, the absence of the
11 system -- symptoms, the absence of clinical findings
12 that go along with nerve root, tension, her symptoms
13 are those of soft tissue complaints.

14 Q. Okay. Moving on to the next slide, 8.

15 Tell the jury what these slides represent and
16 the dates of these slides.

17 A. This is August 22nd. All these are the same.
18 August 22nd. And what I wanted to show you on this --
19 now, this is looking at her at a bit of an angle.

20 Q. Sorry, Doctor. What's -- I'm sorry. What's
21 August 22nd?

22 A. This is -- let's see. Excuse me. I
23 missed -- let me get over and get one. That's a little
24 bit fuzzy because of the blowup.

25 Q. Yeah, it is.

1 A. This is -- excuse me. This is 1/19/12 and
2 1/26/11 comparison. Okay?

3 Q. 11 -- it's 11/19/12. It's cut off on the
4 left side.

5 A. Excuse me. 11/19/12 and 1/26/11. In other
6 words, the 20-month hiatus -- 22-month hiatus.

7 Q. Okay.

8 A. And this -- this one -- both these show this
9 beautiful-looking nerve root as it's coming out on both
10 sides. This is the nerve root. Sometimes you don't
11 always get such a nice one on an MR.

12 Here's the -- this looks oval here because of
13 the angle, but it's the vertebral body. You can see
14 the nerve root coming out as it's coming down and as
15 it's exiting. There is just no pressure or deformity
16 on this nerve root at all.

17 Q. And what level is that?

18 A. This is at L5-S1, the S1 nerve root.

19 Q. Okay. And -- and so the top row of slides
20 are from 2012, and the bottom three slides are from
21 2011?

22 A. Yes, you can see here. You've magnified
23 this, so it does -- cuts off the date. Here's '11;
24 here's '12, 22 months later.

25 Q. Okay. So what, if any, appreciable change do

1 you note, if any, from 2011 to 2012?

2 A. None.

3 Q. Okay. All right. Moving on to Slide 9.

4 MR. SMITH: Objection, Your Honor. Outside
5 the scope of his opinions. This is what we discussed
6 at the bench.

7 MR. MAZZEO: Judge, can we approach on this?

8 THE COURT: Sure.

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

11 MR. MAZZEO: Curt, could we have lights,
12 please, for a minute. It's too dark to see the words.

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

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

16 THE COURT: You can.

17 Was there an objection to this specific
18 slide?

19 MR. SMITH: Yes.

20 THE COURT: Because I took the slide down.
21 You want to move on to a slide that might not be
22 objectionable?

23 MR. MAZZEO: Well, you didn't sustain the
24 objection with regard to the slide.

25 THE COURT: Turn the TV off so I can look at

1 the slide again.

2 MR. MAZZEO: I think it's off, Judge. And
3 I'll turn to it. There we go, Slide 9.

4 THE COURT: Well, if -- if the problem is, if
5 I put the slide back up, you're going to see it. So
6 turn the TV off.

7 JUROR NO. 3: The TV is off.

8 MR. MAZZEO: It's off, Judge.

9 THE COURT: Now there's a slide there; right?

10 MR. MAZZEO: No. No. It's just turning on.
11 I'll shut it off.

12 There we go. It's off.

13 MR. SMITH: Your Honor, may we approach about
14 this one? Because this is a different one than we were
15 discussing.

16 THE COURT: Yep. Come on up. Sorry, folks.

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

19 THE COURT: Jury needs a break. Okay. Let's
20 take a break.

21 All right. Folks, let's go ahead and take a
22 break. During our break, you're instructed not to talk
23 with each other or with anyone else about any subject
24 or issue connected with this trial. You are not to
25 read, watch, or listen to any report of or commentary

1 on the trial by any person connected with this case or
2 by any medium of information, including, without
3 limitation, newspapers, television, the Internet, or
4 radio.

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

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

14 See you in ten minutes. We'll take a quick
15 one.

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

18 THE COURT: All right. While we're outside
19 the presence of the jury, let's go ahead and put this
20 on the record since we've been having a lot of time
21 spent up at the bench.

22 With regard to these various slides, my
23 understanding is that Dr. Klein testified on page 29 of
24 his deposition that he saw a postoperative MRI. So I
25 let you ask questions about the postoperative MRI or I

1 said that I was going to.

2 You then switched the slide to discuss a
3 postoperative X ray, which apparently is not referenced
4 in the deposition. And I said that, because the slide
5 or the exhibit has apparently been shown to other
6 doctors, you can ask him whether or not, after seeing
7 this slide or this X ray, his opinions have changed.

8 Doctor, while you're here, I'm going to make
9 it real easy for you.

10 The instruction was, if the opinion has not
11 changed, then he will answer no and you can move on to
12 the next question. If the opinion has changed based on
13 anything you show him and he answers it yes, I'm going
14 to strike the opinion because it's not previously
15 offered. Okay?

16 MR. MAZZEO: Yes.

17 THE COURT: Anything else we need to discuss
18 as it relates to those?

19 MR. MAZZEO: No, Judge.

20 MR. SMITH: One other thing that we
21 discussed, Your Honor, is the opinions regarding the
22 postsurgical MRI. And the only disclosure to us of him
23 reviewing a postsurgical MRI is that page 29 of the
24 deposition, where he says, if you look at the
25 postoperative lumbar MRI, there's still fatty

1 infiltration of the multifidus muscles that we saw on
2 the preoperative MRI. So her obesity is a factor and
3 her deconditioned status as the basis for her ongoing
4 low back pain.

5 When we got his reports, neither of his -- or
6 his initial report identifies the scans that he has
7 reviewed. And that report does not mention the
8 postsurgical MRI that he intends to testify about.
9 And, in fact, that report was generated before she had
10 that MRI.

11 His subsequent two reports do not mention
12 this postsurgical MRI. And, in fact, on January 6th,
13 2016, Dr. Klein authored a report where he said, "I was
14 not provided any additional diagnostic studies for
15 review."

16 Our understanding at the time of the
17 deposition was that he was talking about having
18 reviewed the report. We also were time-limited in his
19 deposition and cut off by defense counsel because the
20 time ended. So we didn't have an opportunity follow up
21 on things like this because there were other parts of
22 the deposition that we thought were more important.

23 If Dr. Klein is going to testify about the
24 postsurgical MRI, which we don't think he should be
25 allowed to because he never offered any opinions and he

1 says specifically on January 6th, 2016, he did not
2 receive that film. And we should be allowed to rely
3 upon his statement on January 6th, 2016.

4 But to the extent he's allowed to testify
5 about it, the only opinion he should be allowed to give
6 is the opinion that I read into the record that's in
7 the -- in the deposition. He should not be allowed to
8 expand upon that opinion or talk about how that MRI
9 relates to the presurgical MRIs in any other way
10 because those opinions have never been offered.

11 And as we discussed at the bench, as an
12 expert witness, he cannot expand upon his opinions or
13 offer new opinions at trial. This MRI is from
14 October 2014. He has had sufficient time to provide us
15 with the opinions that he intends to offer in front of
16 the jury and have -- has issued two reports since that
17 MRI. And having not provided those opinions to us
18 before today, then he's not allowed to testify about
19 them.

20 THE COURT: I tend to agree. Are you
21 planning on offering or asking him questions based on
22 those post -- that postoperative MRI in addition to
23 what he offered in his -- in his deposition?

24 MR. MAZZEO: From -- that would be from
25 October of 2014?

1 MR. SMITH: No. It's October 2014. June is
2 the X ray record.

3 MR. MAZZEO: So you're talking about the
4 October 2014 MRI?

5 THE COURT: He apparently offered a specific
6 opinion in his deposition at page 29 as it related to a
7 postoperative MRI. I think that opinion is fair game
8 for trial today.

9 MR. MAZZEO: Okay.

10 THE COURT: Any other opinions as it relates
11 to postoperative MRIs, I think I agree with Mr. Smith.
12 If it wasn't previously disclosed, it can't be offered.

13 MR. MAZZEO: Well, Judge, with regard to his
14 January 6th, 2016, report, to the extent that he didn't
15 review any for the purposes of that report doesn't
16 preclude him from offering opinions where he's reviewed
17 them prior to other -- prior to some of the other
18 supplemental reports that he's provided. And that's
19 what I'm looking at right now, if I can just have a
20 moment.

21 THE COURT: If you can find me something that
22 shows that he looked at these postoperative films and
23 offered opinions on them in his reports, then I allow
24 it.

25 MR. MAZZEO: Okay.

1 THE COURT: Why don't we -- why don't we go
2 off the record. We'll take our break. And if you find
3 something, you can let me know when we come back. Fair
4 enough?

5 MR. MAZZEO: Yes, Judge.

6 MR. SMITH: Thank you.

7 THE COURT: All right. Off the record.

8 (Whereupon a short recess was taken.).

9 THE COURT: Back on the record. We're still
10 outside the presence.

11 MR. MAZZEO: Okay. All right. So what we
12 discussed off the record, Judge, which we're going to
13 put on the record now, is that what I intend to -- how
14 I intend to proceed with Dr. Klein is, I'm going to
15 show him that Slide No. 7, and it shows the post-op
16 X rays. I'm going to ask him that one question that we
17 discussed earlier about whether his inspection and
18 review of that imaging study changes any opinions that
19 he's expressed in this case with regard to the
20 necessity for fusion surgery or the condition of the
21 spondylolisthesis postaccident.

22 Same thing with the 10/11/14 MRI slide, which
23 is No. 8 and 9 in the presentation. Just those one --
24 just those questions. And then the 10th slide is a
25 comparison that shows the 10/11/14 post-op versus the

1 1/26/11 and 11/19 pre-op images.

2 Again, my question to you is whether that
3 changes any opinions with regard to the condition of
4 the spondylolisthesis postaccident, postsurgery.

5 THE COURT: As long as you're just asking him
6 if seeing these things is changing his opinion, I'm
7 okay with it. If you ask him now to offer a new
8 opinion comparing the three MRIs, that's where they're
9 going to have an objection because that's apparently
10 what wasn't previously disclosed; right?

11 MR. MAZZEO: That's correct.

12 MR. SMITH: And there's a separate issue with
13 this. He's not just showing them the images. They
14 have words on here that are new opinions from him or
15 that could -- some of them are new opinions, and some
16 of them could lead the jury to believe that there are
17 new opinions.

18 So if counsel wants to ask if he's reviewed
19 the X rays or the MRI -- or this X ray or this MRI and
20 did it change your opinions, or if he wants to show the
21 actual X ray or the actual MRI film, that's one thing.
22 If he wants to show these slides that have words on
23 them, that have the opinions that are being excluded,
24 that's a problem.

25 THE COURT: Can you do it without the words?

1 MR. MAZZEO: No, Judge, and that would be
2 unfair rulings from the bench with regard to plaintiff
3 versus the defense. We had an artistic image by the
4 plaintiff that I objected to because they put the word
5 "edema" on something that half their experts disagreed
6 with, but they put it in there anyway. I objected to
7 it, and you said, no, that's just their artistic --
8 they put in words to describe various conditions that
9 are on -- on the imaging studies that none of their
10 treating physicians testified to.

11 THE COURT: Show me the slides that you want
12 to put up. Let me see what the words are.

13 MR. MAZZEO: Sure. Actually, I can give
14 you --

15 THE COURT: That's fine.

16 MR. MAZZEO: It has the wording on it. It
17 starts from -- that -- top of the -- the slide at the
18 top is Slide No. 7, which is what was -- we were
19 talking about.

20 So these are just descriptive words, and the
21 captions just identify the content in the slide, but
22 he's not going to testify to that. So it -- it -- it
23 puts context to what this slide represents. That's
24 all. He's not offering any opinions, though, other
25 than what we had discussed.

1 THE COURT: Is there a dispute about the
2 lateral position of the L -- right L5 pedicle screw?
3 There's no dispute about where the positioning is;
4 right?

5 MR. MAZZEO: I don't think so, Judge.

6 MR. SMITH: Well, I guess I -- there's no
7 dispute about where it is. I guess I don't understand
8 why he's showing a slide that says the jury's supposed
9 to note that and insinuating to the jury that there's
10 something wrong with the lateral position of the right
11 L5 pedicle screw, which is not something he's ever
12 testified to. He's never said, in anything, that the
13 right L5 pedicle screw was improperly placed.

14 MR. MAZZEO: It gives context for the doctor,
15 Judge, for what slide is -- is now being -- coming up
16 on the screen. So I don't have to give preamble about
17 what the slide depicts and what it represents before I
18 ask the question.

19 THE COURT: He's not going to say that they
20 were installed or positioned incorrectly; right?

21 MR. MAZZEO: I'm not -- no. I'm not allowed
22 to ask him that. I'm not asking him that, and that's
23 not indicated in the caption.

24 THE COURT: I don't think -- I don't think
25 the note says that it's positioned improperly or

1 anything, so I'm okay with what it says.

2 MR. MAZZEO: Thank you, Judge.

3 MR. SMITH: Then there's the next one that
4 says, "MRI 10/11/14 post-op versus 1/26/11 and
5 11/19/12 pre-op. Note, epidural scar tissue anterior
6 and posterior to thecal sac on post-op scan."

7 So there he is testifying about scar tissue
8 on the postoperative scan, which is, again, a new
9 opinion that he did not testify to.

10 MR. MAZZEO: What slide are we looking at?

11 MR. SMITH: I don't have numbers on the one
12 he gave me.

13 MR. STRASSBURG: 15.

14 MR. MAZZEO: Oh. The last one.

15 MR. STRASSBURG: Our Slide 15.

16 MR. MAZZEO: No, I only have 14.

17 THE COURT: On the bottom of page 6.

18 MR. STRASSBURG: I numbered it. 15.

19 THE COURT: The one on the bottom of page 6.

20 MR. SMITH: And there's no reason to show him
21 an additional picture of the October 2014 MRI. The
22 only thing he's allowed to ask him is, did -- did the
23 review of this change your opinions?

24 MR. MAZZEO: That's Slide 12, Judge. I think
25 that's what he was referring to.

1 THE COURT: I don't have numbers on it. The
2 one that says MRI 10/11/14 post-op versus 1/26/11.

3 MR. MAZZEO: Oh. Yeah. Okay. I have that
4 up on the -- on the -- okay. Yes, I see.

5 So, again, the caption just gives --
6 identifies the content and gives a frame of reference
7 for what Dr. Klein is referring to. I don't want to go
8 into the details nor have him discuss the content. It
9 gives him a reference point.

10 As with the artistic rendition by plaintiff,
11 where they provided these postoperative -- or actually
12 operative drawings of the procedure that's taking place
13 and -- and then identified certain structures that are
14 in dispute. And specifically that word "edema," which
15 no treating physician ever testified to, but they threw
16 that in there because a rebuttal expert, who is not
17 even going to testify at trial, made a reference to it,
18 not at the time of his expert reports, but after he
19 reviewed the defense witness's depositions. So -- and
20 you allowed that in. So this is --

21 THE COURT: You're telling me a lot more now
22 about that word than I ever heard when it was --

23 MR. MAZZEO: Yes. And I'm not -- so I'm not
24 asking him to describe -- this gives him a frame of
25 reference so he can go right to it. Doctor, does

1 this -- do the images on this slide change your opinion
2 about any -- about the -- whether the spondylolisthesis
3 had slipped -- or sustained an acute trauma and before
4 or after the --

5 THE COURT: If you can take the words off the
6 top, I don't have a problem with the images.

7 MR. SMITH: Well, including the one on the
8 slide that says "epidural scar," because that's a new
9 opinion.

10 THE COURT: I don't know.

11 MR. STRASSBURG: Judge, can I --

12 THE COURT: I don't see one that says
13 epidural scar.

14 MR. SMITH: You can't -- I can see it on
15 Mr. Mazzeo's screen because the contrast is different.
16 If you look at the picture on the left where it says
17 "epidural," underneath that, it will say "scar" on the
18 black-and-white copies that you and I got.

19 THE COURT: Let's keep this one out because
20 you've already got pictures of the MRI up there in
21 these other slides.

22 MR. STRASSBURG: Judge, can I add some
23 comments upon the scope of disclosure on this
24 scarring -- epidural scarring as the cause for
25 postsurgical pain?

1 MR. MAZZEO: Yes.

2 MR. STRASSBURG: Let me direct your attention
3 to Volume II of Klein's deposition on February 17,
4 2015, where he testified:

5 "One of the downsides of doing this
6 magnitude of surgery is we have no way to
7 control the scarring that takes place at the
8 site of the surgery in the operative field. If
9 you have a patient who develops these symptoms
10 into the right lower extremity and, you know,
11 one of the complications is perineural
12 fibrosis, scarring around the nerve roots and
13 directly at the fusion site."

14 This relates to an opinion in his
15 October 9, 2014, report at page 16, in which he said:

16 "In my opinion, for Ms. Garcia's
17 medical records and per her representation, she
18 did not have pain in -- on the medial lateral
19 or anterior aspect of her right thigh between
20 January 2, 2011, and December 26, 2012. In my
21 opinion, this is iatrogenic in origin and,
22 based upon reasonable medical probability, is
23 as a result of postoperative perineural
24 fibrosis or injury to a portion of the anterior
25 divisional fibers of the lumbosacral plexus."

1 He also has testified that --

2 THE COURT: Sounds to me like that's an
3 opinion he can offer.

4 MR. STRASSBURG: Yep.

5 THE COURT: Probably without looking at the
6 MRI study.

7 MR. STRASSBURG: Judge, if he can offer the
8 opinion, he can describe its basis, and he can explain
9 where it comes from anatomically in this case. That's
10 fair game. It was fairly disclosed, and it's directly
11 relevant to the issues in this case.

12 THE COURT: I don't have a problem with the
13 opinion because the opinion was disclosed. I have a
14 problem with him looking at an MRI study as the basis
15 for it when that wasn't disclosed.

16 Apparently, there was no reference to this
17 MRI study in any of his reports. The only reference
18 was on page 29 of his deposition, and it didn't have
19 anything to do with this opinion. So if the opinion's
20 in the report, that's fair game.

21 As far as this MRI study is concerned, the
22 only opinion that can be asked about it is the opinion
23 that came out during the deposition; otherwise, he
24 would have had to disclose it in his report and say
25 these are the opinions I have based on the MRI study

1 that I reviewed.

2 You guys know the disclosure rules. All
3 right?

4 MR. MAZZEO: Yes.

5 THE COURT: So as far as the slides that talk
6 about the pedicle screws, you are going to ask him if
7 these change his opinion. As long as he says "no,"
8 those are fine.

9 The one that says -- has the three different
10 studies and it talks about the epidural scarring, let's
11 not use that slide.

12 MR. MAZZEO: Okay.

13 THE COURT: Okay.

14 MR. MAZZEO: Yeah. I move that to the --

15 THE COURT: You want to talk to him about the
16 scarring and the opinion is in the report, you can talk
17 to him about that. Here's your slides back.

18 MR. MAZZEO: Also, while we are talking about
19 it, he also gave an opinion about pseudarthrosis
20 resulting from the surgery, and he testified to that.
21 Mr. Smith asked him:

22 "Pseudarthrosis is a potential
23 complication from a fusion surgery; right?"

24 And Doctor -- well, Dr. Klein had testified:

25 "There's a conundrum here. What's

1 going on with Ms. Garcia and why is she
2 remaining symptomatic?"

3 So he -- he discussed the complication from
4 fusion surgery, pseudarthrosis.

5 THE COURT: If it's an opinion he's offered,
6 I'm going to let him talk about it. That's what the
7 rule is. It's real easy, guys.

8 MR. STRASSBURG: Well, Judge, on page 9 of
9 his deposition on February 17th, 2015, he was asked by
10 Mr. Smith:

11 "What's your opinion of the reason
12 for the symptoms Ms. Garcia described to
13 Dr. Gross?"

14 He answered:

15 "Would be multifactorial. She -- she
16 could have the worst-case scenario that she's
17 not completely fused from the procedure that
18 was done on 12/26/12. In other words, she has
19 a incomplete fusion, which we call a
20 pseudarthrosis."

21 THE COURT: Pseudoarthrosis.

22 MR. STRASSBURG: I guess. Yeah. I don't see
23 an "o" there, but maybe --

24 MR. MAZZEO: There's no "o" there. It's just
25 pseudarthrosis.

1 THE COURT: Yeah. That's because you didn't
2 have Kristy as your court reporter.

3 MR. MAZZEO: Judge --

4 MR. STRASSBURG: Well, we tried, but we
5 couldn't afford her, and she was busy.

6 MR. MAZZEO: Judge, I think the actual word
7 is "pseudarthrosis," but I have been corrected by
8 doctors, so ...

9 THE COURT: Okay.

10 MR. STRASSBURG: He furthermore said:

11 "She's having some degree of
12 instability with micromotion at the
13 pseudarthrosis -- pseudarthrosis site, and
14 those would be my concern."

15 Page 9, deposition February 17th, 2015.

16 THE COURT: I don't know that there's an
17 issue about that. Is there?

18 MR. MAZZEO: No.

19 MR. SMITH: That's not what we're talking
20 about. We're talking about whether he can say he then
21 reviewed the MRI and talk about what's on the MRI.
22 That's what this discussion is about.

23 MR. MAZZEO: You made a decision that we
24 can't show that film with the -- the October 2014 MRI
25 versus the November --

1 THE COURT: Not with the language that's on
2 there and the scar references and stuff.

3 MR. MAZZEO: Okay. So I'm not showing that.

4 THE COURT: Okay.

5 MR. STRASSBURG: Okay.

6 THE COURT: Let's go.

7 MR. MAZZEO: All right. I would like to
8 finish direct today.

9 THE COURT: Come on up, Doctor.

10 MR. MAZZEO: Judge, I'm continuing from
11 Slide 9, which is the post-op X ray.

12 THE COURT: Okay.

13 MR. MAZZEO: All right. So I just needed to
14 put on --

15 THE COURT: You want to be able to see it.

16 THE COURT: Let him get the TV working, Curt.

17 THE MARSHAL: Okay.

18 THE COURT: Because I'm not showing -- I'm
19 not seeing anything on my screen.

20 MR. MAZZEO: Right.

21 THE COURT: We good?

22 MR. MAZZEO: Yes.

23 THE COURT: All right. Bring them back.

24 THE MARSHAL: All rise for the presence of
25 the jury.

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

3 THE COURT: I think that was a -- a little
4 more than a ten-minute break. Sorry. Go ahead and be
5 seated.

6 We are back on the record, Case No. A637772.
7 Do the parties stipulate to the presence of the jury?

8 MR. MAZZEO: Yes, Your Honor.

9 MR. SMITH: Yes, Your Honor.

10 THE COURT: All right, Doctor. Where is the
11 doctor at?

12 You're going to be down there talking about
13 it. That's fine. Just be reminded, you're still under
14 oath.

15 Go ahead, Mr. Mazzeo.

16 MR. MAZZEO: Yes. Thank you, Judge.

17 BY MR. MAZZEO:

18 Q. All right. Doctor, take a look at this next
19 slide. It's Slide No. 9 in the presentation of 13
20 slides. And I'm not going to ask you to comment only
21 insofar as in reviewing and looking at the structures
22 that are contained within these two imaging studies.

23 Does anything in this change your opinion
24 about the necessity for a fusion surgery that you had
25 offered previously? Well, actually, you know what?

1 Let me back up one second. Because I don't know if I
2 got to that in my questions of you.

3 Doctor, did you come to an opinion with
4 regard to the necessity for Ms. Garcia to undergo
5 fusion surgery that was performed by Dr. Gross in this
6 case? And, if so, what was it?

7 A. In my opinion, she was not a candidate for
8 the fusion surgery.

9 Q. Okay. At any time, from the time of the
10 accident up until today?

11 A. That's correct.

12 Q. And in -- now, directing your attention to
13 the -- to the image that is in front of us and on
14 the -- on the film, in reviewing the structures that
15 are identified within that -- in these two images, does
16 anything within this imaging studies, in either of
17 them, change your opinion with regard to the necessity
18 for fusion surgery and -- and the opinions you
19 expressed with regard to the fact that there was --
20 Ms. Garcia did not sustain an acute injury to the
21 preexisting Grade II spondylolisthesis?

22 A. No. These images affirm --

23 MR. SMITH: Objection, Your Honor. He can
24 say "yes" or "no" per your ruling.

25 /////

1 BY MR. MAZZEO:

2 Q. Okay. Yes or no?

3 A. It did not change my opinions.

4 Q. Okay. Thank you. All right.

5 So we're going to go on to the next slide.

6 And same question, Doctor. With regard to the
7 imaging -- images that are depicted in this slide --
8 and let me just identify for the record, this depicts
9 an MRI that was taken on October 11th, 2014 -- and from
10 your review of the structures that are contained within
11 these images, did that change any opinions you have
12 expressed with regard to Ms. Garcia's -- whether or not
13 she sustained an acute Grade II spondylolisthesis or
14 the need for fusion surgery?

15 A. No.

16 Q. Thank you.

17 And now we're going to move on to same
18 question with regard to Slide 11, which are axial
19 images of the -- that you can see.

20 Did any structures contained within this --
21 within these images change your opinions that you have
22 offered with respect to Ms. Garcia not sustaining an
23 acute Grade II spondylolisthesis?

24 A. It's not changed my opinion.

25 Q. Or with respect to Ms. Garcia not

1 necessitating a fusion surgery?

2 A. It has not changed my opinion.

3 Q. Thank you. And now we will go on to -- so
4 now I want you to -- to tell the jury what -- what
5 images we see because we're looking at -- what slides
6 are we looking at? And, now, I don't want you to
7 describe in detail the significance and relevance of
8 the findings on these slides.

9 A. These are images from August 19th, 2011.
10 These are sagittal images and demonstrating that, at
11 L4-5, there's just this very minimal bulge. And the
12 axial image shows this very minimal bulge here. But,
13 more so, this beautifully detailed dorsal ganglion in
14 the L5 nerve root coming out. That's point of this
15 image.

16 Q. And what's the -- what's the significance of
17 this -- of the detail and the image of the dorsal --

18 A. Because if Ms. Garcia had sustained an acute
19 slip, L5 would have moved forward. It would have taken
20 these contiguous tissues here, the posterior
21 longitudinal ligament, and the nerve root. The nerve
22 root would look lengthened and thin because it moves
23 along as the vertebral body moves forward. It changes
24 the entire contour of the foramen.

25 Q. And can you -- can you tell the jury what --

1 where -- you pointed to the nerve root, which is the
2 white image on the screen; correct?

3 A. Yes. This is --

4 Q. Can you tell us what's on either side of that
5 structure of the nerve root? And watch yourself,
6 please.

7 A. Okay. So for orientation purposes, this is
8 the front of the abdomen. This is -- Ms. Garcia's
9 laying on her back. This is this large spinal canal
10 she has. These are the other nerve roots that fall
11 down when you're laying on your back. And this image
12 shows the nerve root. And these -- as it shows here,
13 thicknesses are 4 millimeters, each one.

14 So you see the dorsal root ganglion, and the
15 nerve root is moving. It's -- it's -- just as showed
16 on the previous one, it's coming down. So it looks
17 like there's gap here, but the next time you see it,
18 it's here. It's just the configuration of the nerve
19 root. The same here. Now you can see it coming out
20 over here, the white structure. It just demonstrates a
21 pristine-looking L5 nerve root that has not been
22 disturbed in any way.

23 Q. What do you mean by "disturbed?" Are you
24 referring to compression, impingement, or something
25 else?

1 A. Pulling, compression, extrinsic pressure.

2 Correct.

3 Q. Okay. What does that mean? That it's not
4 disturbed?

5 A. It fortunately has not been damaged as a
6 result of an acute movement of L5 on S1.

7 Q. And if it was disturbed by -- by pressure,
8 impingement, or -- or stretching, what would --

9 A. There would --

10 Q. -- what would be the constellation of
11 symptoms or -- related to that?

12 A. It would be, as I have shared with the jury
13 earlier, these immediate symptoms of severe pain into
14 the L5 and S1 nerve roots, the severe sciatica going
15 all the way down to the heel where the S1 nerve root
16 enervates, the hamstring spasm because the L5 is a
17 major enervator of the muscles in the back of your
18 thigh. That history is lacking as part of an acute
19 event.

20 Q. Okay. And moving on to the final slide, tell
21 the jurors what we're looking at and the -- on each of
22 these slides.

23 A. It gives an idea of -- at each level above,
24 from 1 -- L1 to 3, 3-4. At each level, comparing --
25 this is on 11/19/12, looking on. In other words, 22

1 months later. That shows no change, so these are the
2 axial images that correlate to the -- where you see the
3 line.

4 And this is the normal appearance at L1. You
5 can see the canal. You can see the nerve root coming
6 out. Here's L3. When we say L1-2, it's -- the second
7 nerve root coming out, L2. And at L2-3 it's L3. At
8 each level -- and this is the highest one. This is all
9 the way up to the lower thoracic because now you can
10 see a rib coming in. Each one of these are normal
11 levels.

12 And the other part is that it shows normal
13 facets and there's no abnormalities at any adjacent
14 level because that was once discussed, adjacent segment
15 disease.

16 Q. Okay. All right. Anything else with regard
17 to this image?

18 A. No.

19 MR. MAZZEO: Okay. We're done with the
20 slides, then, Judge.

21 THE COURT: You want your lights back on?

22 MR. MAZZEO: Sorry? Yes, please.

23 Thank you.

24 BY MR. MAZZEO:

25 Q. Now, with respect to -- just a few questions

1 with regard to each study. The 1/26/11 MRI, the
2 8/19/11, and the 11/19/12 MRI.

3 How would you characterize the quality of the
4 1/26 MR that you reviewed?

5 A. I would say it was good, average quality.
6 That was the first one that I saw. That was the first
7 sentence I said -- if you look at my report, I said,
8 this is a good quality MRI, which is relatively clear
9 resolution and lacks motion artifact.

10 Q. What is the most susceptible structure to
11 injury in the lumbar spine?

12 A. The nerve root.

13 Q. Okay. Why is that?

14 A. The nerve root is what supplies enervation,
15 especially L5 and S1, to the bladder function, to your
16 function of your bowels, motor to the legs, to your
17 thighs, to your foot and ankle, sensation to your
18 entire buttock, and the entire pelvic structure, into
19 the gynecologic origins, the bladder, and as well as
20 sensation on the bottom of your feet. These are very,
21 very significant nerve roots, 4, 5, and S1.

22 Q. What evidence is there on the -- referring
23 now -- I have a couple questions for you regarding the
24 1/26/11 MRI. What evidence is there, if any, on the MR
25 that the L4-L5 sustained any traumatic injuries as a

1 result of the subject accident?

2 A. None.

3 Q. What is there -- what evidence -- is there
4 any on the 1/26/11 MR that the L5-S1 sustained any
5 traumatic injury as a result of the subject accident?

6 A. None.

7 Q. And what evidence is there on that MR from
8 1/26 of 2011 that shows the presence any acute findings
9 following the subject accident?

10 A. None.

11 Q. And what evidence is there on the 1/26/11 MR
12 that shows any evidence of swelling, edema, or nerve
13 impingement?

14 A. None.

15 Q. There was a reference on the -- from the
16 radiologist regarding the 1/26/11 MR that indicated --
17 indicated an AP diameter of the spinal canal of
18 1.4 centimeters. Would that be considered normal or
19 abnormal?

20 A. That's normal.

21 Q. Okay. And with respect to any other findings
22 on the 1/26/11 MR, was there any evidence, in any
23 indication, that you would deem to be reflective of
24 something that would be acute or traumatic in nature?

25 A. In my opinion, there are no representations

1 of acute injury on the 1/26/11 MR.

2 Q. Directing your attention now to the August
3 19th, 2011, MRI of the lumbar spine. Doctor, you
4 reviewed both the report and the MRI study; correct?

5 A. Correct.

6 Q. And based on your review of either the report
7 or the image, did it show any findings of nerve root
8 impingement at all, at any structure, at any point?

9 A. No. I compared that MR of 8/19/11 to
10 1/26/11. And, in fact, I even, in my report, said -- I
11 referred to images 22 to 25. There is no difference.
12 There is no change.

13 Q. And was there any evidence or finding by
14 yourself of any acute or degenerative -- acute or
15 degenerative findings on the 11 -- I'm sorry -- on the
16 8/19/11 MRI?

17 A. Both MRs show some very minimal desiccation.
18 In other words, what you expect with a Grade II
19 spondylolisthesis of chronic nature. But there's no
20 acute abnormalities when comparing one to the other.
21 No change in the ensuing seven months.

22 Q. Okay. Now -- and I know you made -- you
23 described various findings that you observed when we
24 juxtaposed the three MRIs from January 2011,
25 August 2011, and November of 2012. What -- what were

1 the primary differences, if any, between the
2 January 2011 MRI and the November 2012 MRI?

3 A. Other than some minimal technical
4 differences, there's no change anatomically.

5 Q. And you had mentioned -- well, let me ask you
6 this: What is -- when the radiologist refers to
7 millimeter measurements, what is the preciseness of
8 millimeter measurements by a radiologist on an MRI
9 study?

10 A. They're inaccurate. They're -- these do not
11 have enough resolution, any of these, that you can
12 measure differences in millimeters. There's a good 10,
13 15 percent difference either way. So that's why the
14 radiologist -- the cautious radiologist and -- in some
15 of the reports, clinical correlation warranted. Are
16 there clinical symptoms that go along?

17 Q. Okay.

18 A. These are adjunctive, diagnostic studies.

19 Q. What is the significance, because you
20 testified to this when you -- you referred that there
21 was -- you didn't observe any progressive changes
22 between the January 2011 MRI and the November 2012
23 MRI -- what is the significance of no progressive
24 changes between those two MRIs at the L4-L5 and L5-S1
25 levels?

1 A. That there is stability. That this is a
2 stable spondylolisthesis in which there's no evidence
3 of an acute change taking place nor change taking place
4 over a 22-month period.

5 Q. And based on your experience and expertise
6 and training as an orthopedic surgeon, after reviewing
7 each of these MRIs, what is your opinion with regard to
8 whether fusion surgery was necessitated for Ms. Garcia
9 as a result of the findings on the MRIs?

10 A. In my opinion, there was no necessity for a
11 fusion. She was stable.

12 Q. And so now moving on. Following your
13 interview of Ms. Garcia, your review of the medical
14 records, the MRI studies and reports, in your opinion,
15 what is the recommended treatment for the symptoms that
16 Ms. Garcia discussed with the emergency room physician
17 on 1/5 of 2011?

18 A. The recommended algorithm of care flowchart
19 treatment is an exercise program. In other words,
20 hopefully some weight reduction, improving abdominal
21 muscle tone, paraspinous muscle tone, and
22 strengthening. And over -- little baby steps, trying
23 to improve. And as the spasm and acute pain resolves
24 from the soft tissue component, the weight reduction
25 and strengthening takes place over -- and it varies

1 from individual to individual -- over a three- to
2 four-month period, depending upon the functional level
3 and sometimes depending upon the treater, the use of a
4 brace, as Dr. Cash suggested, at 44 days postinjury.

5 We sometimes will use a corset just as an
6 adjunct to help. But the treatment is conservative,
7 and its success rate in the 90 percent area --

8 Q. Okay.

9 A. -- just with this conservative treatment to
10 get through this acute phase.

11 Q. And during -- and in your review of the
12 medical records, specifically in 2011, in the early
13 part of 2011, was there any indication that Ms. Garcia
14 was making improvement from the treatment she was
15 receiving conservatively?

16 A. Yes. As identified by Dr. Gulitz.

17 Q. Do the records indicate from -- do the
18 records from Dr. Gulitz indicate that Ms. Garcia was
19 making slow but steady improvement?

20 A. Yes.

21 Q. Okay. And -- and in your opinion, based on
22 Ms. Garcia's preexisting, deconditioned status, would
23 you anticipate that it could take longer for her to
24 return to a preinjury baseline?

25 A. Yes.

1 Q. Why?

2 A. She's deconditioned, she has -- doesn't have
3 good muscle tone on the abdominal muscles, muscles in
4 the back, the paraspinous, and the -- and exercise was
5 not a part of her daily routine or weekly routine. So
6 there's an education process, hand-holding, reassurance
7 because when you start doing the exercises, it's
8 painful.

9 It's something she wasn't used to doing, so
10 there's a protracted period of time the patient makes
11 improvement, they plateau, you reassure, they plateau,
12 you reassure. And gradually, as the pain level goes
13 down, her functional level goes up. In the records,
14 fortunately, her functional level didn't change much
15 during that period of time.

16 Q. And what's the relevance of that?

17 A. She was able to function, her activities of
18 daily living, taking care of her children, going to
19 work, with the exception of her visits to Dr. Gulitz
20 and her physicians.

21 Q. Why is it important to note Ms. Garcia's
22 continued functionality postaccident?

23 A. As I have testified, the thing that we're
24 concerned about is, is there any evidence of
25 progressive slip? There certainly is no evidence of

1 symptoms with an acute slip. But she has a preanatomic
2 disposition. She already has a Grade II. Does it
3 continue to slip? Does she have symptoms demonstrating
4 that neurologic deficit that she's reporting? And as
5 the -- the pain level would go up, and her functional
6 level would go down.

7 And it wouldn't be anything she could
8 control. She works in a cage. She stands. Her
9 activities of daily living, she'd have to start giving
10 up things. That's the classic appearance and finding
11 in -- sometimes the physician thinks, well, we've
12 plateaued; we're not making improvement here. Let's
13 reassess things.

14 Hers was the same functional level, able to
15 take care of her kids and work. And -- and if you look
16 at Dr. Gulitz's records, progressive decrease in her
17 visual acuity scale.

18 Q. Okay. And in your reports you opine that the
19 selective nerve root block performed by Dr. Lemper on
20 August 30 of the 2011 was causally related to the
21 accident.

22 Why is that your opinion?

23 A. Suppose we're wrong, that there aren't any
24 symptoms with an acute slip, and the structure at risk
25 is the nerve root. Is it possible that she moved

1 forward a little bit, because this is a -- this defect
2 that I have been showing you is fibrocartilaginous.
3 It's not bone. Did she move forward a little bit, and
4 did she go back? Some people reduce their own,
5 occasionally.

6 Because she's complaining of pain, which was,
7 in my opinion, radiating pain, selective nerve root
8 blocks can be both diagnostic and therapeutic. If she
9 has pressure on her nerve roots and we're
10 misinterpreting the MRs, which are just studies, you
11 can put some local anesthetic around the nerve root --
12 and it's done under fluoroscopy, under sedation -- and
13 you anesthetize the nerve root around it.

14 If you're correct, all the buttock pain will
15 go away. That -- that's typical. It's diagnostic and
16 therapeutic. Yes, we're in the right area. This nerve
17 root is irritated. Something happened. And you would
18 expect, within 72 hours after the injection, a
19 reduction in pain of 80 to 90 percent, and it persists.
20 The pain doesn't come back.

21 So that was very helpful because she didn't
22 get good resolution. Within -- the week later, she's
23 back to her baseline pre-op -- preinjection status.

24 Q. Okay. And what is your opinion as to whether
25 Ms. Garcia sustained an injury to her facet joints?

1 A. There is no evidence. She's not talking
2 about localized facet pain. She's talking about
3 diffuse back pain. And she has preexisting -- as the
4 radiologist described, when you have this slip and
5 settling, it puts pressures on the facet joints. She
6 has a little bit of narrowing at 4-5 and 5-1. We know
7 that. We expect that.

8 I apologize for speaking so fast. At L4-5
9 and L5-S1. We expect that. We know there's going to
10 be some narrowing. It's part of the progressive,
11 degenerative change. That -- there's nothing wrong
12 with those facets. She has diffuse pain, not localized
13 pain where she's saying, Doctor, I hurt right here.
14 Patients will say, with the facet problem, it hurts
15 right there. They point to it. That's not what she's
16 describing.

17 Q. Okay. What's your opinion as to whether
18 Ms. Garcia sustained any injury to her sacroiliac
19 joint?

20 A. None. Her records are devoid of any symptoms
21 or findings of a sacroiliac joint injury.

22 Q. In your opinion, did the injections performed
23 by Dr. Kidwell into the sacroiliac joint have anything
24 to do with her alleged ongoing pain?

25 A. No.

1 Q. Why is that?

2 A. There's nothing wrong with her sacroiliac
3 joint. She's reporting, as I have testified, diffuse
4 pain from a pseudarthrosis.

5 Q. Did you have an opportunity to review
6 Dr. Gross's operative report in this case?

7 A. Several times.

8 Q. And in your opinion, after reviewing
9 Dr. Gross's operative report, what are your opinions
10 with regard to the comments made by Dr. Gross as well
11 as the procedure that was performed?

12 A. Under the heading of indications, Dr. Gross
13 dictated that the indication for the surgery was
14 progressive instability. That's not anatomically
15 correct. There is no evidence of progressive
16 instability.

17 In the operative report, Dr. Gross describes
18 removing all of the lamina at L5, part of L4, and
19 taking out of the facets and then inability to get a
20 purchase of the screw on the right side at L4. The
21 operative report suggests that taking away all this
22 tissue created instability. In other words,
23 biomechanically. It's a technique that we don't do
24 anymore. So I'm not -- now I know that she has a
25 pseudarthrosis.

1 Q. Okay. And let's talk about what -- when you
2 say pseudarthrosis, what are you referring to? What
3 does that mean, by the way?

4 A. The purpose of the screws that you've seen,
5 and the rods, is to create a rigid construct. It is to
6 be done along the weight-bearing axis on both sides,
7 and we put the cages in between. And you've seen
8 those. We filled the cages with bone graft. After we
9 take out the lamina, we morselize it. We have like a
10 little Cuisinart in the operating room. We grind it
11 up, we pack it, and we put it in from the side.

12 When you take out these facets, we now know
13 that's not the proper thing to do. The pedicle screw
14 technique, with the rods, provides the construct, the
15 stability, as well as compression as we tighten the
16 rods down. So the operative report, as he describes,
17 created the basis for what we call "micromotion," and
18 micromotion in the same plane, millimeters of motion,
19 creates a pseudarthrosis.

20 And I have said in my reports and my depo,
21 that's what she has now. She's symptomatic of a
22 pseudarthrosis.

23 Q. Now, when you're doing a fusion surgery in
24 the lumbar spine, what's the importance -- or what --
25 well, what's the relevance or importance of

1 reestablishing the lumbosacral angle?

2 A. Preoperatively, in the planning, we measure
3 this angle, the long axis of the sacrum and the axis of
4 the back of the vertebral bodies. So that's called the
5 lumbosacral angle. In an individual who has a
6 spondylolisthesis, a Grade II, you can, on some
7 occasions -- and Dr. Gross discusses that -- attempt to
8 reduce it, to bring it back. You don't have to do it.

9 Sometimes you're successful, as you -- with
10 the pedicle screws to bring it back, but you want to
11 reestablish the angle and not create a flat back. That
12 anatomically doesn't work. It goes against the
13 weight-bearing axis of the body. That's the point of
14 reestablishing the lumbosacral -- you have to have a
15 clear understanding of the biomechanics of the spine
16 and not create an instability.

17 Q. Based on your --

18 MR. SMITH: Objection. Move to strike.
19 Outside the scope of his opinions.

20 THE COURT: I think it goes with the
21 pseudarthrosis which he testified about. Overruled.

22 MR. MAZZEO: Thank you, Judge.

23 BY MR. MAZZEO:

24 Q. Based on your review of Dr. Gross's operative
25 report, is it your understanding that -- did Dr. Gross

1 reestablish the lumbosacral angle?

2 A. In my opinion, he did not.

3 Q. And in your opinion, following -- you have
4 reviewed the follow-up consultations that Ms. Garcia
5 had with Dr. Gross after the surgery --

6 A. Yes.

7 Q. -- correct?

8 And -- and what did you note, in particular,
9 with regard to the complaints of pain that Ms. Garcia
10 reported following the fusion?

11 A. Just an inconsistency between Dr. Gross's
12 post-op note and when she was being seen either by
13 Dr. Kidwell or -- or his PA, physician assistant, is --
14 she was reporting all the leg pain and Dr. Gross
15 reporting she doesn't have any leg pain. So, in other
16 words, I would rely on what she's saying, but she has
17 the pain into the right leg, which she told me, I
18 didn't have before surgery. So she has postoperative
19 right leg pain.

20 Q. And she's reporting that to Dr. Gross or
21 Dr. Kidwell?

22 A. Well, she's reporting it to both.

23 Q. Okay.

24 A. She's consistent in her story, but it doesn't
25 appear in the records. The inconsistency is in the

1 reporting in the physician's records.

2 Q. Okay. And in your opinion, why is she
3 complaining of pain post fusion surgery?

4 A. In my opinion, she has a pseudarthrosis, she
5 has scarring, and she has scarring around -- I'll show
6 you on here. The pain into the front of the leg that
7 shows here, there's the nerves that come out the back
8 we call the posterior lumbar division and then the
9 anterior.

10 We know, from what she says, "It's in the
11 front of my leg," it has to be one of the front nerves.
12 So the word we use for that -- and that happens after a
13 fusion. You can get -- there's no way for us to
14 control the scar. So she has a little scar around
15 those nerves that -- going down towards the front of
16 her thigh and also the back too.

17 Q. Is there a way to prove or disprove
18 pseudarthrosis?

19 A. Yes.

20 Q. How so?

21 A. You do a postoperative CT scan. You ask for
22 thin slices and three dimensional reformatting.

23 Q. Do you know if Dr. Kidwell or Dr. Gross
24 ordered a postoperative CT scan?

25 A. To my knowledge, it's never been done.

1 Q. In your opinion, is the placement of a spinal
2 cord stimulator going to resolve Ms. Garcia's
3 constellation of symptoms?

4 A. No.

5 Q. What would be your recommendations regarding
6 the future care for Ms. Garcia?

7 A. Ms. Garcia requires a CT scan; she requires
8 postoperative bending films. She requires a -- in some
9 cases -- and not everyone's trained -- is to
10 demonstrate the loosening of the screw that I see on
11 the post-op X rays. And in my opinion, she's going to
12 require another operation because she has a
13 pseudarthrosis.

14 MR. SMITH: Move to strike his comments
15 regarding the postoperative X rays.

16 THE COURT: Come on up.

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

19 THE COURT: All right, folks, you're
20 instructed to disregard. We're going to strike any
21 comments regarding -- regarding the postoperative
22 X rays.

23 BY MR. MAZZEO:

24 Q. Doctor, in your opinion, is the continued
25 performance of facet blocks and radiofrequency

1 ablations, also known as rhizotomies, as well as
2 injecting the sacroiliac joints going to resolve
3 Ms. Garcia's symptoms?

4 A. No.

5 Q. Okay. And in your opinion, did the procedure
6 performed by Dr. Gross represent proper care and
7 treatment for Ms. Garcia's condition?

8 A. In my opinion, no. It was not indicated.

9 Q. Okay. Oh. Also, based on your review of the
10 all of the imaging studies from January of 2011, August
11 of 2011, and November of 2012, was there any indication
12 and any reason to include the L4-5 level as part of the
13 fusion?

14 A. No. That was a normal level. There, again,
15 is controversy, as I shared with you, and some of the
16 articles, should you go a level above the slip? With
17 the instrumentation we have in our armamentarium, all
18 the technique, a single level would be more than
19 adequate if somebody is unstable. And an individual
20 who is not unstable, there's no reason to go up and
21 violate a normal level.

22 Q. Was Ms. Garcia a candidate for the lumbar
23 fusion surgery performed by Dr. Gross on 12/26/2012
24 regardless of whether it's related to the accident or
25 not?

1 A. No. She wasn't a candidate for any
2 stabilization procedure.

3 Q. Thank you. And based on your -- and we may
4 have -- we may have touched upon this, and if you did,
5 then we can move forward. But what diagnoses -- you
6 talked about the -- strike that. Withdrawn.

7 You talked about the injuries that you
8 believe Ms. Garcia sustained as a result of this
9 accident; right?

10 A. Yes, I have.

11 Q. The neck, thoracic, and lumbar sprain and
12 strain; correct?

13 A. Correct.

14 Q. And following your review of the -- well, is
15 there anything else you want to offer with regard to
16 your opinions regarding the injuries sustained by
17 Ms. Garcia in this accident, or did you offer a
18 complete statement?

19 A. No. I think the records clearly identify
20 those are the symptoms she had when she presented to
21 the emergency room three days later, clearly identified
22 to Dr. Gulitz, and continued to continue complain at
23 each of her visits.

24 Q. In your opinion, what were the primary
25 factors that directed Ms. Garcia's treatment protocol

1 in this case?

2 A. Her complaints of diffuse low back pain, not
3 the complaints of radicular pain, which would have been
4 consistent with an anatomic rearrangement and acute
5 slip.

6 Q. In your opinion, in what way was the MRI
7 instrumental in guiding Ms. Garcia's treatment regimen?

8 A. Each MRI -- 1/26/11, the August MRI, and the
9 one in November 2012 -- demonstrated, fortunately, no
10 progressive slip over a 20-month hiatus. Excuse me.
11 22-month hiatus.

12 Q. Okay. Thank you.

13 Doctor, what factors should be present before
14 deciding to do a fusion surgery on a Grade II
15 spondylolisthesis?

16 A. Symptoms consistent with the nerve root
17 irritation either at L5 or S1, evidence of instability
18 on flexion and extension X rays, lateral views,
19 evidence of some type of progressive neurologic
20 deficit, watching the patient walk, as I did.

21 As the nerve roots get irritated, patients
22 will take on this posture: Flex at the hip and flex at
23 the knee because of the hamstring spasm. The patient's
24 complaint of progressive decrease in doing things,
25 sitting for prolonged periods, bending, standing. So

1 everything correlates. Symptoms, objective findings,
2 sometimes hyper reflexes. The nerve root's irritated,
3 so when you tap the knee, it jumps very quickly. We
4 call hyperreflexia.

5 The clinician takes all the symptoms,
6 findings, there's progressive change and corroborative
7 MRIs and X rays, and then decides that the patient has
8 maxed out on all the conservative treatment. Done the
9 exercises, has lost weight, demonstrated motivation.
10 And you discuss, these are your options. You could
11 wear a brace the rest of your life or consider an
12 operative procedure, which is called a fusion.

13 Q. What is your opinion whether -- as to whether
14 the conservative treatment was properly explored prior
15 to the interventional treatment by Drs. Lemper and
16 Kidwell?

17 A. In my opinion, it wasn't. It halted, even
18 though she stayed with Dr. Gulitz up through May of
19 2012, but there was hiatuses, breaks in the treatment.
20 And so you have to get back -- get the train back on
21 the track and start again from point zero.

22 Q. And -- and when you mentioned Dr. Gulitz, you
23 meant May of 2011, not 2012?

24 A. Excuse me. Did I -- did I say '12?

25 Q. I think so.

1 A. I meant May -- excuse me. That was May of
2 2011. Correct.

3 Q. And what evidence was there whether
4 Ms. Garcia engaged in any regular exercise programs
5 prior to submitting to the fusion?

6 A. There isn't any. There is one mention,
7 but -- and that was from that she used to exercise by
8 going up and down the stairs where she worked, but I
9 don't know -- that's just mentioned.

10 Q. Okay. Dr. Gross states in his January 7th,
11 2013, report, about 13 days -- 12, 13 days after the
12 fusion, he states, "Amazingly, her low back pain has
13 improved compared to prior to the surgery."

14 Would you agree with that statement?

15 A. I was --

16 MR. SMITH: Objection to the foundation.

17 THE COURT: Sustained. I think he answered
18 it that way too.

19 MR. MAZZEO: He answered it which way?

20 THE COURT: He wasn't there.

21 MR. MAZZEO: Oh.

22 THE COURT: Lacks foundation.

23 MR. MAZZEO: Okay. Fine. Fair enough.

24 BY MR. MAZZEO:

25 Q. Doctor, in the course of your reviewing

1 medical records, did you review Dr. Gross's records of
2 his consultations with Ms. Garcia pre- and postsurgery?

3 A. I was provided those, yes.

4 Q. Did that include a review of Dr. Gross's
5 postsurgical consultation on January 13th of 2013?
6 January 7th of 2013.

7 A. Yes, it did.

8 Q. Okay. And -- and did you note in your review
9 of Dr. Gross's record on January 17th of 2013 where he
10 states that amazingly her low back pain is improved
11 compared to prior to the surgery?

12 A. I saw that comment, yes.

13 Q. Okay. And do you have an opinion as to
14 whether you agree with that statement that Dr. Gross
15 made and inserted into his report on that date?

16 MR. SMITH: Object to the foundation.

17 THE COURT: It's the same question.

18 Sustained again.

19 BY MR. MAZZEO:

20 Q. Okay. What is your -- Doctor, what is your
21 understanding as to the purpose for the -- Dr. Gross
22 doing these multiple follow-up consultations between
23 January 7th of 2013, and December of 2015?

24 A. Well, there normally are post-op visits for
25 the first three months.

1 Q. Okay.

2 A. Depending on how the patient's doing at the
3 three-month period, we may say come back in six months.
4 In other words -- and then X rays along the way to
5 evaluate if the fusion is taking place. And getting
6 history as to any new symptoms, such as the right leg
7 symptoms, which were affirmed by Dr. Kidwell and his
8 physician assistant. In other words, things that occur
9 that normally weren't expected.

10 Q. Okay. Now, Dr. Kidwell refers to -- refers
11 to the fusion on 8/25 of 2014 as a failed low back
12 surgery syndrome. Can you tell the jury what your
13 understanding is of "failed low back surgery syndrome"?

14 A. The last word there, "syndrome," means a set
15 of symptoms, not just one thing. Failed back, as
16 Dr. Kidwell's opining, she's had surgery, but she's not
17 recovering as would be expected. She shouldn't be
18 having all the constant low back pain, as is recorded.

19 So meeting an expectation after a fusion --
20 and it can take a minimum of a year for the fusion to
21 take place -- but there's an expectation at six months,
22 patient returning, reintroducing their activities, and
23 their pain gradually subsiding. That it's tolerable.
24 Not that they're pain-free, but they're reintroducing
25 things. They're doing their exercises, weaning

1 themselves out of the brace, expectation.

2 The -- in Ms. Garcia -- unfortunately, in
3 Ms. Garcia's case, she now had pain into the right
4 thigh, numbness, and recurrence of her low back pain --
5 her preoperative pain. Dr. Kidwell opined that she had
6 failed back syndrome and discussed that she may need a
7 spinal cord stimulator. And that's at nine months
8 post-op, very early in the game.

9 Q. Now, what is your opinion of the benefit
10 Ms. Garcia received from the injection provided by
11 Dr. Kidwell on 9/27 of 2012?

12 A. You mean the preoperative.

13 Q. Pre-op. Correct.

14 A. Yes. On 9/27/12, there -- it was another set
15 of selective nerve root blocks, what had been done by
16 Dr. Lemper. And the -- it just didn't relieve her
17 pain. She said she had relief of a pain -- pain for a
18 day or two, same thing she told Dr. Lemper in 2011.

19 So, again, it's affirmation it's not the nerve roots --

20 Q. Doctor --

21 A. -- that are painful.

22 Q. Dr. Lemper and Dr. Kidwell testified at
23 trial, last week or a few weeks ago, that what that --
24 that relief was, in fact, diagnostic. Why do you
25 consider that not to be diagnostic?

1 A. Because she says she had improvement for a
2 day or two. She told me, when I asked her, that the
3 injection -- her comments to me were, "The injections
4 provided absolutely no relief."

5 Q. Okay. And now, you've -- in the course of
6 your -- your career, your clinical practice as well as
7 your forensic practice, you have evaluated patients who
8 have received injections, such as Ms. Garcia did, facet
9 blocks, as well as selective nerve root blocks; is that
10 correct?

11 A. Yes.

12 Q. And based on your education and training, do
13 you have an understanding as to why relief might be
14 reported following a procedure like a selective nerve
15 root block, albeit only temporary?

16 A. There's always some relief because of the
17 local anesthetic. Always. We have no control where
18 the local anesthetic goes, where it diffuses. In fact,
19 that was the comment that Dr. Kidwell made. We put
20 steroid in. That decreases -- that is -- steroid is
21 both an anti-inflammatory and provides analgesic. But
22 there's an expectation of what we expect from the
23 injection, some long-term relief, assuming we have made
24 the right diagnosis.

25 Q. Now, we know that Dr. Gross had recommended

1 to Dr. Kidwell -- he directed Dr. Kidwell to perform
2 both sacroiliac joint injection, lumbar facet
3 injection, and to inject the hardware as well.

4 A. Yes.

5 Q. What's your understanding of -- of why that
6 was done -- recommended?

7 A. Anatomically, it makes no sense. It was
8 attempting to relieve her back pain, the pain that
9 she's now having into her leg. When the surgeon --
10 when we start suggesting injecting in around the
11 hardware, we're highly suspect that we have loose
12 hardware, that there's a pseudarthrosis. That would be
13 the only reason to do that is -- even absent injecting
14 the SI joint, every MR that we looked at, her SI joints
15 are normal. Doesn't have any positive findings --
16 positive Patrick's test.

17 Her -- the L2-3 and 3-4 facets are normal.
18 Why would he inject those? But injecting the hardware
19 is indicative and suggestive that Dr. Gross is
20 concerned she has a pseudarthrosis.

21 Q. Okay. And based on the injections that were
22 performed by Dr. Lemper and Dr. Kidwell, did -- did
23 either of them ever identify the pain generator, the
24 source of pain, for Ms. Garcia?

25 A. No. Because she didn't get relief. She had