No. 71348

IN THE SUPREME COURT OF THE STATE OF NEVADA

EMILIA GARCIA,
Appellant,

v.

ANDREA AWERBACH,
Respondent.

APPELLANT'S APPENDIX
VOLUME XXI, BATES NUMBERS 5001 TO 5250

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a day or two of relief, as reported. As she shared with me, she went back to her preinjection set of symptoms and severity level.

Q. Doctor, what -- do you have a copy of the 11/19/2012 MRI report in your -- in your records?

A. I do. Do you want me to get it out?

Q. I want you to take a look at that. Here we go.

What I -- what I want to direct your attention to, Doctor, is -- is what is -- what is noted, particularly, at the levels L1-2, L2-3, and L3-4.

A. I have it in front of me now, Mr. Mazzeo.

Q. Okay. You do.

A. I have the 11/19/12 report.

Q. Okay. So what -- what did the radiologist identify with respect to the structures at L1-2, L2-3, and L3-4?

A. L1-2 disk demonstrates a 2.5-millimeter bulge. Thecal sac measures 1.71 centimeters. The L2-3 disk demonstrates a 2.3-millimeter posterior bulge. Thecal sac measures 1.64 centimeters. Bilateral facet arthropathy. The L3-4 disk is dessicated and demonstrates a 3.1-millimeter posterior bulge. Thecal sac measures 1.71-centimeter.

Q. And what indication, Doctor, is there from -- and you reviewed the study as well?

A. Yes. I was provided the study.

Q. And what indication -- or what is your opinion with regard to the cause of those bulges that appear on that November 2012 imaging study, which did not present or show up on either the January 2011 or August of 2011 MR studies?

MR. SMITH: Object to the foundation on the second part of the question.

THE COURT: Come on up.

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

THE COURT: So I guess, as far as the foundation, I will sustain it. Ask the other questions.

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

BY MR. MAZZEO:

Q. Okay. So, Dr. Klein, you told us what you noted with respect to those specific levels, L1 through L4, on the November 2012 report and your review of the film; correct?

A. Correct.

Q. Okay. What, if any, bulges did you note with respect to those same levels on the January 2011 film

and the August 2011 film?
A. Each -- each of the MRs show the normal physiologic bulging. That's normal. Bulging --
Q. Well, no. I want you to -- each of -- I want you to talk about now the January 2011 MR.
A. You want me to pull the report out?
Q. Yeah. And actually I will show you the report.
A. All right.
Q. I have --
A. That might be a little quicker.
MR. MAZZEO: Judge, I want to use the ELMO, please.
THE WITNESS: I have it in front of me, Mr. Mazzeo.
MR. MAZZEO: Okay. Well, that's -- that's fine. I just want to -- just so there's no confusion here.
BY MR. MAZZEO:
Q. And that's, for the record, Plaintiff's 19, page 5.
So specifically directing your attention to -- this is the January 26th, 2011, film. Directing your attention to the last paragraph.
A. On page 1 or page 2?

Q. Page 1.
A. The last paragraph?
Q. Yeah. What's noted by the radiologist with respect to the -- with respect to the disks at L1-2, L2-3, L3-4.
A. On the 1/26/11?
Q. Yes.
A. The last paragraph says there's mild desiccation, end plate changes, and Schmorl's nodes -- S-c-h-m-o-r-l-'-s -- at T11, T12, and T12-L1.
Q. Okay. And then I -- maybe your report is different. If you look on the screen, we're going to go based on this --
A. You want me to come over there?
Q. Well, you have it on your screen.
A. I guess I better turn this on.
Q. Okay.
THE COURT: Should be a button on the right side, at the bottom.
THE WITNESS: Okay. Right side on the bottom?
THE MARSHAL: Right there. See it?
THE WITNESS: Uh-huh.
BY MR. MAZZEO:
Q. Do you see it?

A. I can, but I need to --
Q. If you --
A. It says, there are no significant posterior or anterior intervertebral disk abnormalities at L1-2, L2-3, and L3-4.
Q. And that would indicate -- would that include that there was no presence of any bulging at those levels as of that date?
A. Correct.
Q. Okay. And then on the August 2011 MRI, were there any -- was there any indication of any bulges at those same levels as of August of 2011?
A. I would have to pull that one out as well.
Q. Sure.
A. Or do you have it handy?
Q. Actually, I can simplify it for you, Doctor. If you were to -- give me one second.
A. I have it in front of me.
Q. Yeah. Okay. Okay. So can you answer the question?
A. L1-2, L2-3, and L3-4, no significant abnormalities noted.
Q. So that would indicate -- and you also reviewed the films. So did -- that would indicate that there was no presence of any bulges as of August of

2011?

A. That's correct.

Q. Okay. So the first time that -- correct me if I'm wrong, the first time that we see the presence of bulges on an MRI study was 20 months after the accident in November of 2012?

A. The first reference to that, yes.

Q. Okay. And would those, in your estimation, be age-related changes or traumatically induced?

A. Age-related.

Q. Okay. When I asked you earlier -- and I just want to be clear for the jury. So when I asked you earlier, Doctor, with respect to -- and I believe I was referring to the L4-L5, the progressive that Dr. Hake in November of 2012 indicated that he thought there was a progressive change to the slipped vertebrae, and you -- your -- your response then was that there was no change between the January 2011 and 2012 report.

Did I state that correctly?

A. You did.

Q. Okay. But with respect to the bulge at L1-2, 2-3, 3-4, would that be considered a change between the reports?

A. No. It's simply mentioning something about them. Two radiologists said nothing, another

radiologist said something, but they're of no clinical significance.

Q. For any --

A. For anything.

Q. With regard to anything?

A. Yeah.

Q. Okay. Any indication that those bulges that appeared in -- or that are identified in November 2012 report, any indication that those could have resulted from an acute trauma?

A. No.

Q. Okay.

A. Because there's -- there's nothing to suggest any abnormalities. If you look -- we looked at that MR, and I showed you the axial images. We shared that with the jury at each level.

Q. And, Doctor, are all of the opinions you stated today to a reasonable degree of medical probability?

A. Yes.

Q. Okay.

MR. MAZZEO: Court's indulgence.

Your Honor, at this time I will pass the witness.

THE COURT: Mr. Strassburg, Mr. Tindall,

anything?

MR. STRASSBURG: Yes. A couple of questions, Judge.

THE COURT: Okay. Go ahead.

CROSS-EXAMINATION

BY MR. STRASSBURG:

Q. Dr. Kidwell, good afternoon.

A. Good afternoon.

Q. Just so we're clear, none of the conditions that were addressed by the surgery that Dr. Gross did were, in your opinion, causally connected to the collision; true?

A. True.

Q. None of the conditions addressed by any of the injections by Lemper or Kidwell were causally connected to the collision?

A. No. I previously opined that Dr. Lemper's selective nerve root blocks were causally related, as a diagnostic tool.

Q. But other ones weren't?

A. Correct.

Q. So just the first Lemper?

A. Yes.

Q. And the radiofrequency rhizotomy by

Dr. Kidwell, again, it would be your opinion that that was related to a condition that was not causally connected to the collision; true?

A. True.

Q. Okay. And would you also be of the opinion that complications resulting from Dr. Gross's surgery would be no more causally connected to the collision than the surgery was?

A. I agree. That is my opinion.

Q. Let me direct your attention to the screen. And this is from Exhibit 19, Dr. Hake's report, dated November 19, 2012, which records his observations about continued anterospondylolisthesis L5 on S1.

MR. STRASSBURG: Can I have the model, please?

BY MR. STRASSBURG:

Q. Do you see that?

A. I do.

Q. All right. And anterospondylolisthesis is a synonym for spondylolisthesis?

A. I have never seen it called anterospondylolisthesis. Never heard the word -- spondylo is understood. You can't have listhesis without a defect in the spondy or the bridge. So the proper word is anterolisthesis.

Q. All right. And so according to Hake, previously, the slippage measured 7.5 millimeters; and then currently, on November19th, 2012, he measured it at 1.02 centimeters. Do you see that?

A. I do.

Q. And how many millimeters is 1.02 centimeters?

A. 1.02?

Q. How many millimeters is 1.02 centimeters?

A. It's 102 millimeters.

Q. No. It's 10 millimeters.

A. Excuse me. 10 millimeters. 10.2.

Q. Right.

A. Yes.

Q. All right. So the difference, then, is 2.7 millimeters; right?

A. 2.7, that's correct.

Q. And does it seem appropriately reasonable to you that if a 7.5-millimeter offset increases 2. -- I'm sorry. Let me withdraw that.

Does it seem reasonable to you that if a 7.5-millimeter offset increases by 2.7 millimeters, that is over a 30 percent increase?

A. Yes. That would represent that.

Q. And would you expect that a -- an over 30 percent increase in offset would be readily apparent

by comparing the MRIs involved?

A. Yes. And I did do that.

Q. Now, let me direct your attention to the -- the first page of Dr. Hake's study. And this -- you know, this was an aspect pointed out by Mr. Roberts, in a comment I appreciate. And it says the prior study was dated January 27th, 2011; right?

A. I see that on the screen. Uh-huh.

Q. Okay. And we all know that what he's talking about there is -- is the January 26th, 2011, study that the radiologist signed the next day; right?

A. Yes. But, you know, we see that all the time in terms of the date dictated and the date typed. Correct.

Q. Okay. And if -- if we look at the -- that study, on January 26th, which I'll show you now. You have that on the screen in front of you?

A. I do.

Q. And you can see it?

A. Yes.

Q. Okay. That's pretty good. All right.

So the January 26th study, the offset was 4 millimeters, L5 on S1; right?

A. Yes.

Q. But Hake, in November of 2012, is talking

about a 7 1/2-millimeter offset; right?
A. Yes.
Q. But there was another study; right? Remember when that was done?
A. August 19th.
Q. So directing your attention to the August 19th study. And there the offset is 8 millimeters --
A. Correct.
Q. -- L5 on S1; right?
A. Right.
Q. Okay. Now I'm out of bullets. I don't have one at 7 1/2 millimeters. Do you know of one?
A. No.
Q. Okay. Now, let me ask you a couple of questions about the first slide Mr. Mazzeo showed you, which in -- which I have as Slide 11, but it was his first one.
MR. STRASSBURG: Permission to show the slide, Judge?
THE COURT: I don't know what it shows. Is it one that we've --
MR. STRASSBURG: It's one we have already --
THE COURT: -- seen before?
MR. STRASSBURG: -- discussed, yes.
THE COURT: That's fine.

MR. STRASSBURG: Thank you, sir.
BY MR. STRASSBURG:
Q. All right. Now, we have talked about the offset. Do you remember you came down here, and we did the thing with the lights, and -- remember that?
A. Yes.
Q. Okay. The lights are fine. I'm okay.
So that's the offset here, and that's already been covered, and I don't want to belabor it. But what I want to draw your attention to is this. Now --
MR. STRASSBURG: Judge.
THE COURT: Come on up, guys.
(A discussion was held at the bench, not reported.)
THE COURT: All right, folks. We've just been talking logistics. Tomorrow's a Wednesday, so we can start at 9:00 o'clock. We've got another defense expert that's scheduled to be here in the morning. We're going to finish up with, I believe, Dr. Klein tomorrow as well, after that. But let's start at 9:00 o'clock. And it will be a full day. Okay?
Sorry to interrupt you. Go ahead, Mr. Strassburg.
BY MR. STRASSBURG:
Q. All right. Would you come down here, Doctor,

please. Why don't you stand on this side? Now, this is, on the left panel, the January 26, 2011, study. And on the right panel, it's the November 19th, 2012, study; right?

A. Yes.

Q. And would you identify this triangularly shaped location.

A. Well, if I might -- it's actually a quadrangle. But this is perineural fat, the hyperintense white. This is the nerve root. This is the back of L5. This is the top of the sacrum here.

So maybe I should stand over there.

Q. Why don't you stand over here. That way, she cannot hear me.

A. So this is actually -- it appears the trauma was actually a quadrangle, because there's a nerve root up here. It doesn't taper off and close. So this is the neural foramen. This is the -- white part is perineural fat. It always accompanies the nerve root. And this is the nerve root as it's coming through -- you can put your -- if I might so you can see it.

Q. So it's like this; right? That's how we're doing it. It's this way; right?

A. Correct.

So -- but it's oblique. Correct.

Q. Go ahead. Keep going.
A. It's demonstrating -- this is the -- the nice and the bad things about MRs. It's a slice, called a parasagittal slice, not right down the center, but parasagittal, demonstrating the nerve root as it's traversing the neural foramen before it exits. And what we like to see is fat around the nerve root. This wasn't shown, as the other ones, that -- the accompanying small vessels. And then, 22 months later, the same configuration.
So appropos to all these measurements you've been discussing, they have no significance because if this moves 4 millimeters or 8 millimeters, as -- as each different radiologist, you're going to see a change. But more importantly, you're going to see symptoms, because the nerve root is not very forgiving if you move it even 4 millimeters or even more, 8 millimeters.
Q. Okay. So the -- the white stuff around -- the nerve root is the center that's --
A. The dark.
Q. -- and the white stuff around is the fat; right?
A. Yes.
Q. And are these -- in looking at the

January 26, 2011, nerve root at L5-S1, comparing to the same location on November 19th, 2012, are those nerve -- nerve roots, are they impinged at all?

A. No. In my opinion, these are the same -- the images are the same, taking in consideration some very minimal changes -- technical issues with MRIs.

Q. Okay. Are they irritated at all?

A. There's -- no. There's no extrinsic pressure on the nerve root.

Q. Okay. Now --

A. And you can't see irritation on an MR. That's --

Q. Talk to them. I --

A. You can't see irritation on an MRI. If the nerve root is irritated, it's not very forgiving. It doesn't like pressure. And on the periphery of the nerve root, if this is -- think of a coaxial cable. The way the nerve was designed, the sensory fibers on the outside -- because the motor fibers are much more important. Paralysis comes from motor fiber damage, a little numbness and tingling or pain from the periphery.

So the nerve root sends out a message immediately if you have pressure on the nerve root by means of immediate pain into the nerve that it's

supplying.

Q. Okay. But Hake -- this one, on November19th, 2012, this is the one that Dr. Hake said is over 30 percent more constricted than something else, like this one.

MR. SMITH: Objection. Misstates the reports.

THE WITNESS: You got an objection.

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

BY MR. STRASSBURG:

Q. Yeah. Explain.

A. You're talking about an MRI report. You never hang your hat on an MR report. It's a diagnostic study, an adjunctive study. How does it correlate to the symptoms? If there's a change -- right? -- there has to be a symptom that goes along with it, not just on an MR. We don't operate on MRIs. We use them to affirm or deny symptoms that don't make sense or symptoms that do make sense. That's the whole point of any diagnostic study. They help us.

But the important thing is you can make the diagnosis of nerve root irritation. And we did it for 50 years before MRIs were around.

Q. Okay.

A. Shall I stay here?

Q. Yeah. Stay there.

All right. Now, we have heard testimony from Dr. Gross regarding this January 26th, 2011, image, Series 3, Image 11. Let me call it up here. Hold on. I'll put it up on the screen.

All right. Okay. Now, we heard testimony from Gross that this nerve root between L5 and S1, it was, as he put it, unhappy because it was flattened. So, now, is this nerve root here the same as -- wait a minute. Sorry. Wrong one.

So is this nerve root here that Dr. Gross fingered as the cause of the pain the same location as this nerve root here?

A. Yes.

Q. Well, then, how come they look so different?

A. Can you sharpen that image. There's a halo around the -- or decrease the magnification.

Q. No.

A. All right.

Q. No. Sorry. That's what we've got.

A. So, again, you have to appreciate --

Q. And, Doctor, you're in the way.

A. Okay. It can be frustrating. As we make the slices through, you see the bottom of L5, the top of S1. You see the front of the foramen right here. You

don't -- because of the slice, 4-millimeter thick. You actually don't see the bone. This nerve root --

Q. Here. Why don't you step over here. Watch this. Okay. Try it from there.

A. This nerve root is exiting -- this piece is in here. But you can see it. It's here. It reformats on the S1. It's not flattened at all. It's of the name -- same thickness here, reconstitutes here, and comes down before it exits out the S1 neural foramen.

This is the same thing that we demonstrated to earlier on that coronal view of those beautiful S1 nerve roots draping around. You have that, the same image.

Q. So do you have an opinion to a reasonable medical probability as to whether this image here on January 26th, 2011, of the nerve roots shown on our Slide 11 compared to the 11th photo that Dr. Gross has previously testified to showing a nerve root in the same condition of nonimpingement?

A. In my opinion, there's no evidence of impingement. It's not stretched. It's as the same configuration as that. Different slice, 4 millimeters or 5 millimeters difference.

Q. Okay.

A. Again, when this is done, there are no

symptoms suggestive of nerve root impingement on the S1 nerve root.

Q. Okay.

A. You wish me to stay here or sit down?

Q. Hold on a minute. Let me look. Yeah. Why don't you stay there a little bit.

Now, let me ask you about the disk. Now, is there protrusion by the disk beyond the vertebra?

A. You mean anteriorly or posteriorly?

Q. At the back.

A. No. It's tapered. 1/26/11, it tapers. It always does that in a chronic slip. It tapers. The disk over here gets -- there's no pinched piece. Sometimes they'll pinch in an acute slip. And you can see the resolution isn't as good here as there. But the disk is right here. And it gradually tapers. Exactly what you see on the little sharper images, the first set that we did earlier today.

Q. Okay. Now, remember talking about this slide, which is my Slide 25?

A. The one I was referencing earlier?

Q. Right. If I could just show you now.

Okay. So is this here an accurate depiction of what the spine looks like viewed from the front?

A. Yes.

Q. And you doctors call that coronal; right?
A. Well, it's not a slice; it's just an anterior view.
Q. Okay.
A. Coronal, yes.
Q. So this view is this view; right?
A. No. Because this -- this is an oblique view. And it shows anterior divisional fibers. This is the L5 nerve root leaving posteriorly.
Q. Okay. And so that would be this nerve root shown here?
This nerve root here?
A. No. It's this part of the nerve root here, this one here that's coming down to make up the sciatic nerve.
Q. I see. Okay.
A. The anterior divisional/posterior divisional fibers.
Q. So this here -- this area here --
A. Yes.
Q. -- and this here --
A. Yes.
Q. -- is this nerve root here --
A. The nerve root right here.
Q. -- right?

A. Uh-huh.
Q. Only, through the MRI, you can look inside the vertebra which is opaque on the picture; right?
A. Well, you can see what it shows because it's this shape. It's -- I said oval before. You're looking at the top up in here. You're seeing -- you see how much wider it is? This is the top of the sacrum here, the sacral promontory. It's a lot bigger than a vertebral body.
Q. Okay. So we're looking at it from this way?
A. Uh-huh. Yes.
Q. This way. Okay.
A. Actually, you're looking at it this way.
Q. Okay. And so what you're seeing are these nerve roots coming out here unobstructed?
A. Like this.
Q. Yeah. Like I said.
A. Oh.
Q. These nerve roots here coming out unobstructed?
A. Yeah. Isn't it beautiful? Beautiful, pristine nerve roots here, here, and here. Exactly.
Q. Okay. And what's this stuff on either side of them?
A. This is the spinal canal. These are the --

the pars and the facet joints here and here. See the facet joint here where it's dark? This is -- and this is the neural foramen. I have been using -- talking about this today. Entering the neural foramen on the pure axial images, we talk about the lateral recess. Here's the nerve root coming out forming that plexus right there.

Q. Okay. So if we call up a cutaway view of what we're looking at here -- oops. Let me move that.

Okay. So as a cutaway view, then, this -- these are -- this is the --

A. Cauda equina.

Q. The cauda equina, the rootlets?

A. Yes.

Q. And this is the conus medullaris?

A. Conus medullaris.

Q. Right. And then these -- the roots come out, and they come down. And this is where they -- they go between -- this is the foramen; right?

A. Yes.

Q. So these are the -- where the -- the roots come out through here; right?

A. This nerve root here is this nerve root here.

Q. Okay. And if this nerve root here was squished between those bones here, would that be

visible on an MRI?

A. If it was squished?

Q. Impinged?

A. Yes. If you say "squished," you're going to fail your boards. You've got to say "impinged."

Q. I'm on a time budget here.

A. But proper terminology is important.

Q. Okay. And there isn't any here; right?

A. No, there isn't any.

Q. Okay. Now, you have -- you have offered -- you can sit back down.

A. Thank you.

Q. You have offered opinions that the explanation for the plaintiff's continued pain since the surgery is nonunion of the bone grafts and the surgical construct which you call pseudarthrosis; right?

A. Yes.

Q. And the cause, you said, was micromotion. Yes?

A. Yes. Micromotion in the same plane reduces pseudarthrosis if you don't have a stable construct.

Q. Is there anything about the configuration of Dr. Gross's construct which, in your opinion, created this micromotion?

A. Yes.
Q. Explain.
MR. SMITH: Objection. Exceeds the scope of his opinions.
THE COURT: Come on up.
(A discussion was held at the bench, not reported.).
THE COURT: All right. You're going to rephrase the question; correct?
BY MR. STRASSBURG:
Q. Okay. Without pointing any fingers critical of Dr. Gross, can you explain how the surgical -- what you've been calling the surgical construct led to this micromotion which led to the -- the nonunion, the pseudarthrosis?
MR. SMITH: Objection. Exceeds the scope of his opinions.
THE COURT: I'm going to let him explain.
Overruled. I'm going to let him go.
THE WITNESS: Dr. Gross clearly identified in his operative report of 12/26/12 he couldn't get purchase of the pedicle screw in L4. So you're left with an asymmetrical construct. And the -- the rod that's there, he used the same length rod, is an irritant.

But with an asymmetrical construct, you're never going to get the same weight-bearing characteristics along the biomechanical stress lines. You create -- instead of a square, you create a rhomboid. So you create torsion around a moment.

BY MR. STRASSBURG:

Q. May I stop you a minute, Doctor. You used the term "rhomboid."

A. Yes.

Q. And I would request permission to show Panel 6 from the plaintiff's demonstrative exhibit on the surgery.

THE COURT: I don't have any idea what that is.

MR. SMITH: If it's what you have on your computer, we have no objection.

THE COURT: Okay.

BY MR. STRASSBURG:

Q. Just so it's clear what you're talking about, when -- when you -- could you come on down, Doctor, and just show -- explain to us what you mean by this rhomboid.

A. This is pedicle screws on the left at L1 --

Q. Doctor, you're kind of in the way.

A. Oh, okay. Okay.

Pedicle screws here, S1-L5-L4, on the left side. Pedicle screws, S1-L5. No pedicle screw here. So you have a rhomboid configuration this way. And when you have -- when you don't have this, and you have weight-bearing stress here and its unequal to here, it's an asymmetrical stress.

So the choice, when you're left with that situation, if you can't get purchase here, like he said, you put a connecting rod across here. And he discussed doing that. He chose not to. Or you put a crossbar here.

So you create a rigid construct in the shape of a rhomboid instead of a square or rectangle. This is not acceptable. You can't leave it like this, because you're going to create a moment, motion around a point, leading to a pseudarthrosis.

Q. Okay.

A. Basic physics.

Q. Well, I don't know. This -- this -- you used the term "moment." Right?

A. Moment.

Q. I mean, what do you mean by -- I mean, you don't mean, like, a moment, oh, how sweet; right? You mean something different; right?

A. An axis of motion, an axle -- right? -- like

on your car. Your car goes -- we -- tires connect to an axle. Okay?

A point -- a particular focus or loci where motion occurs.

Q. Well, how does this construct on this graphic, Panel 6, how does that create this moment you talked about?

A. Because -- you want to create a rigid construct because when -- when you have movement this way -- remember, that the -- that -- if I'm twisting here, I'm creating motion around a point. That's what a moment is.

And if you want to make it rigid so it all fuses into one big piece of bone, you have to have symmetry. It's a basic thing. You can't -- you can't leave it like this. If you can't get a screw, you put a hook in and then you do it. Then you create the construct.

Q. And the hook, you -- you put that here?

A. Yes. Right under L4. It looks -- it has the option. And then you can put the rod from there to there to the hook. Yeah. It's in every set.

Q. Okay. And was this location at L4 appropriate for such a hook?

A. Yes.

Q. Can you enlighten us as to whether the same amount of bone was removed by Surgeon Gross on the right side and the left side, or was it different?

A. In his operative report he talks about using the Kerrison ronjeurs, taking off inferior lamina of 4. I would say it was pretty much symmetrical.

Q. All right. When he removed the facet at L4-L5 and left some facet at L4-L5 on the left side --

A. Right.

Q. -- is -- can you enlighten us as to whether that plays any part in this motion -- or micromotion?

A. It just creates instability. The facets are what create the weight-bearing stability, each facet that you demonstrate on the X rays and also on the MRs and on the models.

Q. Now, also, we have seen and heard some testimony here by Dr. Oliveri, who has shown us and the jury a disk model.

Do you see this?

A. Yes.

Q. After your review of the axial images of the MRIs, did you see anything on those MRIs from January 26th, 2011, to November 12th, 2012, that -- that even remotely resembles this model?

A. None. There is no MR axial image that shows

that.

Q. Would you expect there to be one if that was in fact the true condition?

A. Be one what?

Q. I mean, would you -- if -- if one of her disks really did look this herniated, would you expect that to show up on an MRI, or would that be something they don't get?

A. No. It would be easily seen on an MR. And losing this portion of the nucleus, this would create a surgical emergency. This is a -- it would almost create paraparesis to have that much. It would block the entire canal and get every nerve root that's going by, 4, 5, and S1.

Q. In your review of the medical records and the MRIs, do you agree with Dr. Gross that there was no pars fracture?

A. I would agree there is no pars fracture; there is a defect, a congenital defect.

Q. And, to your knowledge, was the history of the accident that you reviewed and questioned Ms. Garcia about, was it adequate to explain a disruption of the -- the pars defect sufficient to allow slippage by L5 on S1?

A. When you say "the history," the type of

impact, the side impact?

Q. Yeah.

A. It could, yes, that type of impact. I've seen that happen. I just testified today, I'm involved in a similar case.

Q. All right.

A. A side impact.

Q. So you don't know whether the forces in this accident were great enough or not; right?

A. I don't. I focus on the history that goes along with an acute slip. That's what's lacking.

Q. And at the time of the surgery on December 26, 2012, the hooks that you mentioned that could substitute for pedicle screws, were they freely available on the surgical market?

MR. SMITH: Object to the foundation.

THE COURT: Sustained.

MR. STRASSBURG: I don't think I have anything more, Judge. I wanted to be done by 5:00. You look surprised.

THE COURT: I am a little surprised, but that's okay.

Mr. Smith, you just want to wait till tomorrow?

MR. SMITH: Up to you. I'm ready to start.

We can shave ten minutes off of it.

THE COURT: Go for it.

Cross-exam.

CROSS-EXAMINATION

BY MR. SMITH:

Q. Good afternoon, Dr. Klein.

A. Hi, Mr. Smith.

Q. During opening statements, Mr. Mazzeo told the jury that you are, quote, an orthopedic surgeon specializing in diagnosing and treating spinal injuries. Are you aware of that?

A. Yes.

Q. Would you agree that you are an expert in treating spinal injuries?

A. Absolutely.

Q. You would agree that you have not had very much experience treating spinal injuries since the late '80s; right?

A. No. That's not true at all.

Q. Okay. You would agree that Dr. Gross, Dr. Cash, Dr. Lemper, and Dr. Kidwell have significantly more experience treating spinal injuries in the last 15 years than you do; correct?

A. No --

MR. MAZZEO: Objection. Speculation. Foundation.

THE WITNESS: No, they don't.

BY MR. SMITH:

Q. Okay. Then let's talk about your experience, Doctor.

As you testified earlier, you did a one-year rotating internship at Scott Air Force base from 1966 to 1967.

A. Correct.

Q. The total amount of time that you spent during that year on orthopedic surgery was two weeks; right?

A. That's normal. Yes.

Q. For the four years after that, you were a general medical officer in Germany?

A. Correct.

Q. During those four years, you never performed a single spine surgery; right?

A. I did not.

Q. After those four years, you were chief of dispensary services at the same Air Force base in Germany for two years?

A. During the same four years.

Q. During the same four years you were chief?

A. Yeah.
Q. Okay. So, again, you didn't perform any -- any spine surgeries while you were chief of dispensary services; right?
A. It was an outpatient facility.
Q. After those two years, you spent four years in residency starting in 1971 at Lackland Air Force Base; right?
A. That's right.
Q. Of those four years, you estimated only 12 to 18 months were spent on spine-related issues?
A. Yes. A total during the four years.
Q. During those four years, you never once performed a spine surgery as the primary surgeon; correct?
A. The residents aren't identified as primary. The staff is the primary surgeon.
Q. The spine surgeries that you assisted on where you were not the primary surgeon were entirely different from the surgeries that are performed today; correct?
A. In terms of instrumentation, that's correct.
Q. Right. The instrumentation used back then is very different from, for example, what Dr. Gross placed in Ms. Garcia; correct?

A. That's correct.
Q. In fact, the -- the instrumentation that Dr. Gross placed in Ms. Garcia wasn't even invented back then; correct?
A. That's correct.
Q. The materials that it's made from are completely different nowadays; correct?
A. Correct.
Q. Now, after that time -- after your residency, you spent two years as a staff orthopedic surgeon at Mather Air Force Base; right?
A. Mather. That's correct.
Q. Thank you.
That was 1960 -- 1976 to 1977; right?
A. '75 to '77. Two years.
Q. During that time, you were not equipped to take on major trauma; correct?
A. No. We weren't equipped to do major polytrauma.
Q. And the surgeries you were performing during that time period were primarily total hips, total knees, fractures, hip fractures, and wrist fractures; right?
A. No. I did cervical fusions, some lumbar fusions. I think I testified in my depo, 12 to 15.

Q. You did about 12 to 15?
A. Yeah, I think so. Uh-huh.
Q. And not all of those were lumbar fusions; right?
A. No. As you -- as I responded to your question, I did a cervical fusion using the Cloward technique.
Q. And what you're saying is that the fusion techniques that you used back in the '70s are very different from the techniques that are used today; correct?
A. Not the exposure or the anatomy. It's the instrumentation. We didn't have the plates or the screws. We used something -- accomplished the same thing when we left the OR.
Q. Well, there's another thing you didn't have back then, which is MRIs; right?
A. We did not have an MRI.
Q. And you didn't have the ability to use MRIs in your surgical planning; right?
A. No. We relied on cervical myelograms.
Q. You told me at your deposition that your time at Mather Air Force Base, you had done five to seven lumbar fusions; right?
A. At the most, yes.

Q. During that same time you were also at Twin Lakes Hospital and you were not performing spine surgeries at Twin Lakes Hospital; right?

A. I was not.

Q. You were not fellowship-trained; right?

A. That's correct.

Q. You agree that fellowships are beneficial and advantageous for a doctor's training; right?

A. Yes, they are.

Q. They allow a surgeon to hone his or her skills and problem-solving abilities; right?

A. Yes.

Q. They allow a surgeon to learn what works and what doesn't work; right?

A. Yes. As I testified, the fellowship is focusing on problem-solving, yes.

Q. One of the other things that said -- that you said is that a fellowship allows surgeons exposure to instrumentation issues that they might not have seen in their residency; right?

A. Yes. Because it varies from one residency to the other how much exposure they get. That's correct.

Q. And you understand that Dr. Cash completed a fellowship with Bob Watkins at USC?

A. I do.

Q. And his -- his fellowship was specifically focused on the spine?
A. Yes. It was a called a spine fellowship.
Q. You understand that Dr. Gross has -- has a fellowship in spinal biomechanics from the University of New Mexico?
A. Yes.
Q. And his fellowship was under Dr. Benzel, who is regarded as one of the fathers of spinal biomechanics and is a highly regarded spine surgeon; right?
A. I have no reason to doubt that. I don't know Dr. Benzel.
Q. Now, going back to your experience. After what we talked about in 1977, you went into private practice; right?
A. Correct.
Q. You were in private practice from about 1977 until the late '80s or early '90s; right?
A. Well, the only break was in '91, when I got activated for Desert Storm. But I didn't leave private practice; I was on active duty for five months.
Q. Okay. Well, after Desert Storm is when you really started doing expert work; right?
A. Yes. After that.

Q. Okay. So let's talk about the period before that, when you were in private practice and primarily focused on your clinical practice. Okay?
A. All right.
Q. In your clinical practice during that period, you were focused on shoulders, hips, and knees; right?
A. For the elective surgery, yes.
Q. Right. And during that time period, you did maybe 25 to 30 elective lumbar fusions; right?
A. Where I was the primary, that's correct.
Q. But you've never been the primary surgeon for an anterior interbody fusion using cages; right?
A. I have not.
Q. And you've only been the assistant surgeon for one of those at most five times; right?
A. Probably so. Yeah. Five times.
Q. You've never placed a cage during a lumbar fusion; right?
A. I have not.
Q. You've only placed eight to ten pedicle screws; right?
A. Probably eight to ten, yes.
Q. And that's in your entire career; right?
A. In my entire career.
Q. Turning to spondylolisthesis, you've only

been the primary surgeon to fix a spondylolisthesis approximately 10 to 12 times, that's what you told me?

A. Yes. I think 10 to 12 times as primary, yes.

Q. And the last time you were a primary surgeon to fix a spondylolisthesis was in 1988 or 1989; right?

A. That's correct.

Q. So 27 or 28 years ago?

A. Yes.

Q. You would agree, as we sit here today, that the surgery to fix a spondylolisthesis in 1989 was very different from the surgery to fix a spondylolisthesis today; right?

A. No, not -- not significantly different other than the instrumentation. The concepts, the biomechanics, what you set out to do, no, that hasn't changed because the anatomy hasn't changed.

Q. No cages in the '80s?

A. There were no cages.

Q. No bone grafts placed in cages in the '80s?

A. Cages didn't exist.

Q. No rods and pedicle screws in the '80s?

A. Not the rods we have now, no. Different rods.

Q. And you're talking about Harrington rods?

A. Harrington rods or the Dubousset system.

Q. And those are very different instrumentation from what Dr. Gross is using here; right?
A. Yes. Because of the -- the metals today allow for bending and contouring to the lumbosacral angle.
Q. Now, you understand that Dr. Gross and Dr. Cash have performed thousands of spine surgeries; right?
A. I don't know the numbers, but I'm sure a lot.
Q. You would expect that they both have hospital privileges to perform spine surgery; right?
A. Yes.
Q. You do not have hospital privileges anywhere to perform spine surgery; correct?
A. No longer. That's correct.
Q. You are not insured to perform spine surgery; right?
A. I am not.
Q. You would agree that Dr. Gross has spent many hours with Ms. Garcia over a long period of time; right?
A. I would think so.
Q. You met her one time; right?
A. Yes.
Q. And the time that you met her was nearly two

years after her surgery; right?
A. Yes. 21 months.
Q. Now, if you had a close friend that needed a lumbar fusion --
A. Yes.
Q. -- you wouldn't do that yourself; right?
A. No. It's not even considered appropriate.
Q. It wouldn't be appropriate for you to perform it; right?
A. Well, you don't operate on close friends.
Q. Okay. If you had a patient come to you that needed a lumbar fusion, you wouldn't perform it yourself; right?
A. No.
Q. You testified earlier that you would refer your patient to a specialist; right?
A. To the spine team at the university. Correct.
Q. And if you had a patient who required a surgery to fix a spondylolisthesis, you would refer that person to a specialist; right?
A. To a spine surgeon, yes.
Q. Now, you agree that there are many spine surgeons in Nevada, and in California where you're from, that could have been hired to offer opinions in

this case; right?

A. Yes. I know there are some. I don't know if there are many, but I know there are some, yes.

Q. You're not the only orthopedic surgeon that does expert work in the state of Nevada; right?

A. No.

Q. Thank you.

And you understand and you know from your experience that there are orthopedic surgeons who specialize in spine surgery and are active spine surgeons that offer opinions for the defense in cases like this; right?

A. Yes.

MR. SMITH: I don't know how late you want to go, Your Honor.

THE COURT: Probably about right now.

MR. SMITH: Okay. That's -- the note I got handed was 5:00 p.m.

THE COURT: Let's go ahead and take our break, folks, especially since we're coming back at 9:00 o'clock in the morning and tomorrow's going to be a full day. So during our break, you're instructed not to talk with each other or with anyone else about any subject or issue connected with this trial. You are not to read, watch, or listen to any report or other

commentary on the trial by any person connected with this case or by any medium of information, including -- without limitation -- newspapers, television, the Internet, or radio.

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

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

See you tomorrow at 9:00. Have a good night.

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

THE COURT: We're outside the presence of the jury. Anything we need to put on the record, guys?

MR. MAZZEO: No, Your Honor.

THE COURT: All right. Off the record.

(Thereupon, the proceedings concluded at 5:01 p.m.)

CERTIFICATE OF REPORTER

STATE OF NEVADA)
) ss:
COUNTY OF CLARK)

I, Kristy L. Clark, a duly commissioned Notary Public, Clark County, State of Nevada, do hereby certify: That I reported the proceedings commencing on Tuesday, March 1, 2016, at 10:00 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 1st day of March, 2016.

Kristy Clark

KRISTY L. CLARK, CCR #708

CASE NO. A-11-637772-C

DEPT. NO. 30

DOCKET U

DISTRICT COURT

CLARK COUNTY, NEVADA

* * * * *

EMILIA GARCIA, individually,

Plaintiff,

vs.

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

Defendants.

REPORTER'S TRANSCRIPT

OF

JURY TRIAL

BEFORE THE HONORABLE JERRY A. WIESE, II

DEPARTMENT XXX

DATED WEDNESDAY, MARCH 2, 2016

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

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I N D E X

LAS VEGAS, NEVADA, WEDNESDAY, MARCH 2, 2016;

9:05 A.M.

P R O C E E D I N G S

* * * * * * *

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

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

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

Do the parties stipulate to the presence of the jury?

MR. ROBERTS: Yes, Your Honor.

MR. MAZZEO: Yes, Your Honor.

THE COURT: All right. We're not finished with Dr. Klein, but we're going to have another witness before we finish Dr. Klein. If you guys can keep all this straight, more power to you.

Who's our next witness?

MR. MAZZEO: Judge, it's Dr. Thomas Ireland.

THE COURT: Okay. Come on up, sir. Now, you step all the way up on the witness stand. Once you get

there, if you please remain standing and raise your right hand to be sworn.

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

THE WITNESS: I do.

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

THE WITNESS: Okay. Thomas Robert Ireland.

MR. MAZZEO: May I proceed, Your Honor?

THE COURT: Go ahead.

MR. MAZZEO: Thank you.

DIRECT EXAMINATION

BY MR. MAZZEO:

Q. Good morning, Dr. Ireland.

A. Good morning.

Q. Would you tell the jurors what your occupation is?

A. I'm an economist. I guess I would describe myself -- for most of my adult life, I have been a college professor of economics, but I quit doing that as of 2006. I haven't taught any classes since then. And now what I'm doing is what I am doing here, working

for attorneys and testifying in court cases.

Q. Okay. And how long have you been doing that for?

A. Well, actually, I had my first case -- was in 1974. And so I have been doing it -- this is my -- working on my 42nd year.

Q. Okay. Okay. And would you describe your educational background after high school?

A. Yes. I went to Miami University of Ohio and earned a bachelors of arts degree in economics in 1964.

Then I went from there to the University of Virginia, where I earned my PhD in 1968. In economics. I'm sorry.

Q. And what does the field of economics encompass?

A. Well, in -- in many ways, we cover a lot of things, but I have often said economics is the science that looks at the implications of the fundamental economic problem, which is that there are scarce resources and unlimited wants for what those scarce resources could produce.

But, actually, economics can apply to almost any aspect of life where people have to make choices where they give up something in order to get -- to receive something else or use the resources they have

to combine them and -- and earn an income, earn or -- buy goods and services that improve the quality of your life, and you have to choose between what sets of goods and services and so forth.

Q. Let's define that a little bit more for the jurors.

Can you tell them what the nature and scope of your work is as a forensic economist?

A. Well, in forensic economics, first of all, it just -- it's a term that says, we have special obligations for how we go about being economists because there are -- are rules about how you testify that you have to be very careful about not violating those legal rules because there's some things you're just not allowed to talk about or mention in a court case without causing a mistrial or something of that sort.

But, also, every legal venue that you go into has somewhat different rules for how certain things should be done. And if you're going to be testifying, you have to know what those rules are and comply with them. But we essentially are still being economists.

It's -- the forensic part has to do with the fact that you need to know those legal rules and you need to comply with them. The economics part is how

you go about it. But we often are answering questions, as in this case, there's an issue of loss of household services.

Well, most economists would not be looking at trying to figure out what one person's loss of household services would look like. They'd be studying a whole market full of all people who are doing -- making -- creating household services.

So we're focused on individuals, when we go into a courtroom situation, in places where most economists doing regular research would not be looking at specific people. They would be looking at generalities of what a large body of women at a certain age might produce in the way of household services or men at that same age would be producing of household services and so forth.

Q. Okay.

A. We are going to rely on those -- we have to rely on those broader categories in order to apply them to an individual, so we're still economists.

Q. And with respect to your degrees, you have degrees -- you have bachelor of arts?

A. Bachelor of arts and a PhD. And those are the two degrees that I have.

Q. Okay. And what postgraduate training and

experience have you received over the years?

A. Well, not really much of -- I mean, basically, once you've got a PhD, you've got as high a degree as you can -- you can get unless you want to go get a second PhD, or some people do go back and get masters in different fields and that sort of thing.

But I have never had any postgraduate education formally, other than the experiences I have teaching in college classes and working as a professional, publishing in journals, and so forth.

Q. And maybe my question wasn't clear. I was asking about the training or the experience that you received after you finished your schooling, after you obtained your PhD.

A. Well, the experience is -- the first -- my first experience -- set of experiences was as a college teacher. Now, those started a little bit before I got finished my PhD. My very first class was as a graduate student teaching high school teachers, all of whom were a lot older than me. And that's certainly not a problem I have now, but I think I grew a mustache to try to look a little bit older at that time than I did.

But from I -- that was in 1966 or '67 that I taught that first class. And I -- you -- I moved around a few years. I taught at Loyola University of

Chicago; at Perdue University in Hammond, which is in the Chicago area; Illinois State University; University of Wisconsin Milwaukee. And I came to Saint Louis, where I now live, in 1972, where I -- the first year I was there, I was actually there on a half-time basis and -- as a trailing spouse to my first wife. And she -- she went -- ended up leaving, and I stayed. And I have been at the University of Missouri at Saint Louis. I was -- and still there. In a sense, I'm now a professor emeritus, which means they give me certain privileges, but they no longer pay me anything.

And --

Q. And how many publications have you authored during the course of your career in the field of economics?

A. Well, first of all, all of my publications in the early years had to do with economics in general and the courses I was teaching because I started teaching in college classes in 1968 on a full-time basis.

And as of 1974, the first experience I had working on one of these cases -- like, I had one or two cases a year, and they really didn't affect me very much, but I did discover students absolutely love to learn about what happens in a courtroom. I mean, you had this usual thing where students are bored stiff

with economics, but suddenly you're talking about what happens in a personal injury case that you were involved in, and everybody wakes up immediately and they're fascinated as long as you talk about it.

But I continued being a teacher then until I gave up tenure and became professor emeritus as of 2002. And I must say, the term of professor emeritus just means you haven't done anything to really irritate the administrators or anybody in your department. So once you formally give up tenure, they give you that award as long as you -- as long as you haven't done anything to make them not give it to you. But I have continued in that role ever since, and it -- I -- my last -- I -- immediately following retirement, I had one -- I was given one class a year to teach as part of the retirement package that I accepted.

And once that ran out in 2006, there have been times when they thought -- they've talked to me about possibly stepping in to teach a class, but I think, anymore, they don't even think about it, but they did for a while.

Q. With regard to publications, though, how many publications have you authored in the field of economics?

A. I have -- I have taught -- I published about

12 books. When I say "published," that would mean either written, edited, cowritten, coedited sets of books, the 12 books. And I have something in excess of 150-odd publications in journals. But the point I was going to make, which slipped my mind -- one of those senior moments -- is, in the early years, the -- the publications didn't have much to do with this type of work. But since about 1990, everything I have published has been in the area of forensic economics. It is something relevant to what economists do in the courtroom.

Q. And have you authored any publications in -- regarding valuing economic damages in personal injury cases?

A. Yes. Well, basically what I was saying was that the vast majority of my publications, I would say my first 4 or 5 books were not; the last 6 or 7 were. And the first, say, 10 or 15 of those 150 papers probably were not in forensic economics and the rest have been.

Q. Okay. What memberships and associations do you belong to?

A. I belong to the American Economic Association, the Western Economic Association, the National Association of Forensic Economics, the

American Academy of Economic and Financial Experts, and at various times, other -- a number of other different organizations.

Because often I will join an organization so that I can go to one of its professional meetings at members rates, and -- means, in effect, you get the journal for that organization without much additional cost. So I have been a member of the Eastern Economics Association Midwest. I am still a member of the Missouri Valley Economic Association and probably a few others I'm not thinking about right now.

Q. Okay. Thank you.

And what honors and awards have you received in your field of expertise?

A. I have got -- I guess I got the -- the past president's award for excellence of some sort from the National Association of Forensic Economics, which is the biggest organization for people that do this kind of work.

Q. Okay. Thank you.

And what, if any, pro bono work do you do with other economists?

A. Well, I don't -- pro bono carries the implication that you are doing work that you normally get paid for in a context where you don't get paid for

it. Well -- and that wouldn't work very well with this kind of work because if you did pro bono work, you're already saying, well, I'm biased toward the favor of this client.

But I do a lot of work in the field of forensic economics for which I receive no compensation because it's part of my professional activity. And that includes -- I spend a lot of time working on publishing papers, I review articles, I am on the journal editorial staff of the Journal of Legal Economics, and I read, review articles, and work with people who are writing papers to try to help them get those papers into publishable shape so they can get publications.

I make presentations at a number of professional meetings, and I attend probably -- in a typical year, I probably go to five or six professional meetings, traveling around the country to do that. And I'm almost always on the program because they're always looking for someone who's willing to put themselves out and do that.

But the other thing that I'm doing when I'm there is I sit and listen to the other presentations of other economists who have done work and are basically teaching me. And I think it's a matter -- a good

forensic economist is going to spend a lot of time doing these kinds of things because, not only do you want to share what you know, but you want to gain what other people know and are willing to share at those same meetings.

Q. Thank you.

Doctor, if you would, because we're having everything reported in this courtroom, if you could just slow down the pace a little bit for the benefit of our court reporter.

A. I've heard that before. I'm sorry.

Q. Okay. Thank you.

All right. Now, in this case, you were asked to review the economic reports prepared by Dr. Stan Smith; correct?

A. Yes.

Q. Have you ever previously evaluated litigation reports drafted by Dr. Smith?

A. Yes. I have seen a fair number of Dr. Smith's reports over the years.

Q. And have you ever agreed with his methodology for calculating hedonic damages?

A. No.

Q. Okay. And we'll get to the topic of hedonic damages in a little while.

Would you describe your experience in performing forensic evaluations as you did in this case.

A. Well, first of all, this case has somewhat unique features because most of the cases that forensic economists work on don't really involve any hedonic damages. You indicated we'll deal with that later.

But in a typical case where I would be working, there would be an injury. And the injury would have some kind of consequence on the individual, at least allegedly. And we never get involved in whether these -- in the liability aspect of cases; that is, we don't know whether the person was really injured, and we don't know whether the defendant caused the injury, but we do know -- we have -- we're given a set of facts that we are asked to assume, and we calculate the value of certain damages.

And then -- now, if I was on the plaintiff's side, that's what I would do. A plaintiff attorney would call me and give me an assignment, give me various data and tell me what he wanted me to calculate, and I would complete that assignment. On the defense side, I am often asked -- as I was in this case -- to look at the work of another economist and to respond to that -- the -- that economist and to offer

my opinions. But that was the latter assignment in this case because that is what I was asked to do initially.

Q. And how many forensic evaluations have you performed, let's say, in the last ten years?

A. Well, if we're just saying how many -- I think it would be better to ask how many cases I have asked -- been asked to do assignments. Because sometimes the assignments will change in the course of a case, different things will happen and --

Q. That's a better question. Okay. Let's go with that.

A. And I would guess that I have probably done -- in taking the past ten years, I'm figuring I probably -- for a long time, I was taking in about 70 cases a year. So if I took ten years times 70, that would be 700. That's slowed down a little bit. I'm hoping to enjoy life a little bit more than I have been as far as having time free to do the other kinds of work I like -- I -- activities I want to do.

But I'm probably taking in about 50 a year now. But your question was in the range -- about the last ten years, and I'm going to guess that I was probably more like 700 than 500.

Q. Okay. Thank you.

MR. MAZZEO: And, Your Honor, at this time, I would move the Court to recognize Dr. Ireland as an expert in the field of forensic economics.

MR. ROBERTS: No objection, generally, Your Honor. Objection to the qualifications of Dr. Ireland as an expert in hedonic damages.

THE COURT: We'll accept him as an expert economist.

MR. MAZZEO: Thank you.

THE COURT: On hedonic damages, if there's a specific objection, you can voice it.

MR. ROBERTS: Thank you, Your Honor.

MR. MAZZEO: Thank you, Judge.

BY MR. MAZZEO:

Q. So now getting to the assignment that you were given. And I believe you already articulated that and told the jury what that assignment was, to look at the reports of Dr. Smith in this case.

A. Right.

Q. And that was to -- more specifically, that was to -- was it to assess the validity of Dr. Smith's calculations and figures for lost household services, the life-care plan, and loss of enjoyment of life for hedonic damages assessment?

A. Well, that certainly was the assignment that

I -- I'm here today to talk about.

Q. Why don't you tell the jury the steps you undertook to carry out this assignment.

A. Well, the first and obvious thing is that if you're going to evaluate someone else's report, you get a copy of the report and you read it. And then you gather certain information that would be -- that would correspond to that, which would be, in this case, I wanted -- Dr. Smith prepares work notes. And I knew that from the fact that I have done other cases where he was involved.

But he prepares those work notes, which provide backup information, which makes it easier for me to know why he did what he did. So the first thing I would -- would do in any -- in any case where Dr. Smith was on the other side is request his work notes so that I can answer some of the questions. And I can usually figure out how he did what he did even without those work notes because I've had enough experience with it, but it saves a lot of time if I have those work notes.

So I got his work notes and looked at them, and so I -- first of all -- by the way, my assignment goes beyond a little bit what we talked about because when an attorney hires me, he's hoping I will explain

to him what that report's doing. I mean, I'm going to -- one of my jobs is to help the attorney understand the report that was prepared by the other expert, if that's -- if my assignment is to deal with another expert's report.

So I prepare certain -- certain things I do is just to explain in more detail than is provided in Dr. Smith's reports why he did what he did and how he got to where he got. And that was a lot of what my report did. Went into a lot of detail about Dr. Smith's calculations that he didn't provide in his report or in his work notes, things that I have learned because I worked on other cases, and I have read depositions where some of those -- the questions were answered by Dr. Smith and so forth.

Q. Can you tell the jury how much you have been paid for the services you were provided in this case?

A. Well, I don't have an exact figure, but I -- I will -- I'm going to guess that it's in the range of 15,000 to 20,000 so far in this case. We had a lot of different work. I have had my deposition taken. This is my second trip to Las Vegas to testify. The last time it was when they took my deposition, and that was a year ago last December, and so forth. But I think -- I think it's in that range. I could figure it out

exactly, but I don't have the specific number.

Q. Fair enough. Thank you, Doctor.

And were you paid to offer any -- offer any particular opinion?

A. No. At no point -- I started with different attorneys. You're, I think, the third attorney I was responsible -- directly responsible to, but none of the attorneys have ever suggested that I should develop any particular opinions. They've only suggested they wanted me to pay attention to particular damages and to provide my opinions about what those damages were and how Dr. Smith got there.

Q. Thank you.

You're also being paid for your time to testify here today; is that correct?

A. Yes.

Q. How much?

A. My billing rate for this case -- and I -- actually, the reason for that is I was retained, I think, in 2013 in this case. My billing rate at the time was $340 an hour. And that's still the rate that I will apply through the completion of this case.

Q. Okay. Thank you. And -- and in addition to Dr. Smith's notes and his -- the reports that he created in this case, what other information did you

review or rely upon to perform your evaluation?

A. Well, at various times, I was provided with the deposition of Emilia Garcia. I was provided with various other depositions that I'm -- I think I -- I read one by a Heidi Heath and some other people.

And then I have -- I have seen the reports of various doctors. Now, normally I don't hold myself out as a medical expert, so looking at medical records is not something that I gain a lot from. But these particular records had to do with the issue of whether the various damages were actually caused by the injury or not. So I was provided with them -- these medical records only on that particular -- on that basis but -- that these medical doctors were saying that the injuries were not caused by the injury in question.

Q. Okay. And are all your opinions that you are going to give today to a reasonable degree of economic probability?

A. Yes.

Q. Thank you.

So what we'll do now is we're going to talk about initially the -- the three areas: lost household services, life-care plan, and then loss of enjoyment of life damages that are being sought.

A. Yes.

Q. So can you tell the jury, when the reference is made to a party seeking lost -- the damages for lost household services, can you describe and explain that to the jury what that means?

A. Yeah. Well, first of all, household services, as I understand that term, are the ordinary things that people think of. It would be like taking out the garbage, cleaning, washing the dishes, doing the laundry, fixing the car, handling -- taking care of family bills, helping with cleaning around the house, and maybe painting the house, maybe putting on roofs, depending on which sex -- where we were in the traditional sex roles that have always -- men tend to provide certain services and women do other ones, although that's certainly blending and changing dramatically in modern society for the good.

But it -- they're basically all the services you provide around the home. And the reason why they would become a damage category is that, if you are injured and someone has injured you and you can't do those things, you have a loss. And the loss can be replaced in the commercial market because we can hire people in the commercial market who can provide those household services.

So if we have a loss of household services,

the -- the underlying concept is, we can hire somebody in the commercial market to come and replace those household services that were lost because that person can't do them anymore because of the injury. And if we do that, what would it cost us to get those household services in the commercial market and -- so that they're not lost in the future.

I mean, the idea is we're going to prevent the loss from actually occurring by hiring somebody to replace the services that the person, because of the injury, can no longer provide. And we have data about how much time generally people spend on providing household services.

And in this case, Dr. Smith relied on the same source I would rely on as far as data about household service provision. And that's a document produced by -- called *Dollar Value of a Day*. And it's -- someone takes figures and they -- the original time use amounts come from the American Time Use Survey, which is produced by our Bureau of Labor Statistics. It doesn't have any bias one way or another. It's -- those are the time amounts they get in the survey.

And then *The Dollar Value of a Day* puts dollar values on those -- adds wage rates to those

values and calculates how much, on average, a person with specific characteristics will actually provide. And this -- this actual publication is very detailed. It's got 200 -- the current version is 219 tables. And you can get things like household services of a woman who is married and works, whose husband doesn't work or does work, with children in the home between the ages of 0 and -- and 13 or 13 to 17 or when there's no children in the home under 18 and so forth. So there are -- there are lots of different categories.

And you just go to the -- but all of that is provided and worked out for us. So it's a standard source that most forensic economists do work from. And then go -- and somehow come up with a dollar value.

Now, Dr. Smith did substitute some wage rates he took from different sources for the wage rates --

Q. Before we get into what Dr. Smith did, I want to direct you -- I just wanted to know what -- what was meant by the loss of household services.

Now, Dr. Smith assumed that Ms. Garcia lost 80 percent of her ability to perform household duties. Do you agree with that -- that figure that Dr. Smith relied on?

A. No, I don't. And it's my opinion that an economist -- there's nothing about being trained as an

economist that allows us to determine any particular percentage. 80 percent is the figure he used, and I think that's a figure perhaps that was provided to him by Ms. Garcia.

But I'm not an expert even on the amount of household services I provide. And I recently had a hip operation which precluded me from doing some of those services. And I don't know what percentage reduction I had from that.

So what I'm really saying, in answer to your question, is I don't have -- I don't think an economist is qualified or a plaintiff is qualified to measure a specific percentage reduction in their own ability to provide household services.

Where I normally would value them is in a death case. When -- when a person's been killed, we know that whatever household services they lost, they -- they lost all of them. And in that case, we can value the total value.

And what I did in my own calculations was to calculate the value of the total -- I calculated a total value of the ability of a woman Ms. Garcia's age to provide household services rather than 80 percent of that amount.

Q. Okay. And -- and I guess you -- in that

answer you gave us some of the -- an explanation as to some of the difficulties in determining the percent of lost household services --

A. Oh, certainly.

Q. -- for a person?

A. I'm basically saying there's no training in any graduate course or any undergraduate course in economics about what percentage of somebody's ability to provide household services they lost because they have an injury.

We -- we are -- we do have background that would allow us to look at the totality of somebody's ability to provide household services, presumably before an injury. And that's what I meant about the -- I can calculate the value of somebody's full ability to provide household services; I just can't calculate -- I can't determine a particular percentage by which it should be reduced.

Q. Let me ask you this, Doctor: Do household services decline as -- as we age?

A. Well, I certainly think mine did, and I think everyone else's probably does. In general, the data that we look at doesn't really break down and calculate the productivity. All we can calculate with these time-use surveys is the amount of time we spend doing

it.

Well, as we age, we don't get as much done during the same time period. We take more breaks, and we move a little bit more slowly and so forth. But the data isn't going to let us determine the exact rate at which we slow down as time goes by.

Q. And in what way did Dr. Smith provide for the decline in household services for Ms. Garcia?

A. Well, his calculations basically assumed that she would continue providing household services right to the end of her normal life expectancy. And he had -- because he was adding a 1 percent growth rate to that, in effect he was saying that, on the day -- the day before she died, she would have done -- she would have been at her most effective in providing household services even though she at that point would be at a much older age.

That's a limitation that anyone would have if you carried the production of household services all the way to the end of life expectancy simply because we don't have a measure of how much we lose in the way of getting stuff -- getting household services provided within an hour of time that we spend providing household services.

Q. Okay. And what assumptions did Dr. Smith

make with regard to -- to the degree of which Ms. Garcia was impaired to perform household services, if at all?

A. I don't understand the question.

Q. Let me move on.

Did you make a -- did you make any determination as to whether Ms. Garcia needed or sustained a loss of household services?

A. Normally I would not be able to do that. That's something a vocational expert would do rather than an economist.

But it's not uncommon for an economist to be given direction saying, "Well, assume the correctness of what the vocational expert assumed about something of that sort."

Q. And what is the importance of identifying when a -- when a calculation is made for lost household services, what is the importance for identifying the -- a baseline figure for the household services that were provided prior to the incident?

A. Well, first of all, it matters. Remember that, when we're looking at a time-use survey, we're looking at an average. And different people provide different amounts of household services.

I would -- if you're looking at a specific

person, you'd want to know what household services were being provided. We know that there's some difference between two people who would otherwise be very similar, but one lives in a ten-room house and the other person lives in a three-room apartment. So the amount of household services you need in those two situations are different.

But normally I would like -- if I were -- want to give a set of directions, I'd say, "Well, provide me with a list of the things the person was able to do before the injury and, after the injury, then tell me which of those services can the person not provide at all, which of those services can be provided but they take longer, and which of those household services really aren't affected.

And typically, at least paying bills and things like that, which mean just sitting down with a checkbook and not being very physical, there are a number of -- in a typical case, a number of these household services would not be affected.

And that kind of analysis was not provided in Dr. Smith's report, but then I didn't have a basis for making those kind of calculations either. So I didn't -- I'm not claiming that I have done that. I'm saying that, if I were on the other side, that is

something I would at least recommend to the attorney, that we develop a baseline list of things that you did, things that you can't do now.

And at least those things would speak for themselves when testifying because, I mean, anyone can understand those kinds of -- of -- of changes. That still doesn't lead to a specific percentage reduction, but it does give you some guidance as to what you're dealing with.

And the other thing I would normally ask about is what -- which household services -- because there's usually a period of time between the injury and the current time -- which of those household services has the person chosen to replace?

Now, I would be careful about that because, after an injury, if a person has any -- has various losses because of the expenses of the injury, they may not be able to afford to replace them. And the mere fact that they can't afford to replace them should not be a source of penalizing the person and not taking that into account.

So knowing you didn't replace them doesn't guarantee that you have lost them and -- haven't lost them in some sense, but I would at least want to know what -- what have they replaced and what have they

spent doing it.

Q. Now, assuming -- assuming that Ms. Garcia does not prove that she sustained any loss of household services following this accident and related to this accident, is she entitled to any damages for loss of household services?

A. Well, obviously -- you're asking me what essentially is a legal question. And I want to be very careful about saying it's -- any answer I give is not -- is not an expert answer.

MR. ROBERTS: Objection. Calls for legal conclusion.

THE COURT: I think it does. Sustained.

BY MR. MAZZEO:

Q. Okay. And, Doctor, I'm not asking you for -- a legal question. I'm asking you a factual question.

Assuming Ms. Garcia does not prove factually does not prove that she sustained --

A. Okay. Fair enough.

Q. -- any loss of household services as it related to --

A. As long as I don't have to reach that first part, I'm okay.

But if -- if -- obviously, a loss is supposedly caused by an injury. If -- if the injury

didn't cause that loss, the value of replacing that loss is not a part of damages.

Q. Thank you.

Moving on to Dr. Smith's calculation -- projection for the present value of Dr. Oliveri's life-care plan.

Are you a life-care planning expert?

A. No.

Q. Is Dr. Smith a life-care planning expert?

A. No.

Q. Assuming that Dr. Oliveri's life-care plan that he's proposed for Ms. Garcia is not related to the injuries that Ms. Garcia sustained in this accident, would a life-care plan be appropriate for Ms. Garcia?

A. Well, again --

Q. Factually.

A. Given the assumptions you've given me, as long as I don't have to reach a conclusion about it --

Q. You're not going to.

A. Obviously, if the injury didn't cause the need for the life-care plan, the cost of the life-care plan is not a damage caused by the injury.

Q. Now, finally, moving on to hedonic damages.

A. Yes.

Q. Dr. Smith is claiming -- or has calculated

figures for the loss of enjoyment of life as pertaining to Ms. Garcia as a result of the subject accident.

A. Yeah.

Q. When we talk of -- can you tell the jury something about loss of enjoyment of life and/or -- and hedonic damages?

MR. ROBERTS: Objection. Foundation. Beyond the scope of his expertise.

THE COURT: You can lay some foundation first.

BY MR. MAZZEO:

Q. Sure. Are you familiar with the -- with the term "loss of enjoyment of life"?

A. Yes, I am.

Q. And -- and is that -- is that a term that's interchangeable with "hedonic damages"?

A. It is some of the time. It's not always, but ...

Q. Okay. Tell us your understanding of what is meant by loss of enjoyment of life.

A. Okay.

MR. ROBERTS: Objection. Foundation.

THE COURT: Overruled.

THE WITNESS: Okay. As a result of an injury, if -- if -- a simple kind of example. If I

love playing golf and I'm injured in such a way I can't play golf anymore, I've lost that enjoyable activity of life. And that's an example of loss of enjoyment of life caused by an injury.

If I -- if someone is killed, obviously whatever enjoyment of life they had is gone. And so that's another way that people lose enjoyment of life.

But loss of enjoyment of life is a -- is a damage category that often comes up in various cases that I'm involved with. Normally I'm not asked to say anything about it because it's my opinion that economists don't have any valid way to put any dollar values on anyone's loss of enjoyment of life. But --

MR. ROBERTS: Objection. Move to strike.

MR. MAZZEO: Can we approach, Your Honor?

THE COURT: Sure.

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

THE COURT: All right, folks. The statement was "It's my opinion economists don't have any valid way to put value on loss of enjoyment of life." The Nevada Supreme Court has indicated otherwise.

So I'm going to ask you to strike -- that statement will be stricken, and I'm instructing you to disregard it.

You can still ask additional questions.

MR. MAZZEO: Thank you, Judge.

BY MR. MAZZEO:

Q. So, Dr. Ireland, what we're going to do is specifically talk about Dr. Smith's methodology for how he calculated loss of enjoyment of life.

A. Fair enough.

Q. All right. So, now, one of the things that Dr. Smith did is he assigned a dollar value for the enjoyment of the life of the average person, and he calculated -- I'm not saying "he calculated."

He -- he assigned a figure of 131,001 -- $131,119 to the loss of enjoyment of life per year per person.

Do you recall that?

MR. ROBERTS: Objection. It mischaracterizes the report. Compound.

MR. MAZZEO: Hold on.

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

THE WITNESS: Okay. Well, the -- the concern was correct. In -- in the report that I was asked to comment about, Dr. Smith's figure for loss of enjoyment of life was actually 132,437, which was his figure for the year 2014. He had used the figure you had

mentioned, 131,119, for the year 2013, which was what was in the first report of Dr. Smith that I managed to see.

BY MR. MAZZEO:

Q. Thank you for that correction.

A. So there's no -- we're not having any -- any differences there.

But let's explain what that number is. That number is a -- supposedly, each of us last -- in 2014, enjoyed our lives at a dollar value rate of $132,437. And exactly what that means is not very clear.

It's -- you couldn't sell any and you couldn't buy any more enjoyment of life just by spending money or taking it back and forth. It's -- it's simply a number. And I don't think it occurred to any -- any -- to me or anyone else that I enjoyed my life in the year 2014 at a -- at a rate of $132,437. And this was net of your earnings. This is anything you bought with your goods and services, like consumer goods. Any enjoyment you got out of that is separate from this value that Dr. Smith is talking about.

And it's -- what it means is -- and it was well described in -- in one early *Wall Street Journal* article as the ability to smell -- stop and see beautiful sunsets and smell the roses. I mean,

basically it's -- it's the enjoyment of life that comes from simply being and living, being able to walk along and enjoy life.

And I have no question that we can all -- we all have enjoyment of life and that, if we get injured, we all lose -- potentially lose some of it.

My -- my only concern is that I don't know how to calculate a number that I think is exactly what that dollar value -- what dollar value I could attribute to that for. From my own personal -- from my only personal standpoint, I've never been able to feel that any method I could use would validly measure anyone's enjoyment of life at that kind of level.

And so that -- that's -- essentially, I think I've fully answered your question by this time.

Q. Sure. And is this figure provided by Dr. Smith recognized in any economic literature?

A. No. It's -- it's a figure that is unique to Dr. Smith. No other economist uses that specific number. And -- and, indeed, there are other economists who testify about this sort of thing. They use different -- different approaches, but that's Dr. Smith's particular approach.

And I know how he gets to it, which is he -- he has explained that over the years. It's -- you

start from some figures that -- he did a survey in 1988. He made adjustments to that figure. He started out with a figure.

He said the whole value of a human life was 3.1 million in 1988. You subtract 800,000 for what he called "human capital," which means the earning capacity and the household services produced by an average person.

Well, the average person in 1988 had a life expectancy of 45 years. So he's using -- he's saying that 3.1 million is the value of the life of someone with a life expectancy of 45 years. And then he takes -- takes -- subtracts the 800,000 from the 3.1 million. That leaves you 2.3 million.

Then, given that he was using a discount rate -- he's -- which today the one he's using is 101.25 percent. You calculate what the starting value has to be in order to produce a present value in 1988 of 2.3 million for a person who has a 45-year life expectancy. And the answer was 60,000 per year in 1988.

Now, what he did after that is take that 2.3 million, add to that the consumer price index, which is basically add to that inflation. And he says in his report that, as of the year 2014, the value of

that 2.3 million in 1988 is 4.5 million in 2014.

And, again, he goes back and says, "All right. That's for a person with a 45-year life expectancy. We'll figure out what the starting value has to be in order to get that figure." And that starting value in 19 -- in the year 2014 had to be 132,437.

And every year he recalculates that based on -- he adds a -- another CPI adjustment to that and recalculates back. And so the annual base figure he starts from changes from year to year and -- it doesn't change a lot. I have a whole series of these. I've got all the numbers down to the last -- through 2015. And they're all in the range of 128,000 to 133,000 as of the current year.

But once you have that figure, then he's saying, "Well, I'm going to assume that, as a result of this injury, Emilia Garcia has lost either 40 percent or 75 percent of her ability to enjoy -- or 70 percent of her -- it's 45 percent and 70 percent of her ability to enjoy life." And you can multiply 45 percent times 132,437 or 70 percent times that figure and get numbers. And those numbers then become the basis of his lower and upper impairment ratings.

Now, I had criticism of the impairment

ratings because economists don't do impairment ratings. That's not something that economists set out and come up with criteria for. But that's how he came up with the numbers he came up with.

And when I look at all these steps that I'm looking at, each of these -- none of these steps made any good sense to me. I mean, I don't think his figure in 1988 of 3.1 million was necessarily that far off, but I -- he's never provided a list of the -- of the research that he did to come up with that number of how he -- how he said that's the central tendency of it.

But he worked from that figure on up to the present, and I've seen various changes he's made over the years in making the calculations. When I look at them, they all look to me as if they're contrived. That is, they get you there; you get a number; but what is the number going to mean once you've got it?

And ultimately that is not -- those annual values with reductions by impairments are -- they just strike me as very contrived calculations that don't really have any significant impact in -- in realistically measuring a person -- what someone lost in a personal injury.

Q. Are you familiar with the development of value-of-life literature?

A. Yes.

Q. And what's the purpose for the -- this literature?

A. Well, the primary purpose of this literature -- and I can even go into the background as to how it got started. But economists realized they could calculate estimates of how much a large group of people spend to -- to prevent the loss of a human life. Now, we do this two ways.

One way is to have a group of people who are buying something that produces safe results like, for example, various Subarus and various automobiles are known to be safer and less likely to result in a fatality than any other car.

And when you do research and you break down the price of a Subaru, you can figure out how much are people paying for the extra reduction in fatality risk that comes from that. And if you know how much they're paying for that risk and you know how much safer Subarus are than any other car, you can estimate how much owners of Subarus are willing to pay to prevent the loss of one human life in the form of buying Subarus rather than --

THE REPORTER: I'm sorry. "Are willing to pay to prevent"?

THE WITNESS: I'm sorry. You're right. I deserve to be kicked. I get enthusiastic, and I try to normally be more cooperative and sensitive to the needs of court reporters than I'm being here today. If this court reporter doesn't want to hang me, I'd be surprised. But, anyway, I'll try to talk slower.

But the point here is the other way that we sometimes calculate this is we know that policemen have more dangerous lives than secretaries, and we can calculate the extra fatality risks involved in being a policeman or being in any other dangerous occupation. Because there's some occupations that are a lot more dangerous than even being a policeman.

But we can take, though, how much would people get paid for the extra risk that they're going to get killed on the job. And, basically, that's what it is. If you -- if you take more risks, you're likely to be compensated for it.

And we can figure out how many people get killed, how much is being paid extra to -- for the people bearing those risks. And from that we come up with numbers. And these numbers, if you look at them, they range anywhere -- well, there are some people who argue the literature is not valid. I'm not one of them. I think this is a perfectly important part of

the economics.

And -- and I will say I taught this literature as part of my work in teaching public microeconomics classes when I was a graduate student.

Sorry. I'm speeding up again.

When I was a -- when I was a -- I'm sorry. When I was a teacher at my current university, one of my responsibilities for three or four years was to teach this course in our master's of public policy administration because these kinds of numbers go into cost-benefit analysis when you're trying to decide whether governments should buy or not invest in a particular kind of public project or not.

So what happened in 1976 is the -- President Reagan ordered all of the federal agencies to come up with some sort of a standard for values of life that they use when they're trying to plan projects. And the various agencies chose different studies to pay attention to.

And I happen to know which one the Department of Transportation relied on. That's a study by Dr. Ted Miller, who I know personally and -- and Dr. Smith knows. And he's a friend of both of us. But those -- different agencies use different studies. And that's how these studies have typically been used.

Now, the other way they're, of course, used is that, since this is a part of economic analysis and since, if you do a study in this area -- and it's a lot of work, and it's a very difficult process -- you can get those articles published in journals. And if you get articles published in journals -- all of you've heard of publish or perish.

So the top economics departments in the United States like to have somebody who's doing that research in that kind of an area, and they have to keep publishing. And so we get a -- we have a steady flow of new studies coming in on the value of statistical lives on a regular basis.

And we have -- and these studies may have as many as hundreds of different values of life in them depending on which particular configuration of the study that -- that they were working on at that point.

And in order to come up with what Dr. Smith did, you have to digest all of this into a single number, you know, saying, "Okay. His single number in 1988 was 3.1 million, and then he worked from there to get to the figures that he would have used here."

But there are questions about whether that's the best number. There are questions about which of the methodologies he relied upon, et cetera. All of

those things relate to the statistical life. But the issue is not about whether that literature is valid, because it is. The issue is about how that literature is used to try to come up with how much somebody personally enjoys their life less because they got injured.

BY MR. MAZZEO:

Q. That leads me to my next question.

Do you have any opinions as to whether Dr. Smith's estimates for the value of human life are consistent with the literature that you've just described?

A. I think you can find parts of the literature that would certainly support what Dr. Smith's figures were, yes.

Q. Okay. And in what -- in what way did Dr. Smith rely on Ms. Garcia's subjective opinions regarding her diminishment in the value of life?

A. Well, I think this goes back to this term that he used of impairment rating. Now, that term bothers me because when I hear the word "impairment rating," I'm assuming there's some sort of a process that's being involved in determining what those percentages are. And in -- indeed, Dr. Smith cited a paper that he wrote with two other authors and

published in one of our journals in 1990 where they talked about the need to have a psychologist come in and provide those percentages.

But Dr. Smith did -- just provided them based on -- I've forgotten exactly how it went. I think it was on a good day -- he talked about testimony that, on a good day, Ms. Garcia thought it was maybe only a 40 percent reduction. On a bad day, it was 45 percent; and on a bad day, it was 70 percent or something like that.

Those are not impairment ratings. Those are essentially random percentages somebody's coming up with because they were asked a question that most -- most of us couldn't answer. I can't compare how much I enjoy life on a good day versus a bad day myself. I mean, I have good days and bad days, and I know that some are more enjoyable than others, but I can't compare them.

Q. Okay. And, also, do you consider it important to distinguish, do we all have the same enjoyment of life from one person to another?

A. Well, we don't. Obviously, some people enjoy their lives a great deal more than other people. And the big thing here is, an economist can't go around interviewing people, saying -- and talk to them for 20

minutes or something or have one of your associates talk to somebody and say, well, is this person average or not? Well, Dr. Smith hasn't claimed that at all. He said -- he's basically relied on something, I think, that Emilia Garcia said.

But these are -- there is nothing about the training of an economist that allows you to assess the reasonableness of any such percentage, and that -- and --

Q. Dr. Ireland --

A. Go ahead.

Q. I'm asking you to -- to stay focused on Dr. Smith.

A. Yeah.

Q. Okay? We're talking about Dr. Smith here today.

A. Yes.

Q. Okay. So what testing has been done to -- with regard to support Dr. Smith's methodology, if at all?

A. It would be impossible to run a test. I mean --

Q. On his methodology, we're talking about specifically.

A. I know -- you're saying -- the test of his

methodology would be, if we could have -- someone could run a test on Emilia Garcia and say, well, she lost 40 percent on -- that's -- that's our overall conclusion after we have gone through a -- a very careful study, and we concluded that she lost -- and you could have a study. And, by the way, I'm not criticizing the idea that you could have a range. You could lose 45 percent, or you could lose 70 percent. The question is, how do you get to that percentage?

And all I'm saying -- and I'm specific to Dr. Smith because other people -- I don't know of any other economist --

Q. We're just talking about Dr. Smith.

A. Yeah. Well -- okay. He has a -- how do I say -- I guess I can't say it without talking about somebody else. But I have never seen anything like these percentages in any of the work I have ever done.

Q. Fair enough. Okay. And you were talking about the percentages that Dr. Smith had employed and relied upon to calculate his numbers.

A. Again, we're talking about applying the -- these percentage reductions to the 132,000 as of the year 2014, and we haven't talked about the fact he was going to add some -- in addition, he's going to add cost of living. And I don't have a problem with that

either. He's adding 2 percent. If I knew what it was in 2014, adding 2 percent to it for 2015 would not strike me as an unreasonable thing to do.

But he does add percentages going -- as we move up to the present, and he would subtract percentages as he moved back to the date of the injury. Again, I don't have any criticism of those things. My criticism is of the 2014 value of 132,477 and the percentage reductions that he is saying can be made in that figure. And I don't think -- I don't think those numbers make any sense. They have -- nothing in his report suggests that there's any justification for them that I would attribute anything to as an economist.

Q. Okay. And what -- what standards or controls for the methodology -- were employed for the methodology used for -- that was used by Dr. Smith?

A. None that I can see.

Q. Okay. And by the way, Doctor, should sympathy or likability of -- for the plaintiff or of the plaintiff be used to award loss of enjoyment of life?

A. Well, again, you're -- at this point, you're asking me a legal question again.

Q. No. No, no. I'm asking you a factual question. Sympathy -- should -- the jurors will make a

determination as to the facts.

So I'm asking you, should -- in determining loss of enjoyment of life, should the trier of fact -- not trier of law, trier of fact -- look at factors such as sympathy or likability of --

A. Well --

Q. -- of a -- of a party in a case --

A. Well --

Q. -- in determining loss?

A. I'm just saying that I think the jury should follow the judge's instruction and not some opinion of mine on that issue. Because I don't -- if you ask my personal opinion, I don't think you should take into account those things, but that's a personal opinion and it's certainly not an economic opinion.

Q. I'm asking you as an -- as -- as -- as an economist expert.

MR. ROBERTS: We'll stipulate to this, Your Honor. It's Nevada law.

MR. MAZZEO: It's what?

MR. ROBERTS: It's Nevada law. We stipulate.

MR. MAZZEO: Okay. That's not what I was asking, but thank you, Counsel.

BY MR. MAZZEO:

Q. So as -- as a professional economist, though,

in looking at -- you -- you gave a description to the jury and -- and defined for the jury the -- what loss of enjoyment of life entails; right?

A. Yes.

Q. So in -- in looking at damages for the loss of enjoyment of life, would that include some factors such as sympathy or likability? Does that have anything to --

A. Well --

Q. -- do with one's loss of enjoyment of life?

A. I can -- this I can answer. Dr. Smith's calculations don't involve -- invoke any assumption of sympathy or -- or those sorts of things.

Q. Fair enough.

A. And since I'm not making these calculations anyway, I would -- if I did, they would -- sympathy wouldn't enter into it. But I wouldn't -- but -- you're -- you're asking me something sort of beyond my --

Q. Fair enough.

A. -- personal experience.

Q. That's fine, Doctor. And do you have an opinion as to the amount -- as to any amount that Ms. Garcia should be entitled to for loss of enjoyment of life?

A. No.
Q. Okay. Why is that?
A. Well, I think for all of the reasons that we we've talked about. I don't find the method that Dr. Smith used to produce any kind of reliable results for all the reasons that I have just explained and answered. And since I don't -- I don't have an alternative to offer myself, I don't -- I'm just saying -- I don't think the numbers he provided are meaningful or reasonable or accurate and can't be measured, all the different problems we have with it.
But I don't have a -- an alternative to offer, and I -- I think that's -- I mean, you -- the jury has a tough job to play. And I wish I could help, but I don't think I can.
MR. MAZZEO: Thank you, Doctor. Pass the witness.
THE COURT: Mr. Strassburg? Mr. Tindall?
MR. STRASSBURG: No questions, Judge.
THE COURT: Mr. Roberts?
MR. ROBERTS: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. ROBERTS:
Q. Dr. Ireland, you've never been qualified as

an expert witness to calculate the loss of enjoyment of life in any court; correct?

A. That's correct.

Q. And you did not -- as you just told Mr. Mazzeo, you did not calculate any competing opinion for Ms. Garcia's loss of enjoyment of life; correct?

A. That's correct.

Q. You said that you did not find Dr. Smith's methodology to be reliable.

Did I get that right?

A. Yes.

Q. Okay. Did Dr. Smith use the willingness-to-pay theory?

A. I believe that he -- based on his -- his statement of the survey, he looked at that survey to start with to arrive at the position of 3.1 million. Now, I have never seen the studies -- a list of the studies that he actually looked at at that point. He claims he doesn't remember what it is, but I -- I would have no doubt that he read part of that literature because he cited part of it in various -- over the years when I've seen various other reports.

So I'm sure that he does know something about the value of statistical life literature himself, and he has read various studies.

Q. You brought up literature. You agree that all the literature in Dr. Smith's report is peer-reviewed; correct?

A. Well, I -- I am assuming it is, but I have not individually checked out every -- the peer-review status of every article that would be mentioned in Dr. Smith's report.

MR. ROBERTS: Permission to publish Dr. Ireland's deposition, Your Honor.

THE COURT: That's fine. It will be published.

MR. ROBERTS: Permission to approach the witness, Your Honor.

THE COURT: That's fine.

BY MR. ROBERTS:

Q. I'm going to provide you a copy of your deposition here, Doctor.

A. Okay. Wow.

Q. Yeah. I think a lot of attachments are on there.

A. Yeah. It looks like every -- everything that we marked as an exhibit at the time is attached here. I do have a copy of that deposition in my file --

Q. Okay.

A. -- but it isn't this thick.

Q. That's the attachments. They'll do that. Although, I'm going to rebut my own premise here when I ask you to turn to page 163 of your deposition.

MR. MAZZEO: Objection, your Honor. No foundation for prior inconsistent statement.

THE COURT: I don't know yet.

MR. MAZZEO: Well --

MR. ROBERTS: I'm sorry. That -- that -- I wasn't saying that ...

THE COURT: I don't know what the question is yet. Let's -- let's --

MR. MAZZEO: Okay.

MR. ROBERTS: You may have misunderstood. I will try again.

THE WITNESS: I have opened -- I have opened to that page, 166. I'm sitting here looking at it.

BY MR. ROBERTS:

Q. 163, line 19 to 164, line 4.

A. 163 -- oh, wait a minute. Page --

Q. 163 --

A. Okay. I'm sorry. I had went to 166.

Q. -- line 19 to 164, 4.

A. Yeah. Do you want me to read that?

Q. Just -- you can just read it silently to yourself.

A. Yeah. I think here I'm saying that I agree that --

MR. MAZZEO: No, you don't read from it. Just read it to yourself.

THE WITNESS: Okay.

BY MR. ROBERTS:

Q. Does that refresh your recollection that you agreed that all the literature's peer-reviewed, you just disagree with his interpretation?

A. Yeah, I -- when I answered your question before, when I was -- I thought this was more in a kind of a detailed circumstance of whether I had checked out of the peer-review status of each of the articles. I believed then, and still believe, that every article he mentioned in his report is -- was editorially peer-reviewed; that is, it went through some kind of a review process and was published only after some reviewers determined that it was publishable.

Q. Okay. And you're not criticizing the peer-reviewed literature that Dr. Smith relies on itself, you criticize the use of that literature to calculate hedonic damages?

A. That's correct.

Q. And you don't criticize the way Dr. Smith applied the willingness to pay; you just disagree with

any type of willingness-to-pay analysis in order to calculate hedonic damages. Right?

A. I don't think -- the question was not worded in a way I'm comfortable with, but it's -- basically what I'm saying -- it was -- he hasn't done -- can perform these studies himself. They're studies that exist and have been published by other people. But I don't have any -- any basic criticism that they're part of the literature of my field and that, indeed, the -- I taught from that literature before I ever heard the concept of hedonic damages.

Q. So, Doctor, there is absolutely no methodology that Dr. Smith could have used to calculate hedonic damages that you would not find unreliable; correct?

MR. MAZZEO: Objection. Assumes facts not in evidence. Overly broad.

THE WITNESS: I am --

THE COURT: I'm going to allow it.

THE WITNESS: Okay. You're correct. There's no method that I would consider reliable for using the value of statistical life literature to arrive at specific dollar values for anyone's loss of enjoyment of life following an injury.

/////

BY MR. ROBERTS:

Q. So you don't just disagree with Dr. Smith; you disagree with Nevada law. Right?

MR. MAZZEO: Objection, Your Honor. Calls for a legal conclusion.

THE WITNESS: In this case --

MR. MAZZEO: No, wait. Objection.

THE WITNESS: Okay.

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

BY MR. ROBERTS:

Q. You disagree that the willingness-to-pay methodology can be applied in any way to calculate hedonic damages; right?

A. I do.

Q. And that's why you criticize Dr. Smith's methodology; correct?

A. No. I have other criticisms of Dr. Smith's methodology that are specific to Dr. Smith's particular version of how he has calculated loss of enjoyment of life. And also because there was a legal conclusion that I am apparently allowed to talk about, if I read the decision in the Banks case, the Banks decision said that I should have been permitted to testify in that case. And -- and I was, in fact, the defense economist

in the Banks case. And the plaintiff -- and the defense attorneys decided not to have me testify. And the Court basically said that the defense should have had an expert testify, as I am here.

Q. To criticize, according to the supreme court, the method -- that his methods were inaccurate or unreliable?

A. Right.

Q. Can you point me any part of the Banks decision where it says you could testify that Nevada law was wrong?

A. I'm not testifying that Nevada's law is wrong. I don't have an opinion about that. I have an opinion about what -- I know what the Banks decision said, but I'm -- as far as I'm concerned, I'm -- I'm testifying in a way that is consistent with the Banks decision, which is what I understand to be the law.

I -- but as far as -- if someone tells me I can't do that, the judge here is the expert who makes that decision, not me.

Q. And you're no expert in hedonic damages, because if anyone came to you and said, Dr. Ireland, please calculate an estimate for loss of enjoyment of life, you would tell them, I'm sorry. I don't know how to do it. Right?

A. I would tell them something more like, it would take me a quite a long time to get up to -- up to full speed on how -- how that type of research is being done. And I would also want to know what particular kind of research did you want me to do? Did you want me to do one that has to do with consumer purchases, or one that has to do with wage risk?

And I would want to know, what is the purpose of that study? And what are you going to use it for? But if I was paid enough, I could do it. It would -- I mean, I would have to spend a lot of time preparing. And -- and in that respect, Dr. Smith and I are similar. He's never conducted a research that uses the willingness-to-pay methodology, and I haven't either.

Q. Do you follow Dr. Smith all around the country testifying against him?

A. No. I don't usually follow him. I have cases -- the last time I testified and did any travel was in Stanford, Connecticut, but that's not all around the country. Stanford is somewhere close to New York City, actually. But I was there earlier this year. I have come to -- out to Las Vegas several times.

But no, I don't travel -- I don't follow him around the country. That's sort of a -- there -- I -- I -- I accept assignments where they come from, and --

and if -- if need be, I will go there and testify but not following. The term "follow," it almost, like, means like a lawyer chasing after an accident to try to solicit clients or something like that. I certainly don't do that.

I get calls -- I never know where the next telephone call is going to come from. It comes -- some call comes in, and an attorney has a case, and he wants me to look at it. And I will look at it.

Q. So you testified in this case you've been paid in the range of 15 to $20,000; right?

A. Yes.

Q. In fact, at the time of your deposition, back in December of 2014, it was just north of 19,000; right?

A. Okay. Well, I don't remember that, but that sounds like -- it certainly could -- if that's what I said, I will trust you that that's probably correct.

Q. And I'll -- 19,465. That could be correct?

A. If you -- if you -- if that was my answer in this deposition, that's correct.

Q. And from December of 2013 -- 2014 until when you arrive home tonight, how much additional do you expect to bill to the plaintiff -- to the defendants?

A. I think actually most of my billing was done

through that deposition, but I am going to answer your question. It will take me a second to think it through. Because, obviously, I spent two days -- or not a full two days if -- depending on what time we quit today, if I can catch an earlier flight.

But I will probably have a billing of -- for a full day. If I have one full day, that would be at three -- at eight -- let's just say ten hours. 3400 for that. And then the cost of my airplane fare. And it looks like I had a total of -- I had a total of five hours of additional preparation. But really I haven't -- I haven't spent a lot of time working on this case since that deposition because there wasn't that much more to do.

Q. So somewhere over 23 and less than 26, maybe?

A. Yeah. Something like that.

Q. Okay. And is it fair to say that you have been retained as an expert to write opposing reports and testify against Dr. Smith at least 50 times in your career?

A. Yes.

Q. And maybe up to 100?

A. That would -- I probably have had maybe a little bit more than 100, because my deposition was in December of last year, and I probably had another ten

or so cases in this past year, came in from other sources.

Q. So if we run those calculations out, you have made somewhere between 1 and $2 million testifying against Dr. Smith?

MR. MAZZEO: Objection, Your Honor. No foundation. There's no consistency from one case to the next.

THE COURT: He can answer.

THE WITNESS: Yeah.

THE COURT: Overruled.

THE WITNESS: And that would be my answer. This case has had -- has stayed -- usually, if I get involved in a case, it doesn't last three years. And -- and I don't have lots of different things that happen over the course of that period. I have looked at several versions -- three or four -- three versions of different reports from Dr. Smith over the course of this period and so forth.

In a typical case -- and I think I mentioned that previous case where I was in Stanford -- I think my total bill was more like 10 or 12,000, and that included the travel. And in most of these cases what actually happens -- and this is not unique to this type of case, where there's hedonic damages -- most cases

settle. So I don't end up making that amount of money on most cases.

I probably -- this is -- I think is the third time in the last 12 months that I've testified in a case where Dr. Smith was on the other side in -- at a situation. And so those are the ones where -- when a trial takes place, those are the ones where I spend a lot more time than the ones where I just simply write a report.

Q. You do agree that enjoyment of life has value; right?

A. I certainly do. Yes.

Q. And you agree a person can suffer loss of enjoyment of life from injuries?

A. I do.

Q. And you said that Dr. Smith's methods have never been tested, and you have a fundamental disagreement with his calculation of 132,000 a year; right?

A. Yes.

Q. If you knew that tomorrow you were going to get banged on the head and die, would you pay $132,000 to live another year?

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

BY MR. ROBERTS:

Q. Economist is all about willingness to pay; right? What's -- what's the fair exchange value? A willing seller and a willing buyer -- let's assume a willing seller was offering you an extra year to live.

You're not really telling the jury 132,000 is too much, right, for a total loss of the enjoyment of life?

MR. MAZZEO: Hold on. Objection. Compound. Incomplete hypothetical.

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

THE WITNESS: Most people couldn't afford to pay 132,000 for another year of life. I probably could because I have worked pretty hard, and I probably would. But I don't think that means that that's any particular value. It's -- it's -- it is simply something that would, perhaps, reflect the fact that I have done a little bit better financially than a lot of other people.

BY MR. ROBERTS:

Q. Counsel asked you about sometimes economists will rely on loss of capacity to enjoy life based on a psychiatric analysis or evaluation.

Did I hear him ask you about that?

A. No.

Q. Is that sometimes done?

A. I think -- if you're asking me broadly the question, do I think a psychologist might have something to say about whether someone lost enjoyment of life, and I think they could.

Certainly, the -- what's called hedonic psychology deals with measuring objective happiness. And psychologists are capable of measuring whether a person's at a -- at a 100 scale of happy or a higher-than-the-average scale or below that average scale based on standard tests that they have come up with.

Now, they don't turn those percentages into dollar values. But I certainly think a psychologist who did a thorough study on a person might be able to offer something that was expert in nature that might be helpful to a jury. But how exactly? I mean, I'm not a psychologist, and I'm just giving you generalities about hedonic psychology, which I happen to know a little bit about because economists rely on it to some extent.

But it is objective scales, and it isn't dollar values that -- that -- that psychologists do, but they do have expertise that might be helpful.

Q. And I know you weren't here, but do you know

whether Dr. Smith actually calculated the diminution in Ms. Garcia's capacity to enjoy life, or did he tell the jury that was up to them?

A. Well, I think he probably would have, given other deposition transcripts I have seen from Dr. Smith. So I think he probably told the jury that they could use some other definition if they wanted to.

Why he picked 40 and -- 45 and 70 is my concern. If you were going to try to give a jury something easy to work with, I'd take 10 percent, because you can multiply 10 percent pretty easily by any other number if you -- as compared to using the number -- the particular numbers he did use.

But my concern is that those -- that 40 percent and 70 -- or 45 percent and 70 percent are not expert opinions; they're just, quote, as he would describe them, illustrations.

But what is an illustration? It's not an expert opinion, and it's not an impairment rating. It's just an illustration. It's saying, "Well, it could be this or it could be that. But I happened to pick these two numbers."

Q. Do you even know how he picked those numbers, Doctor?

A. I think we talked about that a little bit.

My impression was it had something to do with a good day and bad day.

Q. By interviewing Ms. Garcia?

A. Yes.

Q. Is there anything else he used?

A. I don't think there is.

Q. Do you have Dr. Smith's report of October 14th, 2014?

A. I do.

Q. Could I have you flip through that to page 10 and look at numbered paragraph 1 at the bottom of the page. Perhaps that will refresh your recollection.

A. He's referring here also to Dr. Mortillaro.

Q. And a global assessment functioning performed by --

A. Global assessment, right.

Q. -- by Dr. Louis Mortillaro; right?

A. Yes.

Q. Do you know Dr. Louis Mortillaro's specialty?

A. No.

Q. Fair to say that, when you've been hired to respond to Dr. Smith, you've never agreed with his calculation over 100 times; right?

A. Huh? You mean I haven't agreed with him 100 times?

Q. Well, you've told the jury that you've been hired to respond to his calculations over 100 times.
A. Yes.
Q. And over 100 times you've disagreed with him; right?
A. Well, yes, I guess I have disagreed on some aspects in some of his reports. We weren't that far apart in this case on the cost of the life-care plan, but ...
Q. You -- you speculated on direct examination with Mr. Mazzeo that you weren't hired and paid to provide any particular opinion.
A. Yes.
Q. Don't you think that counsel knew what those 100 opinions were that you'd issued every other time you've been hired?
A. Well --
MR. MAZZEO: Objection. Foundation.
THE COURT: Sustained.
THE WITNESS: Okay.
BY MR. ROBERTS:
Q. You've been retained to testify as an expert in Nevada 20 times, and only one time was on the plaintiff side; correct?
A. Yes.

Q. Loss of household services.

You agree that economists can provide a figure that's reliable enough to be helpful to a jury; right?

A. Yes. I think that an economist can value the -- for an average person. Now, we can't evaluate specifically Ms. Garcia compared to anybody else.

But she was a female with children and -- and -- and a specific status in life, and those -- there are tables about women at her age like that in *The Dollar Value of a Day*.

Q. And what was the total value of household services that you calculated for Ms. Garcia's remaining life expectancy?

A. My figure was -- actually, let me -- I have that marked. I have two figures that I really talked about.

One is, if I used most -- almost all of Dr. Smith's assumptions, I would have come up with 519,000. If I used all of my own methods -- and this is for the total value of the household services, not 80 percent reduction. This would be -- this would be equivalent to 100 percent reduction. I found the figure of 373,053.

Q. Now, assuming that Ms. Garcia was injured in

the collision and assuming she did not have the capacity to perform 100 percent of the household services she could perform before the collision --

A. Yes.

Q. -- do you agree that it would be reasonable for her to hire someone to perform those services instead?

A. Well, I don't want to give advice to Ms. Garcia. But I certainly understand that the courts might provide damages to allow her to replace those household services.

Q. But that's the premise of the calculation that you did, right, is what's the market value of those services?

A. Well, the premise of my calculation was what was the total value of her ability to provide household services if she was like an average woman with all the characteristics we've talked about. And I believe, yes, I can calculate that; and, yes, if a percentage of that got lost, it would be appropriate for some sort of an award to be made.

That's certainly the premise on which I work in all cases which I work, that there -- if there's damage and if the defendant is held liable, then -- if we can remove the damage by a certain amount of money,

we would award the sum of money to remove the damage.

Q. Now, under your plan and your calculations, you value the household services at the market rate in the community; right? That's what you're trying to do?

A. Well, you're -- I don't think either Dr. Smith or I made very specific assumptions about the -- the Las Vegas area. But there's not a lot of difference between Las Vegas and the national percentages that are used in the -- in the typical studies of *The Dollar Value of a Day*. But the data that we're relying on is time-use by average Americans, not Las Vegas.

Q. Isn't it fair to say that the biggest difference in your calculation and Dr. Smith's calculation, if we're just looking at the calculation of 100 percent loss, is that you use the rate that someone would be paid, the hourly rate to perform those services, and Dr. Smith uses the hourly rate plus the markup that an agency would apply?

A. Certainly that is a fundamental difference between he and me.

Q. So under your plan, Ms. Garcia couldn't call up Merry Maids and say, "Hey, could you send a maid down?" She'd have to look on craigslist or find someone willing to come; right?

A. Yes.
Q. And you mentioned you taught.
Where did you teach?
A. I teach -- well, most of my career, I taught at the University of Missouri at St. Louis.
Q. And you -- are you still a member of the American Academy of Economic and Financial Experts?
A. I am.
Q. Is that the second-largest organization of its kind for people who do your kind of work?
A. Yes.
Q. And you joined in 1992?
A. Yes.
Q. And a motion was brought to the board of that organization to censure you for your conduct?
A. Well, this was -- we were having a political fight. And some members of the board of directors who were -- I was on the president's side during the fight, but I was one of the more vigorous supporters of the president. And a motion was brought -- there were two motions. One, to restrict the president from being able to fire an editor that we had at the time who I thought was unethical. And there was another motion to -- that -- that the other members of the board would like to have had register against me for churlish

behavior unbecoming a member of the board of directors of the association.

And ultimately we -- my side prevailed, which is why I'm still a member. I'm still -- I'm -- I am still on the journal's -- *Journal of Legal Economics* board. We got a new editor, as I wanted to.

And yes -- but there were -- but a number of the then existing board members who were part of the old establishment got overthrown. And they -- they did make an effort to try to censure me by passing around some emails. And -- and a number of them voted for it, but they lost. We won.

Q. Well, when you say "a number of them voted for it."

There were 18 people on the board, and 10 voted in favor of censuring you, and 8 people abstained, and no one voted against it, right, Doctor?

A. Well, as I said, eight -- as I have often said, I didn't vote on this any more than any of the other ten did. There was no authorization for the email to be circulated. No process was involved. They circulated this as a part of having -- waging the fight. And I don't treat it as if it was a serious effort on their part.

But you're right. There were 10 people out

of 18 on the board of directors who were on the other side, and we got rid of them.

Q. And you mentioned that you're still a member of that organization.

But you're no longer a member of the National Academy of Economic Arbitrators; correct?

A. That is correct.

Q. And you're not a member because the board voted to revoke your membership; correct?

A. No. Well, it is correct to a point. Basically, I -- they -- they told me that, if I did not agree not to discuss that association on the website of a -- or on the -- one of the electronic lists of another group, that they would vote me out of office or vote me out of membership. And they did because I told them, "No. I'm not going to change this. I didn't join this to be in a secret organization." So they did. And this was a group of 20 people, and nothing of -- ever has concerned me.

MR. ROBERTS: Thank you, Your Honor. I'll pass the witness.

THE COURT: Mr. Mazzeo?

MR. MAZZEO: Yes, Judge. Thank you.

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REDIRECT EXAMINATION

BY MR. MAZZEO:

Q. Dr. Ireland, on cross-examination, you were asked to look at Dr. Smith's report with regard to what Dr. Smith relied on for determining the --

A. Yes.

Q. -- Ms. Garcia's loss of enjoyment of life, that percentage.

A. Yeah.

Q. And you made a reference to -- you cited the global assessment functioning scale --

A. Yes.

Q. -- right?

And do you know whether or not that's a self-assessment that's completed by the patient?

A. It is, but -- yeah.

Q. Okay. So is that basically -- is your understanding of that global assessment functioning scale basically a subjective self-appraisal?

A. Yes.

Q. What was -- what is the underlying assumption for whether Ms. Garcia's entitled to damages for household services in this case?

A. Well, it is that the injury caused her inability to provide those household services. And

if -- if the injury -- the automobile accident didn't cause the -- her inability to provide the household services, then clearly that there's no connection between the accident and her need for household services, however it's measured.

Q. And what was the reason for you supporting the president to fire the -- I think you said the editor?

A. Yes.

Q. Yeah, what was the -- what was -- give us the background. Tell the jurors the background of the situation concerning that.

A. The situation was that we had a -- a -- a journal editor brought in. And I was supposed to be on the selection committee, and I was just ignored. They hired him without bothering to -- they asked me to be on the committee, and then they hired him without actually even consulting me, but ...

I did not consider him qualified to deal with it from the beginning. But in the process of handling this job, he managed to subvert what -- the peer-review process; that is, he had people that -- things were getting published that shouldn't have been published without going through adequate review.

Now, again, adequate review means you get an

article submitted, you send it out to three objective people, and you follow the directives of those people who recommend either publishing or not. And I thought it was absolutely critical that we not, for that association's reputation, to continue having this kind of inappropriate publication of articles purely for organizational political fighting to go on.

And that -- that was the issue I was concerned about, and I was very unhappy with the way that the whole selection had gone on because it was just -- it was set up to make it -- give appearances that were not followed through on in terms of my participation, and it made me look bad.

Q. You were also asked a question with regard to a situation when you were a member of the National Academy -- National Academy of Economic Arbitrators --

A. Yes.

Q. -- was that correct?

And -- and you mentioned -- you referred to churlish behavior.

Can you tell the jurors what that churlish behavior was?

A. Well, basically, it came down to when -- when I think somebody's lying, I don't have any hesitance about saying they're lying. And they didn't think that

was very nice. And -- but I'll -- we are a little bit confusing this.

Because the other situation, the National Association of Economic Arbitrators, we had a little organization of 20 people. And we were kind of as a group. And I had observed that this little organization of 20 people was playing an overly predominant role in an organization that had 500 people; that is, all of the officers, we were the sort of inner core.

And I said -- somebody was running for office on the basis that this inner core had an undue influence on that much bigger organization, and I was saying something about it, that I agree with that. And my agreement with that was what they were unhappy about. And they wanted me to agree never to mention the organization again as a condition of remaining a member.

And I said, "Look, I've -- I didn't intend to join a secret organization when I joined this. And I certainly -- but if you want me to -- if you -- as a condition of allowing me to stay, I have to start treating this as a secret organization, I won't. But you make the decision whether you want to fire me or not, but that's -- that's up to you."

Q. Okay. Thank you, Doctor.

Nothing further.

THE COURT: Mr. Strassburg? Mr. Tindall? Anybody? Anything?

MR. STRASSBURG: No, Judge.

THE COURT: Mr. Roberts?

MR. ROBERTS: Nothing further, Your Honor.

THE COURT: Ladies and gentlemen, any questions?

Not seeing any hands. Thank you, sir. You're excused.

THE WITNESS: Okay. Thank you.

THE COURT: Need a break? Let's take a quick break.

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

You are not to conduct any research on your own, which means you cannot talk with others, Tweet others, text others, Google issues, or conduct any

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

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

Plan on ten minutes. We'll see how that goes.

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

THE COURT: We're outside the presence of the jury. Anything we need to put on the record, counsel?

MR. MAZZEO: No, Your Honor.

MR. ROBERTS: No, Your Honor.

THE COURT: All right. We're off the record.

(Whereupon a short recess was taken.)

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

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

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

Do the parties stipulate to the presence of the jury?

MR. MAZZEO: Yes, Your Honor.
MR. SMITH: Yes, Your Honor.
THE COURT: We've got Dr. Klein back from yesterday.
Doctor, because we've had a witness in between, I'm going to have you resworn again. So if you could please stand and raise your right hand.
THE CLERK: You do solemnly swear the testimony you're about to give in this action shall be the truth, the whole truth, and nothing but the truth, so help you God.
THE WITNESS: I do.
THE CLERK: Please state your name and spell it for the record, please.
THE WITNESS: Michael Robert Klein Jr., K-l-e-i-n.
THE COURT: Go ahead. So this is cross-examination.
MR. ROBERTS: That's right.

CROSS-EXAMINATION

BY MR. SMITH:

Q. Dr. Klein, we finished yesterday discussing your surgical experience, and I'd like to start today by talking about your pain management experience.

You have never performed selective nerve root blocks on a patient; correct?

A. That's correct.

Q. You've never performed facet injections on a patient; correct?

A. That's correct.

Q. You've never performed a rhizotomy on a patient; correct?

A. Correct.

Q. You would agree that both Dr. Lemper and Dr. Kidwell specialize in treating the spine; right?

A. Yes.

Q. And they both specialize in the spinal injections that we just discussed; right?

A. Correct.

Q. You have also never prepared a life-care plan detailing medical treatment a person will need for the rest of their life; right?

A. That is correct.

Q. We briefly talked about some MRIs yesterday, but I want to talk about your experience with MRI and CT medical imaging in general.

You didn't take or learn to read CT scans when you were in medical school; right?

A. No. They didn't exist then.

Q. They weren't invented; right?
A. Correct.
Q. That's the same with MRIs like we talked about yesterday?
A. Correct. When I was in medical school, that technique didn't exist.
Q. And you told Mr. Mazzeo yesterday that you read approximately 200 MRIs per year; right?
A. At a minimum, yes.
Q. The vast majority of that is as a defense expert; right?
A. The vast majority, that's correct. I do read them on the patients in my clinics that I order and on the 10 to 15 percent plaintiff cases where an MRI is indicated.
Q. But, again, the vast majority of the MRIs that you look at is as a defense expert; right?
A. Yes.
Q. You agree that you're not trained as a radiologist or a neuroradiologist?
A. That's correct.
Q. Radiologist is a specialty in medicine that specializes in reviewing imaging; right?
A. That's the focus of their training; correct.
Q. And radiologists specialize in reading MRIs;

right?
A. They do.
Q. And in your practice, you would defer to the reading of an MRI that was done by a radiologist; right?
A. Not always, no. The -- the radiologist, unfortunately, doesn't have the background or the clinical history or examine the patient. So depends what information you give them. If their interpretation differs significantly from mine, I'll take the opportunity to go sit with the radiologist and give them more information. So I don't always agree with them. And depends upon who the radiologist is.
Q. Radiologists can be board-certified just like orthopedic surgeons; right?
A. Oh, yes.
Q. They have to go through similar testing and convince other radiologists that they're at the upper echelon of the qualifications; right?
A. That's correct.
Q. And the radiologist that you were talking about yesterday, Dr. Hake, is board-certified, isn't he?
A. Yes, he is.
Q. What you're telling the jury today is that

you believe you are more qualified to read an MRI of Ms. Garcia, who you met one time, than a board-certified radiologist?

MR. MAZZEO: Objection. Misstates the evidence.

THE COURT: Overruled.

THE WITNESS: In this case, I am more board-qualified -- more qualified because I have the entire big picture, as it sits here. And the clinical history and that which took place during the treatment period gives me another layer of qualification that was not provided to Dr. Hake.

BY MR. SMITH:

Q. You agree that Dr. Gross is a board-certified, fellowship-trained neurosurgeon; right?

A. Yes.

Q. And he specializes in spine surgery?

A. He does.

Q. He saw Ms. Garcia many times over the course of her treatment; right?

A. Twice or three times before surgery and, as far as I know, four times post-op.

Q. He's been inside her spine and saw what was going on when he did the surgery; right?

A. He did.
Q. You're telling the jury that you are more qualified to read Ms. Garcia's MRI than Dr. Gross?
A. Oh, yes.
Q. One of the things that you talked about yesterday is that you're a professor at UC Davis; right?
A. Correct.
Q. You're not a full-time, paid professor; you're a volunteer professor one day a week. Right?
A. Yes.
Q. All of the paid work that you do in your career right now is as a litigation expert; right?
A. 95 percent of my income is from litigation. Correct.
Q. Your medical practice that you talked about yesterday is in California; right?
A. Yes.
Q. Obviously, UC Davis is in California; right?
A. Yes.
Q. The -- any treating physician things that you've done in your career have been in California; right?
A. Yes.
Q. You did obtain your license to practice

medicine in Nevada in 2008; right?
A. Correct.
Q. The only reason you obtained your license in Nevada is to perform expert work like you're doing in this case; right?
A. That is correct.
Q. You've never treated a Nevada patient; right?
A. I have seen seven or eight patients that were Dr. Selznick's patients because he wasn't available in his office, but I wouldn't say I was the treating physician. You're correct.
Q. And Dr. Selznick is the person that owns the consulting group that you're working for today; right?
A. That's correct.
Q. The Consultants Medical Group that you talked about?
A. He is the owner.
Q. So you helped him out a few times, but you don't have your own patients in Nevada?
A. No, I do not.
Q. You've been retained by Mr. Mazzeo six to eight times besides this case?
A. I think -- yes. Six or eight times.
Q. And the firm Mr. Mazzeo was working for at the time you were hired, and the firm that hired you,

is Barron & Pruitt right?
A. That's correct.
Q. You've been hired by that firm about 25 times?
A. I think maybe more since I was deposed. Maybe 30 times.
Q. Okay. And all of those 30 times, approximately, were for the defense; right?
A. That is correct.
Q. And you may have testified to this yesterday, but 90 percent of your expert work is for the defense; right?
A. Here in Nevada, that's correct.
Q. Of the 90 percent defense work that you do in Nevada, you disagree with the diagnosis of the treating physician 50 to 60 percent of the time; right?
A. At least. Yes.
Q. And your disagreement with the actual treatment that was rendered to a plaintiff is much higher. You disagree with the treatment rendered to a plaintiff, when you're a defense expert and it's a spine case, 85 to 90 percent of the time; right?
A. Yes.
Q. In those cases where you're disagreeing with the treating physicians, 85 to 90 percent of the time

what you are saying is that you are right and the spine specialists who are treating the patient are wrong; right?

A. No. I think it's -- what I'm saying is that -- my opinion is based upon abrogation digressing away from evidence-based medicine and using techniques that are not indicated when other conservative treatment is indicated. Though -- not that they're wrong. It's just that their approach and their recommended treatment protocol is something that I disagree with in terms of giving an opinion.

Q. Well, if you're saying that they should have done something different, then what they did is wrong; right?

A. No. That's -- I don't say that what they did was wrong; I said I disagree with the indications. And I will usually say, as I did in this case, it's either causally related or causally unrelated. It's not as simple as right or wrong. It's an assessment using the history, the findings, and recommending a technique.

Q. So there's more than one way to treat a spine patient is what you're saying?

A. Of course. I mean, that's -- that's obvious.

Q. And even though you're disagreeing with the treating doctors, that doesn't mean that -- that what

they did was incorrect?

A. Not based on their assessment. Each physician, surgeon, evaluator is entitled to an opinion. That -- that's -- sometimes we're correct; sometimes we're incorrect. So that's the whole approach is try to get -- establish an anatomic diagnosis and then design a treatment program. Sometimes we miss the mark. That's human nature.

Q. And as it relates to the patient, you would agree that it's reasonable for a patient to follow her doctor's advice; right?

A. As long -- yes. As long as she is supplying accurate information upon which the physician or surgeon is designing a treatment program. That's correct.

Q. And you would agree, especially after obtaining a second opinion, it's -- if it's the same as the first opinion, it would be reasonable for a patient to believe that that course of treatment is the appropriate course for her; right?

A. Yes. I think in some cases it can be confusing, but I don't think you can pick on the patient for following a recommendation.

Q. And you don't believe that a -- a layperson who has severe low back pain would know what the best

treatment for her is; right?
A. It varies, Mr. Smith. Depends upon their level of intelligence, how they surf the Internet, what information, so it varies. Some patients are very -- very well versed in the cause of their symptoms. I'm quite amazed. The Internet has provided a very educated patient population.
Q. You don't believe that Ms. Garcia was in a better position than her treating physicians to know what the best course of treatment was; right?
A. I would agree.
Q. Let's talk about your charges in this case. As we just mentioned, you're testifying through a company called Consultants Medical Group; right?
A. That's correct.
Q. They're the ones who sends the bills to the defense attorneys; right?
A. They do.
Q. How much does Consultant -- Consultants Medical Group charge for your time?
A. For today or up to the total?
Q. Total up to now.
A. I have spent about 100 hours as -- before we -- I started yesterday. And they charge $750 an hour. So I think the total is right around $75,000.

And then, as Mr. Mazzeo had me testify yesterday, a full day in trial is 12,000. So that would be 12 plus 75 plus a half day today.

Q. So about 93,000?

A. Yes. Around there. Uh-huh.

Q. Let's talk about your examination of Ms. Garcia.

A. Certainly.

Q. When you examined her, you thought she was being honest with you; right?

A. Yes, I did.

Q. You didn't think she was lying, and you said specifically before that you thought she was being forthright when she was talking to you; right?

A. Yes. I think she understood my questions and gave an honest answer.

Q. And when you examine patients as a defense expert, you do various tests to try and determine if those people are faking; right?

A. Not necessarily that they're faking, in other words, suggesting that there's some pre -- premeditation on their part. We do testing -- I do testing to see if there's something that doesn't make sense, something during the exam. So not as in from an accusatory standpoint.

Q. Do you remember when I asked you that question at your deposition?

A. No. You'd have to give me the page and line. I remember the -- that you did ask me in that area.

MR. SMITH: Your Honor, I'd ask permission to publish Dr. Klein's -- we'll do both of them actually -- his two depositions to the jury. And we only have a certified copy of the first deposition. We have a sealed copy of the second.

THE COURT: That's fine. Give it to Alice to be published.

BY MR. SMITH:

Q. Do you have that in front of you? Is that what you're looking at?

A. I do, Mr. Smith. I have both.

Q. Just so the jury's not confused, you were deposed in this case twice; right?

A. Correct.

Q. And the reason for that is that you didn't have enough time the first day, so we had to come back a second day; right?

A. Yes.

You want me to use these or mine?

Q. You can use the ones I just gave you.

A. Okay. Thank you.

Q. If you take a look at your first deposition, page 127.
A. Uh-huh.
Q. You remember, for your deposition, I came over to your office at Consultants Medical Group; right?
A. Yes. We were in my conference room.
Q. You were put under the same oath you were put under today?
A. That's correct.
Q. If you take a look at page 127 --
A. Uh-huh.
Q. -- line 19. Does that refresh your recollection about your answer to my question?
A. It does.
Q. So when I asked you, "When you examine patients as a defense expert, you commonly give them tests to see if they're faking injury; right?" what did you answer at your deposition?
A. I said, "Yes."
Q. Okay. And the test that you give patients, you -- you have various ones, but one of them, for example, is you put your hands on top of the patient's head and you rest them there. You tell the patient you're going to push down. You don't actually push

down. And then you ask the patient if that's causing pain; right?

A. Correct.

Q. Another one, you do the same thing like that on top of their shoulders. You say you're pushing down. You don't really push down; right?

A. Correct.

Q. You gave those tests to Ms. Garcia, and she didn't claim that she had pain; right?

A. Correct.

Q. You talked about a couple of them yesterday. You talked about simulated axial rotation, and you talked about this one where you have them push their hand against yours. That shouldn't cause pain. You talked about another one where she's supposed to pull her toes towards her nose. That's not supposed to cause pain.

And Ms. Garcia didn't claim she had pain in any of those tests; right?

A. Correct.

Q. Now, when you come into the exam room as a defense expert, you know you are going to do these tests; right?

A. Not always. Depends upon the history. I don't always do the same set of tests. Some of them --

some patients give such an accurate history of a radiculopathy, the test you just demonstrated, the -- the vertical compression test, that would aggravate their symptoms. I wouldn't do that.

Q. In Ms. Garcia's case, you read all of her medical records before she came into your office; right?

A. I did.

Q. So when she walked into the room, you knew you were going to give her these tests to see if she was fake; right?

A. I knew I was going to do the tests. In her case, I didn't think she was going to fake because some of the -- she had such good medical records, as I brought with me, that no one else had ever noted any of these. So I feel I need to be consistent in my exams.

But she was such a good historian in terms of response to my questions. So I -- I just do the same thing each time.

Q. And what you mean by that is, you reviewed her medical records, and it looked like her pain complaints were real?

A. Yes.

Q. And her doctors thought that she was really in pain when she came into their office and complained

of pain; right?

A. She -- yes. One of the things I testified yesterday is her consistency in her presentation of her symptoms.

Q. And that's important to you, right, when a -- when a patient's consistent in their presentation of symptoms?

A. It is.

Q. It generally means to you that those symptoms are real; right?

A. I wouldn't agree with the word "real," but that at least it leads us to think there's some anatomic reason for the symptoms. Correct.

Q. And you've given the opinion before, not in trial, but before, with respect to Ms. Garcia, under oath, that she is not a malingerer and she's not engaging in malingering behavior; right?

A. She does not. She has never done either that I'm aware of.

Q. So she's not embellishing her complaints to get treatment or something like that; right?

A. I don't think she was embellishing. I think she was somewhat, at times, alarmed by her symptoms, concerned about her progress, confused temporally about onset of symptoms. But I don't think at any point she

purposely embellished.
Q. And the things that you just mentioned are all reasonable things for a person who's having severe low back pain; right?
A. At times severe, at other times improvement, and then an exacerbation of symptoms. In other words, instead of making gradual improvement, the symptoms come back. That's correct.
Q. Your exam was on September 24th, 2014?
A. That's correct.
Q. You said yesterday that that's 21 months after her surgery; right?
A. I may have miscalculated. I think --
Q. I'm not saying you're wrong.
A. Oh.
Q. I think you're right.
A. Yeah.
Q. So we're just in agreement. It's 21 months after surgery?
A. It is. She was -- surgery was 12/26/12. So that would be 21 months.
Q. Because you didn't see her until 21 months after her surgery, you haven't done anything to personally verify any complaints that she had prior to the surgery; right?

A. Other -- you mean I -- other than reviewing the records, accepting that that which is reported by the treaters is accurate information.

Q. The same goes for the year after her surgery when she says she was doing a lot better. You never met her during that time period, and you don't have any personal information of her condition at that time; right?

A. Right. That's correct.

Q. So the physical examination that you performed of Ms. Garcia in September of 2014, the one that you described in a lot of detail yesterday --

A. Yes.

Q. -- that's irrelevant to telling the jury what her condition was prior to surgery; right?

A. Yes. Because the surgery created a significant change in her anatomy and in the weight-bearing biomechanics of her spine. You're absolutely correct.

Q. You also haven't examined Ms. Garcia since she receive the more recent facet joints injections and rhizotomies from Dr. Kidwell; right?

A. That's correct.

Q. So, again, you have no personal knowledge of how she's doing, for example, today?

A. That's correct.
Q. And yesterday, when you were discussing this question that you had of Ms. Garcia about what treatment helped her the most, she hadn't yet had the rhizotomies at that point; right?
A. That's correct. The rhizotomies had not been performed.
Q. So when she said, in response to your question, that the surgery gave her one year of relief, she couldn't have said at that point that the surgeries plus the rhizotomies was the treatment that gave her the best benefit; right?
A. That's correct.
Q. You did say yesterday that you believe Ms. Garcia suffered a sprain/strain injury in the January 2011 crash; right?
A. That is my opinion.
Q. A sprain is a sprain of a ligament. A strain is a strain of a muscle; right?
A. Correct.
Q. You also said that you believe it would be reasonable for a sprain/strain injury to come on over a few days, so it wasn't uncommon that Ms. Garcia would have had pain start a few days after the accident; right?

A. Usually the symptoms begin before a few days. And you remember she said to me, she noticed it when she was standing in the cashier's cage the next day in terms of whatever symptoms. And she reported she thought she had some numbness in her foot. So she was symptomatic, as she shared with me, within 24 hours of the event.

Q. You don't think the presentation that she described to you of when her pain began or her symptoms began is uncommon for a sprain/strain injury; correct?

A. Correct.

Q. You also agree that the chiropractic treatment she received, the treatment from Primary Care Consultants, and Dr. Lemper's first injection were all reasonable and necessitated by the January 2011 crash; correct?

A. Correct.

Q. And you said that all of the treatment that Ms. Garcia received up to September 1st, 2011, is related to and caused by the crash; right?

A. Yes.

Q. There's been some discussion in this case about whether our -- our firm referred Ms. Garcia to her chiropractor. You agree that it would be reasonable for our firm to have sent her to a

chiropractor if she didn't have another way to get medical care; right?

A. Yes.

Q. Now, it's your opinion when we talk about the sprain/strain injury that those injuries get better within a few months; right?

A. In most cases. In some cases -- I testified yesterday that, depending upon the body habitus of the individual, the person who's overweight and deconditioned, it's going to be more protracted. But in -- in most cases, it's a few months. It can be up to six months in some cases.

Q. So in the outside extreme, if a person is very deconditioned, which is the word you have used in your report, it might take up to six months for a sprain/strain injury to heal?

A. Yes, depending on the term "heal." We know that, at the microscopic level, it doesn't take the cells that long, but patients can remain symptomatic for up to six months.

Q. It can take up to six months for the pain to go away?

A. To go away completely --

Q. Yes.

A. -- yes.

Q. And if it's a -- if somebody has a sprain/sprain injury, their pain should have gone away within six months; right?

A. 95 percent of cases, yes, depending upon preexisting degenerative changes in either muscle, ligaments, disk spaces, facet joints. All those have to be taken into consideration.

Q. So the sprain/strain injury can affect the facets and the disks?

A. A very severe, isolated sprain in association with a severe rotatory injury could affect facets. A sprain/strain from a severe compression injury could affect the disks. In other words, all this -- all this tissue is contiguous and works together with the other tissue.

Q. You -- you agree that conservative care, like chiropractic care, is reasonable to speed up the healing process that we're talking about; right?

A. It doesn't -- there isn't any modality I'm aware of that speeds up the process. That's -- that's part of each individual's ability to heal both at the microscopic and macroscopic level. The chiropractor is a guide, as is a physical therapist. It doesn't speed up any healing process.

Q. It helps with the healing process; right?

A. Yes. Especially the soft tissue modalities, they feel good. Education of the muscles is important. Initially, they cause increase symptoms, but it doesn't speed up any process.

Q. You said in your deposition that a sprain is like when you twist your ankle; right?

A. That's one example near a weight-bearing joint; correct.

Q. And that's something that most people have experienced at some point in their life by the time they get to 30 years old; right?

A. Correct.

Q. A strain is like when you pull a muscle; right?

A. Correct.

Q. Those are the types of sprains and strains that get better within a few months if you, you know, rest them and take care of yourself; right?

A. In most cases, depending upon the magnitude of the injury, the age of the patient, preexisting anatomic abnormalities, all that has to be taken into consideration. But in general I agree with you.

Q. You would also agree with me that, if somebody sprains their ankle, it generally causes immediate pain; right?

A. It does.
Q. Now, you agree, from your review of all the medical records, and you -- well, strike that.
You reviewed all of her medical records carefully; right?
A. I did. Some of them several times.
Q. And you agree that all of the doctors and all of the experts that you've seen in this case have said that the spondylolisthesis she had predated the crash; right?
A. Yes.
Q. You agree with that also; right?
A. I do.
Q. None of the medical experts in this case are -- are saying that the -- medical -- excuse me.
None of the medical experts or treating physicians in this case are saying that the crash caused a break in the bones of her lumbar spine. That's right?
A. That's correct. And no one has testified, that I'm aware of, or opined in a report that she sustained a pars fracture. That's correct.
Q. So all of the questioning that you got yesterday about whether the accident caused a break in her spine and all of the other questioning that's gone

on in this case about whether the accident caused a break in the bones of her spine is completely irrelevant to -- to your opinions and the medical records that you have reviewed; right?

MR. MAZZEO: Objection, your Honor. Misstates testimony and questions.

THE COURT: I'm going to overrule it. The jury's going to have to use their memory of what was said.

THE WITNESS: Can you repeat the question, please?

MR. SMITH: Can you read it back for me?

(Record read by the reporter.)

THE WITNESS: Wrong.

BY MR. SMITH:

Q. Do you think it's relevant to discuss whether the crash caused a break in her spine when not a single doctor has said that that's what happened?

A. Well, first of all, in the line of questioning yesterday, we didn't use the term "break." I think that's an inaccurate term.

No one has opined that she has a break anyplace in her spine. That's the lay term for a fracture. So that's -- that doesn't really make sense to say that.

The issue is whether or not -- the whole line of questioning using the diagnostic studies is did her preexisting Grade II spondylolisthesis change in any way creating a situation of instability and pressure on those structures at greatest risk, the nerve roots. That is what went on for three hours yesterday with -- under direct.

We never talked about a break in her spine. I'm not -- I can -- I'm concerned that you use even that terminology because no one's ever said she's had a fracture, none of her treaters, none of the radiologists, or myself.

Q. Let me use your words.

A. Sure.

Q. You said "wouldn't make sense."

A. Yes.

Q. So you agree that it wouldn't make sense to have asked the treating physicians about whether the accident caused a -- a break in the bones of Ms. Garcia's spine; right?

MR. MAZZEO: Objection. Misstates the testimony.

THE COURT: He's asking whether a question would have been appropriate. I'm going to allow it.

THE WITNESS: I can't see it as a posed

question from a treater. I can see Ms. Garcia saying, "Did I sustain a fracture" or, in lay terms, "a break"? but not from a -- a treater.

All the treaters she's seen, beginning with the ER doctor to Gulitz, hopefully they know that a break produces severe symptoms almost immediately. So that's sort of a non sequitur. It doesn't make sense.

BY MR. SMITH:

Q. That's the testimony you gave yesterday, right, that a break produces immediate severe symptoms; right?

A. No. I didn't use the word "break." So if you keep saying the word "break," I'm not going to agree with you.

I said movement irritating the nerve root, the structure at risk, produces immediate symptoms if there is movement at a spondylolytic defect.

Q. The real dispute between you and the doctors over her symptoms, the treating doctors --

A. Yes.

Q. -- is whether the spondylolisthesis she had that predated the crash began causing her pain after the crash; right?

A. Yes. I think that is the -- is the issue. You're absolutely correct.

Q. And you agree, based on your review of the records and your discussion with Ms. Garcia, that her pain did not get better after six months; correct?
A. The pain she initially had, Mr. Smith, or the pain that was there at three months, four months, or five months?
Q. She wasn't pain-free in her low back after six months; right?
A. She was not.
Q. She was not pain-free in her low back a year after the crash; right?
A. That's correct.
Q. She was not pain-free in her low back when she went in for surgery on December 26th, 2012; correct?
A. Yes. Based on her representations, that is absolutely correct.
Q. And you've said you believe her representations?
A. I do.
Q. Let's talk about spondylolisthesis in general.
A. Sure.
Q. You believe that 8 to 12 percent of the general population has a spondylolisthesis; right?

A. It's -- yes, it's the oft-time repeated, you know, percentage in -- in -- among my specialty; correct.

Q. Of those 8 to 12 percent, only 7 to 14 percent ever develop symptoms from the spondylolisthesis; right?

A. Yes. I think those are the numbers I gave you in my depo, yes.

Q. And -- and you've said that 10 to 12 percent of women with a spondylolisthesis develop pain from their spondylolisthesis before the age of 33; right?

A. Yes. As I mentioned yesterday, it occurs very commonly during the third trimester of pregnancy.

Q. What literature are you relying on for that opinion?

A. My 45 years of experience as an orthopedic surgeon and what patients report to me and also the fact that I did a lot of prenatal care for four years.

Q. We're going to come back to that opinion and discuss some of the literature that you have cited in this case.

A. Certainly.

Q. You've also said that, of those 10 to 12 percent of women who might develop pain, only 5 to 6 percent ultimately have surgery; right?

A. That's what I have in my memory base, yes.
Q. So 5 to 6 percent of 10 to 12 percent is about a half a percent; right?
A. Seems to be.
Q. 1 in 200; right?
A. Yes.
Q. It's -- it's rare that a person with a spondylolisthesis is going to need a surgery to fix pain from the spondylolisthesis; right?
A. Well, it varies depending upon the age of the patient, the things that they do, willing to make modification. You printed some of the articles that I mentioned looking at 45 years of follow-up, conservative treatment.

So you're absolutely correct; a small percentage require the surgery.
Q. But the surgery in those cases is appropriate; right?
A. Yes. Because they usually demonstrate instability after in-depth evaluations. And they've failed all types of conservative treatment, including weight loss, improvement in reversing deconditioning. All those factors are in the articles that you printed and read.
Q. The North American Spine Society that you

said you are a member of --

A. Yes.

Q. -- they publish guidelines; right?

A. We did in 2014.

Q. And their guidelines say that surgery is an appropriate way to fix a symptomatic spondylolisthesis; right?

A. Yes.

Q. According to the North American Spine Society -- you want to call them North American Spine Society or NASS? What's going to be easier for you?

A. What's ever comfortable for you.

Q. According to the North American Spine Society, fusion is successful 75 percent of the time in relieving symptoms from -- from a spondylolisthesis; right?

A. Yes.

Q. And -- and you agree with that number; right?

A. I do.

Q. When we're talking about the success rate, though, you also agree that that doesn't mean all of a person's pain is alleviated; right?

A. Yes. Patients -- the prudent spine surgeon would say to the patient, "There's no guarantee you're going to be pain-free, but you're going to be improved,

you're going to be better," whatever that means.

Q. And, in fact, it's unlikely that a patient would be pain-free from a spinal fusion surgery to fix a spondylolisthesis; right?

A. Yes. But, as you remember from the articles that I mentioned and that you printed out and read, the purpose of the surgery is demonstration of instability. And the purpose of the surgery is to prevent further progression for making a symptomatic Grade I to become a II, a symptomatic Grade II to become a III. That's clearly identified. And that's why the patients do make improvement, but they aren't always asymptomatic.

Q. Right. Because the improvement is some improvement in pain or function.

But, again, you're not looking for a complete resolution of pain; right?

A. No. The focus is on structural stability, understanding they have an unstable segment that is producing symptoms. Do we have an ability as surgeons to stabilize that segment and prevent further progression? That's the whole point of the surgery.

Q. So we just talked about that the likelihood of needing a spondylolisthesis fixed by fusion surgery is a half percent for the age of 33.

You have also said that the average woman who

doesn't have a spondylolisthesis has a 4 to 5 percent chance of needing a fusion surgery prior to -- to 33; right?

A. No. Well, depends how you look at the data. The 4 to 5 percent of the individuals who have a symptomatic -- in other words, you can first take and say, "We've got 8 to 12 percent of the population that has a spondylolisthesis," usually Grades I and II; IIIs are not that common.

Of those that become symptomatic who didn't know they had spondylolisthesis, like Ms. Garcia, 4 to 5 percent of those eventually end up having a reconstructive stabilizing procedure. It's a small percentage.

Q. And I'm asking you a different question.

A. Oh, then, I'm sorry. I misunderstood.

Q. And maybe I phrased it poorly.

I'm talking about the general population of women under the age of 33 --

A. Yeah.

Q. -- whether they have a spondylolisthesis or not.

A. Yes.

Q. You've told me that the rate of back surgery in that population is 4 to 5 percent; right?

A. It may be even less than that. But remember I'm seeing patients that are coming to me who have symptoms or patients that are referenced in the reports I read or the meetings I go to. So it's -- I keep seeing a subset of patients, but I don't know -- it's a small percentage under the age of 33.

Q. But when we look at the percentage of a half percent of women that have a spondylolisthesis --

A. Uh-huh.

Q. -- and 4 to 5 percent of women in general --

A. Uh-huh.

Q. -- then it's much more -- or -- or it's no more likely than, with a spondylolisthesis and absent trauma, a woman under the age of 33 is going to need a spine surgery; right?

A. I would agree. I think you have a good handle on the numbers.

Q. Yesterday you talked about a couple of postsurgical complications that Ms. Garcia had from the fusion surgery.

A. Yes.

Q. You mentioned internal scarring and a pseudarthrosis; right?

A. A pseudarthrosis and scarring.

Q. Both of those are potential complications

from a fusion surgery; right?

A. They are.

Q. They are things that a doctor might even explain to a patient before the surgery as a potential complication for afterwards; right?

A. I would hope so.

Q. The scarring that you're talking about, if Ms. Garcia has that, that doesn't mean that Dr. Gross did something wrong when he operated on her; right?

A. No. I wouldn't use the term "wrong," but there are techniques that we employ now to avoid the scarring. In other words, limiting the dissection. So that doesn't make it wrong. It depends upon his training and understanding. It isn't necessarily wrong, but there's ways to avoid developing the scarring.

Q. And he testified about some things that he did to avoid scarring.

And if he did those things, she could still have developed scarring; right?

A. Yes. One of the things that we know that happens is placing foreign bodies into the bone and soft tissue.

Q. And the other thing that you talked about, the pseudarthrosis, that also doesn't mean -- well,

strike that.

If Ms. Garcia actually has the pseudarthrosis, that also doesn't mean that Dr. Gross did something wrong when he performed the surgery; right?

A. In my opinion, he did do something wrong.

Q. You have never given the opinion that Dr. Gross did something wrong that led her to have a pseudarthrosis in this case; right?

A. Well, yesterday I did allude to that in terms of failure to develop a symmetrical construct. I've never put it into one of my reports. But in response to the questions proposed under -- by Mr. Strassburg, that came up.

Q. That's a brand-new opinion you brought up at trial; right?

A. No. That happens. That can't be news to you that -- depending on the questions and the evidence presented.

Q. You have previously said under oath --

A. Yes.

Q. -- that Dr. Gross did not commit any malpractice; right?

A. That's still my opinion. He didn't commit any malpractice.

Q. You don't think that he committed malpractice in any of his care of Ms. Garcia; right?
A. In my opinion, nothing that he did is substandard care. There's some technical issues but not substandard care.
Q. And you understand that there's a -- there's a standard of care in -- in the community that doctors are supposed to meet when they're providing care to their patients, and you would agree that Dr. Gross met the appropriate standard of care; right?
A. Yes.
Q. He was not extraordinarily negligent, was he?
A. He was not extraordinarily negligent. He was not.
Q. And you agree that all of the other treating physicians whose records you reviewed met the appropriate standard of care; right?
A. In the techniques they employed; correct.
Q. You would agree that none of Ms. Garcia's treating physicians committed malpractice when they treated her?
A. I would agree.
Q. You would agree that none of Ms. Garcia's treating physicians were extraordinarily negligent in their treatment of her; right?

MR. MAZZEO: Objection, Your Honor. Beyond the scope of direct. Not relevant to this case.

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

THE WITNESS: Can you read back the question, please?

BY MR. SMITH:

Q. You would agree that none of Ms. Garcia's treating physicians were extraordinarily negligent in their care of her; right?

A. I would agree. I don't agree with some of their assessments. But, in my opinion, none of them did anything that would be substandard.

Q. Let's talk about another statement you made yesterday.

MR. SMITH: And, Audra, can you put up page 59, lines 12 to 17?

THE WITNESS: Is that going to appear up here?

BY MR. SMITH:

Q. It will as long as the TV is on.

Do you see that on your screen?

A. I do.

Q. You were asked the question, "What did Ms. Garcia tell you with respect to whether she lost

any time from work following this incident?"

And your answer was, "Other than her physician visits, like the ER or when she started her chiropractic care with Dr. Gulitz, she had not lost any time from work."

That was your testimony yesterday; right?

A. Yes.

Q. And you're looking at your report right now because you know that testimony is not the same as what you put in your report; right?

A. Let's see.

Q. Why don't you look at page 2 of your initial report.

A. I am.

Yes, the statement is incomplete because she did tell me -- she said she lost no time from work except for her injections but was off for four months after the spinal surgery.

Q. And you know from your detailed review of Ms. Garcia's medical records that she also took FMLA leave; right?

A. She did.

Q. And you saw in your review of those records that Dr. Gulitz, Dr. Lemper, and Dr. Gross all submitted FMLA paperwork to her employer so that she

could take off time for pain as needed; right?

A. Yes. However, part of the testimony in her depo -- and I don't remember exactly -- she was terminated from that position she had. So there was a period of time that she had no employment, and then she got reemployed. So that may be part of why I responded that way.

MR. SMITH: Your Honor, I move to strike as that misstates the evidence and violates the Court's order.

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

THE COURT: Sure.

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

THE COURT: Okay. The question is going to be granted. The word "termination" is going to be stricken from the record. That's -- that's not something you're to consider.

BY MR. SMITH:

Q. And you said a moment ago that you carefully review all of the records; some of them you reviewed more than once. Right?

A. Yes. Some are more meaty than others.

Q. Yesterday you mentioned a CT scan of Ms. Garcia's head and an X ray of her chest at

MountainView.

Do you remember that?

A. Yes.

Q. You detailed both of those in your reports; right?

A. Well, I didn't mention them because I never was provided the CT of the head, just the report.

Q. You had the report from MountainView; right?

A. I did.

Q. And you talked about it in -- in your report; right?

A. Yes, I did.

MR. SMITH: Audra, could you put up Exhibit 8, page 18, please.

BY MR. SMITH:

Q. This is the CT scan report that you reviewed very carefully; right?

A. Well, I just -- I read the report. I don't know that I carefully -- I just read, you know, what the opinion was of the radiologist.

Q. Did you read the patient's name?

A. It says "Garcia, hyphened, Elvira Elvia."

Q. And the age?

A. 38.

Q. Is this a CT scan of Emilia Garcia's head?

A. No, it's not.
Q. Can you put up page 19, please.
Same question with this record. Is this an X ray of -- of Emilia Garcia's chest?
A. It is not.
Q. And you didn't notice that these were from a different patient when you did your evaluation of Ms. Garcia; right?
A. You mean when I reviewed the records?
Q. Correct.
A. No, I didn't.
Q. Well, and by the time you evaluated her.
You didn't change your opinion because you wrote a report after you evaluated her and said that these were from Ms. Garcia; right?
A. Yes, I did.
Q. All right. Let's talk about another discussion you had with Mr. Mazzeo yesterday about changes at the L1-2, L2-3, and L3-4 level on the MRI.
Do you remember that discussion?
A. I do.
Q. And you remember that Mr. Mazzeo gave you the reports of those MRIs instead of asking your opinion about your review of the MRI scans; right?
A. Yes. Regarding one radiologist talking about

bulges and another not mentioning bulges.

Q. And what you're talking about is the first two reports say no significant posterior bulges at those levels; right?

A. Correct.

Q. And the third report shows some small bulges at those levels; right?

A. Correct.

MR. MAZZEO: Objection, Your Honor. That's not what the reports state.

THE COURT: He just agreed that it did.

MR. MAZZEO: I'm sorry.

THE COURT: He just agreed that it did, so objection's overruled.

BY MR. SMITH:

Q. You would agree that the bulges mentioned in the last MRI, the one from November 2012, are not significant; right?

A. Correct.

Q. And you don't see any discrepancy between those three MRIs with respect to L1-2, L2-3, and L3-4; right?

A. No. And, in fact, I was provided all those MRIs, and the findings at each one of those levels has nothing to do with any particular aspect of this case.

Q. And the MRIs are the same at those levels; right?

A. They are.

Q. There's -- there's nothing in those MRIs, for example, that would show some intervening trauma that Ms. Garcia had between August of 2011 and November of 2012; right?

A. Yes. And -- and the significance is, fortunately, she never had any symptoms emanating from any of those nerve roots. You're correct.

Q. Now, when you talk about the MRIs -- I can wait for them to come in.

A. They're just waiting for you to cross-examine them.

Q. I don't have any notes on them.

THE COURT: I don't know how long it'll take them. Go ahead.

BY MR. SMITH:

Q. You don't have a precrash MRI to compare any of these post crash MRIs to; right?

A. No.

Q. So of all the things that you talked about yesterday and you showed on the MRI, you don't have any way to verify whether those were the same on the MRI before the crash versus after; right?

A. Correct. There was no preaccident MRIs.
Q. You mentioned before some of the articles that you talked about in your reports; right?
A. Yes.
Q. One of those articles is an article from Donelson.
And you would agree that that article says that MRIs alone are unable to diagnose back pain in 85 percent of the cases; right?
A. Well, that's Ron Donelson's opinion. But again ...
Q. Well, that's -- that's an article that you cited; right?
A. It's an article I cited to provide some balance and education, exactly.
Q. I didn't do my own research and come up with that; you cited it and gave it to me. Right?
A. I did. And you printed it out. You read the whole article.
Q. And you agreed with that yesterday -- excuse me -- when you said that you never hang your hat on an MR report; right?
A. Yes. That is not the singular index study in attempting to make a diagnosis. You're absolutely correct.

Q. And what you said is, instead of relying upon the MR report, the most important thing is the history; right?

A. Without a doubt, the history.

MR. SMITH: Audra, can you put up page 161, lines 17 to 20 from yesterday?

BY MR. SMITH:

Q. All right. Well, I gave her the wrong page, but what you said yesterday is that she was able to function, her activities of daily living, taking care of her children, going to work, with the exception of -- of her visits to Dr. Gulitz and her physicians.

Do you remember that?

A. Initially, during the treatment, yes. Correct.

Q. Again, that wasn't history she gave you, was it?

A. Well, I didn't ask her specifically about that period of time. I shared with her I had her records, but I didn't -- I didn't, again, ask her each one of those visits she made. No.

Q. But -- and you didn't say this yesterday, but she specifically told you when you met with her on September 24th, 2014, that, prior to the crash, she used to walk up and down the stairs at work and she

used to walk for 30 minutes every night; right?
A. Yes.
Q. And she told you that, after the crash, she couldn't do those things anymore; right?
A. Correct.
Q. She also told you that, prior to the crash, she would volunteer at her children's school and, after the crash, she wasn't able to do that anymore; right?
A. That's correct.
Q. She told you that, after the crash, her housework is limited, especially sweeping and mopping; right?
A. Aggravating factors. That's correct.
Q. She said, after the crash, even though she has three kids, she's only able to do 20 percent of the cooking, 30 percent of the laundry, and 15 percent of the housekeeping; right?
A. Yes.
Q. Those things that I just asked you about, those are activities of daily living; right?
A. Well, wait a second. Those are the things that I asked her for the past three or four months, not right after the crash, Mr. Smith. Those are her limitations. When I interviewed -- when I interviewed and examined her September -- September 24th of '14.

Because I specifically wanted to know about her activities for the past three to four months. It wasn't right after the crash.

How her current constellation of symptoms, as she shared with me, that we spoke about, where it says low back and right leg, under the history, how those were limiting her with her responsibilities at that time, not right after the crash.

Q. Well, you just said -- it's not what your report says, is it?

A. It's exactly what my report says.

Q. Okay.

A. It may be not how you interpreted it, but that's exactly what my report says.

Q. Let's turn to page 3 of your report.

A. Okay.

Q. You wrote, "She stated" --

A. Let me get back to the -- page 3.

Q. "She stated that, prior to 1/2/11" -- and you agree 1/2/11 is the date of crash; right?

A. Right.

Q. "She stated that, prior to 1/2/11, during her one-hour break, she would go to a stairwell that went up and down five stories, and she would climb up and down the stairs for 30 minutes." She has not returned

to that activity."

MR. MAZZEO: Objection, Your Honor. Asked and answered. And that's not -- he's not referencing the question he last asked him before looking at his report.

THE COURT: Overruled.

BY MR. SMITH:

Q. You continue, "She also walked for 30 minutes in the evening. She has not returned to that activity. She did not participate in any seasonal sports. She used to volunteer at her children's school. She has not returned to that activity. She stated her housework is limited."

And -- and I'm not going to read the whole thing, but it gives the percentages that we just talked about; right?

A. Yes.

Q. And you're telling me, when -- when your report says "prior to 1/2/11," I'm reading it wrong?

A. You're not reading it wrong, but you're -- and this is an -- I could say it was an omission on my part, but I very specifically said to her, as if you look down under current symptoms, which is the next long full sentence, which it says "Symptoms -- she's --symptoms" -- excuse me.

"Symptoms she has been having the last three to four months." That -- where it says, "Ms. Garcia states she does 20 percent of the cooking, 90 percent of the laundry, 15 percent of the housekeeping."

Those were her limitations when I saw her because she did all of those things at 100 percent prior to the accident.

Q. Again, you're not correctly stating what your report says, are you?

A. Of course I am.

Q. The -- the section we just read was called Personal Activity Limitations; right? That's the one that I read to you, and you agreed that's what it says; right?

A. Yes.

Q. The next section after that, because they're bolded in their headings, is Current Symptoms, where you say, "Ms. Garcia was asked to describe the symptoms she's been having for the last three months -- three to four months and those anatomic areas she relates to the subject accident."

And then, following that, you discuss her low back, her right leg, and those are the areas -- the anatomic areas that she was having pain in following the accident; right?

A. That's correct.
Q. Okay. Let's talk about motor vehicle collisions in general.
A. All right.
Q. You agree that it's possible to injure the spine in a motor vehicle crash; right?
A. Yes.
Q. You agree it's possible to injure the lumbar spine in a motor vehicle accident crash without also fracturing a vertebra; right?
A. Correct.
Q. You agree a person can injure a disk in their spine -- in their lumbar spine in a motor vehicle accident; right?
A. I agree.
Q. You agree that a person can be in a motor vehicle accident with small visible damage to the vehicles and still injure their lumbar spine; right?
A. Yes.
Q. And, in fact, when I asked you at your deposition what might make it more likely for a person to injure their lumbar spine in a motor vehicle accident that might have small damage, your answer was, "A spondylolisthesis like Ms. Garcia had"; right?
A. Yes. I think I used the term "a preanatomic

disposition."

Q. Well, you specifically referenced Ms. Garcia and her spondylolisthesis; right?

A. Yes. She had a condition which could have been aggravated by a motor vehicle accident.

Q. And would have made it more likely that she would be injured in a motor vehicle accident; right?

A. Yes. The possibility exists.

Q. And -- and you also agree that it's more likely for a person to be injured in a motor vehicle collision if their vehicle spins; right?

MR. MAZZEO: Objection, Your Honor. Speculation. Foundation. Beyond the scope of direct.

THE COURT: I think it is.

MR. SMITH: I'll move on.

THE COURT: I will sustain that.

BY MR. SMITH:

Q. Let's move to another general topic. Let's talk about pain management in general.

A. Sure.

Q. You agree that selective nerve root blocks are an appropriate way to treat structural injuries to the lumbar spine; right?

MR. MAZZEO: Vague.

THE WITNESS: Yeah --

THE COURT: Overruled.

THE WITNESS: I'm not sure I understand the question when you say "structural injury." There -- there's a specific reason for selective nerve root blocks, but part of that -- go ahead.

BY MR. SMITH:

Q. You agree that selective nerve root blocks are an appropriate type of treatment for certain kinds of spine pain; right?

A. Yes. An appropriate diagnostic tool. You're absolutely correct.

Q. And they are not an appropriate treatment for sprain/strain injury; right?

A. They are not.

Q. There's another procedure that you talked about yesterday called a spinal cord stimulator; right?

A. Briefly. I was asked was it my opinion or do I hold the opinion that a spinal cord stimulator is going to resolve Ms. Garcia's current constellation of symptoms. And I opined that it was not.

Q. You never implanted a spinal cord stimulator; right?

A. I have not.

Q. And that's something that's done by a surgeon; right?

A. Some interventionalists are trained, but mostly by surgeons.

Q. You know that the current technologies for spinal cord stimulators is about seven years old, and that's well after you stopped doing any surgeries on anyone's spine; right?

A. That's correct.

Q. Now, you've seen the records where Ms. Garcia had a trial spinal cord stimulator; right?

A. Yes.

Q. Now, the concept of the trial spinal cord stimulator is to implant the leads without doing the surgery to determine if the person might get benefit from the permanent stimulator; right?

A. Yes.

Q. It's -- it's a really beneficial shortcut where you can tell if it's going to work without actually undergoing the surgery; right?

A. It gives you a bit of a sense of direction. It -- it has some limitations, but it's a start.

Q. It -- and you would agree, regardless of what limitations there are, that Ms. Garcia got relief from the spinal cord stimulator; right?

A. In my experience, almost 90 percent of individuals who have the trial get some relief.

Correct.

Q. That includes Ms. Garcia; right?

A. She did. She had some relief.

Q. Now, you said yesterday that you've been on the evidence-based medicine committee of the North American Spine Society since 2012; right?

A. I think it's around -- yeah, I think 2012. Sometime -- let's see. I joined in '09. It may be when I was asked to join. Sometime around there. Last couple of years.

Q. Your period on the evidence-based medicine committee ended in 2014, didn't it?

A. It did. And I -- I was asked just last year did I want to, you know, rejoin.

Q. You're not still on the evidence-based medicine committee?

A. Not right now.

Q. You said yesterday that you're still on the evidence-based medicine committee. That wasn't right; correct?

A. If I gave you that opinion, that's wrong. I was a member.

Q. You're a member of the North American Spine Society?

A. I continue, yes.

Q. And one of the things that you like about the North American Spine Society is that they let a lot of different people become members, not just spine surgeons; right?

A. That's correct.

Q. Chiropractors, rehab specialists, physical therapists, acupuncturists, primary care physicians. Everyone who wants to be on -- a member of NASS can be a member of NASS; right?

A. They let them come to the meeting. They don't let all of them become members.

Q. Well, some of those can become members. Chiropractors can become members; right?

A. Oh, yeah. Sure.

Q. Other physicians and specialties other than orthopedic surgery can become members; right?

A. When you make application, the -- the series of question is to what percentage of your practice is devoted to spine. That's probably one of the biggest issues. Yes.

Q. One of the things that you said yesterday is that 95 percent of spine care is done by nonsurgeons; right?

A. In the United States, yes.

Q. And -- and the list that I was just giving

you is a list that you gave yesterday about the -- the spine care by nonsurgeons?

A. Correct.

Q. Chiropractors, rehab specialists, physical therapists, acupuncturists, primary care physicians, and Pilates instructors. That's what you said yesterday; right?

A. Yes.

Q. You aren't trying to say that an acupuncturist or a Pilates instructor is as qualified as a spine surgeon to diagnose and treat Ms. Garcia's spinal pain, are you?

A. No. I'm just sharing with you where some patients go when they have low back pain, which comes under the heading of spinal care.

MR. SMITH: I don't know what time you want to break. I can keep going or stop.

THE COURT: It's probably a good time to stop if you're at good spot.

MR. SMITH: Okay.

THE COURT: Let's go ahead and take our lunch break, folks. We're on break.

You're instructed not to talk with each other or with anyone else about any subject or issue connected with this trial. You are not to read, watch,

or listen to any report of or commentary on the trial by any person connected with this case or by any medium of information, including, without limitation, newspapers, television, the Internet, or radio.

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

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

Let's go till 1:15. We all stand when the jury comes in and out.

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

THE COURT: We're outside the presence of the jury. Anything we need to put on the record, Counsel?

MR. ROBERTS: No, Your Honor.

MR. MAZZEO: We don't have to put it on, there's just an issue that we have to discuss regarding the -- Ms. Garcia's employment record. We don't have to do that now.

THE COURT: Why don't you come back at five

after 1:00.

MR. MAZZEO: Okay.

THE COURT: That will give us ten minutes before the jury comes back.

MR. MAZZEO: Or tomorrow or this evening.

THE COURT: Okay. That's fine.

MR. MAZZEO: Whatever you want.

THE COURT: If it's not urgent --

MR. MAZZEO: It's not urgent.

THE COURT: We'll do it later, then.

MR. MAZZEO: Okay.

THE COURT: We'll see you back at 1:15. Off the record.

(Whereupon a lunch recess was taken.)

THE COURT: Remain seated. Come to order.

(Discussion was held off the record.)

THE MARSHAL: Jury entering.

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

THE MARSHAL: Jury is present, Judge.

THE COURT: Thank you, Tom.

Go ahead and be seated. Back on the record, Case No. A637772. Do the parties stipulate to the presence of the jury?

MR. SMITH: Yes, Your Honor.

MR. MAZZEO: Yes, Your Honor.

MR. STRASSBURG: Yes.

THE COURT: I don't want to make a real big deal about it, but I told you 1:15, and it's 1:15. It may be the first time during the trial, and we are in week four, but we try.

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

THE WITNESS: Thank you, Your Honor.

THE COURT: Go ahead, Mr. Smith.

BY MR. SMITH:

Q. I want to start this afternoon talking about evidence-based medicine, which is a term that you've used a bunch of times as you sat on the stand yesterday and today; right?

A. Yes.

Q. And -- and I want to get a definition of evidence-based medicine that we can work with. So evidence-based medicine, as you are describing it, means relying upon peer-reviewed literature in addition to just clinical experience; right?

A. Yes. A combination of the two.

Q. It is the idea that a doctor should have some studies and some literature to back up the decisions he's making instead of just relying upon his experience

as a physician; right?

A. Yes. The -- the precursor of what you -- just what you said, is consensus medicine versus data. Correct.

Q. And by consensus you mean relying upon articles and studies as opposed to just the individual doctor's personal beliefs; right?

A. Yes. Or a group of physicians sitting around and saying, well, we think this is the best way to do it. You know, good old boys. Let's get some data and more scientific approach. Correct.

Q. The good old boys is not evidence-based medicine; right?

A. It is not.

Q. So I want to talk about some of the literature that you cite in your report or told us in your deposition that you relied upon for your opinions here. Okay?

A. Correct.

Q. And literature is important to you; right?

A. It is.

Q. So you told me earlier today that the incidence of spondylolisthesis is 8 to 12 percent; right?

A. It's the number that I remember, yeah.

Q. And you -- you admit that the NASS number is 5 percent; right?

A. Yes.

Q. You do admit that the vast majority of those people, as we discussed earlier, are pain-free; right?

A. Yes. The NASS number references a percentage of individuals, population, all age groups, males and females, who don't know they have it. Correct.

Q. And what NASS talks about is most people are pain-free, but other people develop back or leg pain that might require surgery; right?

A. Correct.

Q. Now, during this case, you provided us with this booklet, which is the *North American Spine Society Evidence-Based Clinical Guidelines for Multidisciplinary Spine Care, Diagnosis, and Treatment of Degenerative Lumbar Spondylolisthesis*; **right?**

A. Correct.

Q. You gave that to me; you gave counsel for the defendants a copy. Right?

A. At the time of my deposition.

Q. And you've said that you're relying upon some of the guidelines that are -- are in this booklet for your opinions; right?

A. Yes. Not the ones that -- as you know,

you've reviewed it -- where it says "I," insufficient evidence. And then the comments made next to the question that's posed. Yes.

Q. Well, let's talk about that.

The distinction that you're making is that all of these guidelines are not necessarily based on really good peer-reviewed literature; right?

A. Correct.

Q. And what NASS does is they give a scale, 1 to 5, on how good their recommendation is; right?

A. Yes.

Q. And the scale of -- the number 1. So if -- if we get a Level 1, that means rock-solid, peer-reviewed literature that we can all follow; right?

A. Yes.

Q. And -- and once we get to Level 2, we're beyond that, and it's generally inconclusive; right?

A. Level 2 is a difficult area because so much stuff falls into 2. There's a crossover. But what you have just said is accurate.

Q. Because NASS defines Level 2 as fair evidence for and against recommending intervention; right?

A. Yes. They obviously couch their term by throwing in the word "fair."

Q. And one of the things you have also told me

is that you contributed to -- well, strike that. I think I said that one.

One of the things that you told me is that somebody else wrote the diagnosis and imaging section, but you reviewed it before the final product came out; right?

A. The -- they send me all these emails and they ask you to keep commenting. And the last time it came out, I threw in a couple of comments about terminology, of what -- interpreting. I don't know if they ever took them into -- took my comments to heart, but yes.

Q. And that was on the diagnosis and imaging section; right?

A. Yes.

Q. And you would agree that this document lists the individuals on the NASS evidence-based clinical guidelines committee; right?

A. Oh, yes.

Q. And it lists 19 individuals, and your name is not on that list; right?

A. It would never be on that list.

Q. At your deposition, you told me that you weren't on that list because there's at least 50 people involved around the country that do what you do; right?

A. Oh. I think there's more than that. It's

not just the U.S.; it's international. There's NASS members -- the -- the ones that are in the front -- and I can get my copy out if you want -- but those are the -- they call them -- there's a chair, then there's subsection guides. And then, if you go to the next page, it lists even more. Those of us out in the trenches, we don't -- we don't get recognized. You go to the *Journal of Bone & Joint Surgery*, you wouldn't see my name anyplace. But I review lots of articles.

Q. You've never given us any documentary proof or anything showing that you were actually on the evidence-based medicine committee of NASS; right?

A. No, I don't. I don't even think I -- I may have something at my office where I was invited to join, but I don't have a document.

MR. MAZZEO: Objection to this line of questioning, Judge. Relevance.

THE COURT: Overruled.

BY MR. SMITH:

Q. Now, these are just guidelines; right?

A. Yes.

Q. It's not a standard of care?

A. No. NASS avoids using the word "standard of care."

Q. Well, actually they do use the word "standard

of care" in here, right, when they explain that this is not a standard of care?

A. When they explain it's not, yes.

Q. And that's actually right at the beginning. It specifically says, "This guideline does not represent a standard of care, nor is it intended as a fixed treatment protocol"; right?

A. That's correct.

Q. And what they're saying is something that you said earlier today, which is doctors can disagree on things and they might both be right?

A. That's correct.

Q. NASS also says that -- in the introduction here that it's anticipated that there will be patients who will require less or more treatment than average; right?

A. Yes.

Q. Treatment should be based on the individual patient's need and the doctor's professional judgment; right?

A. Yes.

Q. You agree with those statements?

A. I do.

Q. This guideline is not intended to expand or restrict the healthcare provider's scope of practice or

to supersede applicable ethical standards or provisions of law; right?

A. Correct.

Q. Now, these guidelines do talk about some of the issues that we've talked about in this trial; right?

A. Yes, they do.

Q. For example, this is where you get the idea that surgery's an appropriate treatment for spondylolisthesis; right?

A. Say it again. Repeat. "Is an appropriate"?

Q. Correct.

A. Yes.

Q. These guidelines say that surgery is an appropriate treatment to fix a spondylolisthesis; right?

A. They do.

Q. The guidelines also say that surgery is appropriate to fix a spondylolisthesis if symptoms do not improve after six months of conservative care; right?

A. Yes, it does say that.

Q. Now, one of your primary opinions in your reports is that Ms. Garcia's pain, once she was done with conservative care on September 1st, 2011, was from

being overweight and deconditioned; right?
A. That is one of my opinions; correct.
Q. That's one of the primary opinions in your reports; right?
A. It is.
Q. And to give you an example, you spent a lot of time yesterday talking about nerve roots and nerve root compression.
But in your reports you only mention nerve root compression twice, but you mention Ms. Garcia being overweight and deconditioned 60 times; right?
A. I didn't count them. 60? 6-0? I don't think in my reports. Maybe combined between my deposition and my report.
Q. Well, I'm not going to make you go back and read it today.
But you would agree that you mention it -- you mention her being overweight and deconditioned significantly more than you mention nerve root compression; right?
A. That's correct.
Q. And you actually, in giving your opinions on Ms. Garcia being overweight, you went so far as to tell the jury and anybody that might read your reports that Ms. Garcia is so embarrassed about her weight that she

wears Spanx?

A. Well, I don't know if it says "Spanx," but it was an abdominal binder-type garment. That's my term.

Q. Now, since you discussed her being overweight and deconditioned so much in your reports and you only discussed nerve root compression twice, the opinions that you've given at trial have a much different focus and scope than what you provided in your reports; right?

MR. MAZZEO: Objection, Your Honor. Misstates the testimony of Dr. Klein and the scope of his report.

THE COURT: Overruled.

THE WITNESS: I disagree, Mr. Smith. I think the reason I don't mention nerve root compression is there isn't any on any of the diagnostic studies I reviewed and the lack of symptoms of nerve root compression. That's why I didn't focus on it or use it as a repetitive theme.

BY MR. SMITH:

Q. Now, when we took your deposition, I asked you for studies that you're relying upon to show that Ms. Garcia's continuing pain comes from her being overweight and deconditioned.

Do you remember that?

A. Yes.
Q. And you couldn't identify any studies to support that theory; right?
A. That's right. I can't think of a single study. It's personal observation and years of experience.
Q. And personal observation and years of experience is the anthesis of evidence-based medicine; right?
A. It can be, yes. You're absolutely correct.
Q. Now, the -- the guidelines that you gave me actually say that her weight and her conditioning are not affecting her pain; right?
A. I don't know where it says that in the guidelines. That -- that -- I think it's a consideration, but there's -- I think it also shows at "I" that there's insufficient evidence because there aren't articles and literature to support that.
Patients who are the proper weight, habitus, of good strength -- abdominal, paraspinous -- are also symptomatic of spondylodesis.
Q. And -- and your insufficient evidence argument or statement is fair.
What the guidelines say -- what you told me before is that there's insufficient evidence to make a

recommendation regarding the influence of obesity, BMI greater than 30, and its impact on the treatment outcomes in patients with degenerative lumbar spondylolisthesis; right?

A. You're right. That is correct.

Q. That's how you remember it?

A. Yes.

Q. So your comments about her weight affecting her continuing treatment and her outcome are not based upon the evidence because there's insufficient evidence; right?

A. That was the opinion of NASS. It wouldn't be correct if you were focusing on quality care for a person who has a BMI of 35 or 40 but has instability, radiculopathy, and is symptomatic of an unstable spondylolisthesis.

That patient does need a fusion. That's why they couch their terminology.

Q. In order to -- to create these NASS guidelines, they reviewed all the literature that they could find on these topics; right?

A. They did.

Q. So if -- if literature existed to support your opinions, it would be in here; right?

MR. MAZZEO: Objection, Your Honor.

Speculation.

THE COURT: Let him testify what his understanding is.

THE WITNESS: Yes. I think in their approach, to be as accurate as possible, to come up -- and I think the focus is it's a guideline. It's not something chiseled in stone. It's not a rule. They go overboard to say it's not a standard; it's a guideline to follow.

BY MR. SMITH:

Q. And let's talk about another guideline that's in here.

Another one of these guidelines say that obese patients have a significantly greater benefit from surgical treatment over nonsurgical treatment versus nonobese patients; right?

A. Yes.

Q. Okay. So if Ms. Garcia is overweight, as you're claiming, she's more likely to have a better outcome from having surgery over nonsurgical treatment; right?

A. Yes. That's an opinion in the guideline.

Q. Another one of the opinions that you gave yesterday was that Ms. Garcia should have had flexion-extension X rays to determine if she has

instability; right?

A. It's one way to demonstrate instability.

Q. Another one of these guidelines is that there is insufficient evidence to show that flexion-extension X rays demonstrate instability; right?

A. Yes, as a single diagnostic study. Yes, you're correct.

Q. And, in fact, one of the things that -- that you said before in your deposition is that Ms. Garcia's -- given Ms. Garcia's weight, flexion-extension X rays would probably be inconclusive; right?

A. I did say that.

Q. You still believe that today; right?

A. Yes.

Q. Now, yesterday counsel asked you about why you put certain literature in your report.

Do you remember that?

A. Yes.

Q. And what you said was that you cited to this literature to give your report some balance; right?

A. That was my objective.

Q. Okay. Now, the reason that you gave that testimony yesterday is because you made statements about the literature in your reports.

And when I took your deposition, I pointed out that your description of the literature was wrong; right?

MR. MAZZEO: Objection, Your Honor. Misstates the testimony.

THE COURT: He can say if it does. Overruled.

THE WITNESS: You -- you interpreted my report as it being wrong. We had a lengthy discussion about how you interpreted. And you then came, "Well, didn't Moller say this? Didn't Ekman say this?" And then we had a, I thought, a nice intellectual discussion. I didn't think I was wrong. Maybe it's interpretive.

BY MR. SMITH:

Q. Well, Moller and Ekman, those are two different studies; right?

A. Yes. Remember, either Ekman or Moller, they're -- coauthored one of them. But Moller is the author just by himself in one.

Q. When you say "Moller and Ekman," you're talking about a Moller study and then a five-year follow-up to that study with Ekman; right?

A. Yes.

Q. Okay. And what you said about those studies

in your report is actually the opposite of what the studies say; right?

A. No. Why would I misquote a study?

Q. Well, let's -- let's read what you said, and let's read what the studies say.

A. Okay. And tell me the page you're going to.

Q. Page 14 of your initial report.

A. Okay.

Q. And I'll give you a minute to -- to get there.

A. I have page 14.

Q. Okay. Now, what you say in your report is that "The excellent articles published by Dr. Moller and Dr. Ekman clearly identify there is insufficient evidence to recommend for or against surgical treatment as compared to conservative treatment for the management of adult patients with --

THE REPORTER: With what?

MR. SMITH: Isthmic, i-s-t-h-m-i-c, spondylolisthesis.

And I guarantee I'm not saying it right either.

BY MR. SMITH:

Q. That's what you wrote in your report; right?

A. I did.

Q. That's actually the opposite of what you just told me a moment ago, that there's good evidence to recommend surgical treatment over conservative treatment; right?

A. No. It's not the opposite. I answered my -- the first question when you asked me about what did NASS say.

There is good evidence that NASS agree -- the guidelines suggest that there is good evidence even in obese patients. Maybe it's semantics or misinterpretation, but I have read both those articles, especially Moller's about surgery versus conservative treatment.

But go ahead. Obviously we got some disagreement here.

Q. Well, we'll get more specific.

MR. SMITH: Can you put up page 103, lines 20 and 21, from yesterday's testimony, please.

BY MR. SMITH:

Q. Now, yesterday, consistent with what you wrote in your report, you said that the article shows some patients respond very nicely just to conservative treatment; right?

A. Correct.

Q. And, again, in your report you're saying that

there's insufficient evidence to demonstrate that surgical treatment would be better than conservative treatment; right?

A. Yes. That's what the report says, that there's insufficient evidence that one treatment is better than the other.

Q. Okay. Now, the conclusion in the Moller article --

A. Uh-huh.

Q. -- is that surgical management of adult isthmic spondylolisthesis improves function and relieves pain more efficiently than an exercise program; right?

A. It does.

Q. That study isn't saying there's insufficient evidence; it's saying that the evidence shows that surgical treatment is better than conservative treatment. Right?

A. It does initially, yes. And I agree.

Q. But it not only does initially. The conclusion at the end, they say that surgery was found to decrease pain and disability while exercise only slightly decreased pain and did not decrease disability; right?

A. Yes.

Q. Okay. So patients don't respond nicely to conservative treatment; they respond nicely to surgery?

A. In that article.

But that's -- but I've testified that other patients -- in this trial, I've testified -- do very nicely with conservative treatment.

Q. And I understand you might be talking about other patients, but what you said in your report is that the Moller article says something different than what it actually says.

A. If you're accusing me of misquoting the article, then I think it's a matter of my understanding and experience.

But why would I purposefully misquote an article? What purpose would that even serve?

Q. Let's talk about the Ekman study.

A. Okay.

Q. The Ekman study is a five-year follow-up to the Moller study; right?

A. Yes.

Q. And, again, with the Ekman study, you are saying that it clearly identifies there is insufficient evidence to recommend for or against surgical treatment as compared to conservative treatment; right?

A. Yes.

Q. The Ekman study actually says that the global outcome for patients is significantly better with surgery versus conservative care and that, in the surgical group, 76 percent of patients classified their result as much better or better compared to only 50 percent in the conservative group; right?

A. That's correct.

Q. Now, are you going to tell me again that that's not different from what you said the article said?

A. No. I'm not going to take issue with that. I think it's your understanding of what I said or the way I said it at the time of deposition.

Q. And, in fact, the Ekman article even shows with the patients that are in there that surgery is an appropriate and often inevitable treatment; right?

A. Yes.

Q. And that's because the Ekman article talks about 111 people. And out of those 111 people, they had 34 people that got conservative care; right?

A. Yes.

Q. The rest of them that they were studying had had the surgery when they were looking at the results; right?

A. Correct.

Q. And when they did the five-year follow-up, of the 34 who had conservative care, 9 ultimately had to have surgery just in that five-year period; right?

A. Yeah, the crossover group. And also remember that I gave you another article that you took the time to print out and Beutler's article about a 45-year follow-up.

Q. And that article has the same conclusions; right?

A. It does.

Q. Now, let's go back to some of your other articles.

You also say in -- in a different report that you wrote, in your -- in your second report --

A. Tell me the page, please.

Q. I didn't look at the page, but I can find it for you.

A. Okay.

Q. I think it's on page 2. It's on page 2.

A. The date of the report?

Q. November 5, 2014.

A. Okay. Page 2?

Q. Yes.

A. Okay.

Q. You say, when talking about Ms. Garcia,

"Instead of recommending weight reduction and exercise, which works very nicely for spondylolisthesis, she was immediately subjected to interventional treatment and a major spinal reconstructive surgery by Dr. Gross. The excellent article by Dr. Spratt in the journal *Spine* and the article by Dr. Donelson in the journal *SpineLine* clearly identifies that these patients respond very nicely to a technique called mechanical diagnosis and treatment using the McKenzie exercise program. The program focuses on sagittal stabilization and realignment. This was never offered or suggested to Ms. Garcia."

Did I read that right?

A. You did.

Q. Now, first off, you admit that Ms. Garcia had conservative treatment; right?

A. Initially she did, yes.

Q. And she didn't rush into surgery; she waited almost two years. Right?

A. Correct.

Q. Now, the first article here, the Donelson article, it's not even talking about spondylolisthesis; right?

A. No. It just talks about low back pain.

Q. It doesn't talk about spondylolisthesis or

trauma; right?

A. That's correct.

Q. Now, the other article, the Spratt article, that one doesn't reference the McKenzie program you're talking about, does it?

A. No, it doesn't.

Q. So when you say that that article says patients respond very nicely to a technique called mechanical diagnosis and treatment using the McKenzie exercise program, that's not even mentioned in there; right?

A. I didn't ascribe that to Dr. Spratt's article. I particularly said there's two articles. There's Spratt's article talking about flexion and extension treatment with bracing for back pain and Donelson's article, which is just talking about mechanical diagnosis and treatment with directional preference. Just two different disciplines. They're not one and the same.

Q. Your sentence says that they both talk about treatment of spondylolisthesis with the McKenzie program.

One of them doesn't even talk about spondylolisthesis, and the other article doesn't even talk about the McKenzie program; right?

A. Well, if you read the articles, you -- you're using semantics. You're making -- you're confused. They're two separate articles dealing with conservative treatment.

Spratt thinks that, if you have these people flex and extend, whether -- just because they have back pain, try bracing. Donelson talks about an entirely different discipline of mechanical diagnosis and treatment with directional preference, not talking about trauma, not talking about spondylolisthesis.

Two separate articles and two different ideas of thought.

Q. So Donelson's not talking about what Ms. Garcia has. And the --

A. No, he's not.

Q. And the Spratt article -- let's talk about what the Spratt article says.

That article is a study of 56 patients over a one-month period to see if they improved slightly with a back brace; right?

A. Read the entire article if you're -- you're going to hold my feet to the fire.

For low back pain patients with retrodisplacement spondylolisthesis or normal sagittal translation, a small number of patients -- this goes

back to 1993. His thoughts -- one guy's thoughts about his experience. That's all it is.

Q. It's a small number of patients in a one-month follow-up; right?

A. It is.

Q. So there's nothing long term beyond one month, and we don't know how any of these patients did past one month; right?

A. It's not -- it's -- I thought it was a good article. It -- it doesn't even qualify as evidence, number one, because it's too small an outcome; there's no two-year follow-up.

Q. It's not reliable?

A. No. You can rely on it. If you say it's not evidence, one, you're absolutely correct. Less than 200 people, less than two years' follow-up.

It's just information. It's not -- it's just like what you have in front of you. It's a guideline. It's a thought. "Think about this. This is my experience." It's sharing. That's all it is.

Q. So if we can rely upon that article, we can also rely upon the article's statement that fusion is seen by many as the obvious and perhaps best treatment for instability because it surgically addresses the inherent abnormality; right?

A. Absolutely. You can -- you can use that as well.
Q. Let's also talk about this McKenzie program that you're suggesting for Ms. Garcia.
A. Yes.
Q. There's three McKenzie-trained physical therapists in the entire Las Vegas Valley?
A. Is that all?
I don't know. You obviously looked up the data.
Q. Well, McKenzie's a company; right?
A. No. No. Ian [sic] McKenzie was a physical therapist in New Zealand. I think he's now deceased. And then -- his training programs have been taken to others. So some get trained. And some are called diplomats, those that do the training.
Q. And they have a certification, and you can look up who's certified; right?
A. Yes. Yes.
Q. And you are recommending a treatment for Ms. Garcia that you didn't even bother to look up how available it is for her to do in Las Vegas?
A. Why would that be my responsibility?
Q. It's not your responsibility, as somebody who's going to recommend a treatment, to find out if

that's even something she can get?

A. No. That's not my responsibility. It's the responsibility of treaters. Are you suggesting I take over her treatment and send her someplace?

Q. I'm asking, why would you recommend a treatment that you don't even know if it's available for her to get in Las Vegas?

A. Because it's a treatment that works for people with low back pain. Patients in my own experience that I recommend, and there's articles and literature that shows that it helps. That's why.

Q. Now, if we talk about the standard of care in the Las Vegas Valley --

A. Yes.

Q. -- and there's three people that do the McKenzie program, you would agree that that's not the general standard of care in the Las Vegas Valley; right?

MR. MAZZEO: Objection. Foundation, Judge. And incomplete hypothetical.

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

THE WITNESS: I would agree.

BY MR. SMITH:

Q. Let's -- let's move on to your opinion about

the -- the timing of the onset of Ms. Garcia's pain.

Your testimony has been that, if Ms. Garcia aggravated her spondylolisthesis so that it caused pain, she would have had that pain start within four to six hours after the crash; right?

A. Yes.

Q. Now, when I took your deposition, I asked you, under the guise of evidence-based medicine, what literature you are relying upon to offer that opinion, and you did not have any; correct?

A. No. I have no literature to cite.

Q. And -- and what you're talking about is, you're just relying upon your clinical experiences as an orthopedic surgeon; right?

A. Yeah. I think it's excellent.

Q. And at your deposition, you actually changed from 4 to 6 hours to 6 to 12 hours; right?

A. I think I did.

Q. It's not evidence-based medicine to just rely upon your clinical experience; right?

A. It wouldn't qualify. That's correct.

Q. We also talked earlier about the percentage of women with a spondylolisthesis. You remember that?

A. Yes.

Q. And you didn't cite me to any literature

regarding the percentage of women who would develop pain before they're 33; right?

A. I did not.

Q. And I asked you that, and you didn't have any literature; right?

A. I couldn't come -- I couldn't come up with anything to mind. That's correct.

Q. Now, you would agree that Ms. Garcia was overweight before the crash; right?

A. I would.

Q. You also have never seen any evidence that she had back pain before the crash; right?

A. That's correct.

Q. And, as you said, you believe that she's telling the truth when she talks about her history; right?

A. Yes.

Q. It's still your opinion, as you sit here today --

A. Yes.

Q. -- that her post crash pain is from the same condition as -- of being overweight that she had prior to the crash?

A. No. Not just being overweight. That's not fair. That's not fair to Ms. Garcia. She developed a

significant lumbar myofascial sprain/strain. She became symptomatic. She had trouble standing in the cashier's cage. It increased to the point that, on the 5th, she became concerned and went to an emergency room. So it wasn't just because she was overweight. That's not fair to her.

Q. Well, she's had back pain ever since she went to the emergency room; right?

A. Well, she had it before she went to the ER. That's why she went to the ER.

Q. But at least since she was in the emergency room, she's had back pain that hasn't gone away; right?

A. Yes, of varying degrees, yes.

Q. And you told the jury that her back pain, if it was a sprain/strain, should have gone away within six months; right?

A. Yes.

Q. And the only explanation that you've provided for why her pain didn't go away after six months is that she's overweight; right?

A. No. I actually have not been asked why I think she still has back pain before or after the surgery.

Q. Well --

A. No one's asked that.

Q. You've identified some reasons for after the surgery, so we'll talk about --
A. Yes.
Q. -- the period six months after the crash --
A. Uh-huh.
Q. -- up until the surgery.
A. Yes.
Q. And I asked you this question in your deposition, and you told me the reason why she continued to have pain during that time period was because she was overweight; right?
A. And deconditioned. Not just overweight. She remains deconditioned.
Q. And that's the same overweight and deconditioned status she had prior to the crash; right?
A. Yes.
Q. So is it just a coincidence that her pain started three days after the crash and didn't go away?
A. No. There was a precipitating event, which is the accident.
Q. In offering your opinions in this case, you've never considered what the effect on Ms. Garcia might be; right?
MR. MAZZEO: Objection. Vague.
THE COURT: Sustained.

THE WITNESS: I'm not sure what you mean.
MR. MAZZEO: Objection, Doctor.
THE WITNESS: Oh. Oh.
THE COURT: Sustained.
BY MR. SMITH:
Q. In offering your opinions in this case, you've never considered whether the opinions that you provide to the jury might have an effect on Ms. Garcia's ability to obtain medical care in the future; right?
MR. MAZZEO: Same objection.
THE COURT: I'm going to allow it with the modification.
THE WITNESS: Can you give me -- I'm not sure I understand "effect."
BY MR. SMITH:
Q. You know what? I'll -- I'll move on.
You agree, if Ms. Garcia was not in this crash --
A. Yes.
Q. -- the crash on January 2nd, 2011 --
A. Yes.
Q. -- she may never have had back pain for the rest of her life; right?
MR. MAZZEO: Speculation.

THE WITNESS: It's possible.
MR. MAZZEO: Objection. Speculation.
THE COURT: I'm going to allow it.
BY MR. SMITH:
Q. It's -- it's actually more likely than not because, as you said, it's a very small percentage of people with a spondylolisthesis that would develop back pain; right?
A. With -- yes, with one proviso. Patients who remain obese, in my experience, and deconditioned eventually develop complaints of low back pain. That's my experience in 45 years of orthopedic practice.
Q. Those patients, in your experience, more likely than not, do not develop back pain sufficient to require a fusion surgery; correct?
A. A very small percentage.
Q. And you also agree that, if Ms. Garcia was not in the January 2nd, 2011, crash, she never would have required a lumbar fusion surgery if she remained asymptomatic; right?
A. Well, why would you operate on somebody that's asymptomatic?
Q. That's right. If she never had pain start in her lower back, you would never operate on her, even if she had a spondylolisthesis; right?

A. Yeah. I mean, it stands by itself. You can't make an asymptomatic patient feel better. Why would you do an operation?

Q. You don't do surgery for the spondylolisthesis; you do surgery to fix the symptoms. Right?

A. Or repair instability or radicular symptoms, yes. You -- you don't operate on the X ray or the MRI. You're absolutely correct.

MR. SMITH: Pass the witness.

THE COURT: Mr. Mazzeo?

MR. MAZZEO: Yes, Your Honor. One moment, please.

REDIRECT EXAMINATION

BY MR. MAZZEO:

Q. Dr. Klein, good afternoon.

A. Good afternoon.

Q. Dr. Klein, do you have -- in your file there that you brought with you to court, do you have copies of the MRI reports from January 26th of 2011 and August of 2011?

A. Yes.

Q. Okay. I want you to take a look at the January 26th, 2011, report.

A. I have it in front of me.

Q. Okay. And let me know what -- what did the radiologist note with respect to the disks at levels L1-2, L2-3, and L3-4?

A. On the January 26th, '11, report, Dr. Kittusamy, K-i-t-t-u-s-a-m-y, said, "There are no significant posterior intervertebral disk abnormalities at L1-2, L2-3, and L3-4."

Q. And is there, anywhere on that report --

MR. MAZZEO: Judge, can I have the ELMO, please?

BY MR. MAZZEO:

Q. And that's -- that -- actually, I'm looking at Defendant's, Andrea Awerbach's, M4 exhibit. And that's the same one dated January 26th.

So is there any indication on -- on this report by the radiologist that refers to any bulging disks at those same levels, L1-2, 2-3, 3-4?

A. No. The word "bulge" is used twice regarding L4-5 and again in L5-S1.

Q. Okay. And -- but what about with respect to your -- you also have the August 2011 MRI report?

A. I do.

Q. And does the radiologist indicate the presence of any bulges at those levels -- same levels L1-2, 2-3, 3-4?

A. Dr. Orrison, O-r -- O-r-i -- O-r-r-i-s-o-n, said, "L1-2, L2-3, and L3-4: No significant abnormalities noted."

Q. Okay. And that -- would that indicate to you that there's no presence of -- or that there's a lack of bulging disks at those levels?

A. Yes.

Q. Okay. And then if you look at the November 2012 MRI report, which you have as well?

A. I do.

Q. And that's -- this is also in evidence. This is Andrea Awerbach's M9 Exhibit.

And what does the radiologist note with respect to the disk levels at L1-2, 2-3, and 3-4?

A. Dr. Hake, H-a-k-e, "The L1-2 disk demonstrates a 2.5-millimeter posterior bulge. Thecal sac measures 1.71 centimeters. The L2-3 disk demonstrates a 2.3-millimeter posterior bulge. Thecal sac measures 1.64 centimeters. Bilateral facet arthropathy.

"The L3-4 disk is dessicated and demonstrates a 3.1-millimeter posterior bulge. Thecal sac measures 1.71 centimeters. Bilateral facet arthropathy."

Q. Now, yesterday and today you testified you didn't think that there was any significance or

relevance of the presence of bulges at these levels with respect to this case; correct?

A. That's my opinion.

Q. Okay. What is your opinion as to the -- whether these -- the presence of these bulges that appear are -- are identified on this imaging study are traumatic or age-related in origin?

A. They would be age-related.

Q. Okay.

A. Not posttraumatic.

Q. Thank you. On direct examination, Mr. Smith asked you whether you're more qualified than Dr. Gross to read MRI films.

Do you remember that?

A. I do.

Q. And you testified that you believe that you were more qualified; right?

A. Yes.

Q. Tell us why. Tell the jury why.

A. I have the advantage of looking at a lot of medical records, so -- clinical history before I interviewed and examined Ms. Garcia on September 24th of 2014. So it's, as an opera, being presented. I'm listening and hearing her voice, having not met her, but I hear what she's saying to her doctors. So I have

a picture, a broad, broad picture.

Then I have the opportunity to interview her and examine her. Then I have the opportunity to look at all of the diagnostic studies, including the MRIs. I have been doing this for more than 20 years, and I have no -- what's the -- I'm not involved in terms of making a decision, surgically. I have no -- I'm not vested in that area. I'm not going to make any money from operating on Ms. Garcia.

So, in my opinion, I had the advantage of looking at all of this information. Dr. Gross, in his reports, he identifies what he was seeing. But he didn't see all the MRIs. He -- he actually only saw two. So, in my opinion, I had a better opportunity, more interest, and I have been doing it a lot longer. Plus, I teach MRI studies.

So, in my opinion, I'm better at that. And I also have this advantage: I trained in neuroanatomy, I taught neuroanatomy, I know -- I have in-depth knowledge. I could bore you to death with neuroanatomy. That's -- that's why I feel I'm better at it. And it's one single test. That's all it is. It's an adjunctive diagnostic study.

Q. Okay. Thank you, Doctor. And -- and -- and what opinion do you have as to why Ms. Garcia was not

pain-free 6 months after the accident, 12 months after the accident, 2 years after the accident?

A. In my opinion, the interventional treatment, the first one of which I thought was indicated -- but interventional treatment, in and of itself, is not an innocuous procedure. All these injections that take place. The interventionalists would want us to think that, but they're not.

Including the radiofrequency ablations, there's always an inflammatory response by putting a needle deep into the spine, injecting a material, even local anesthetic, steroid. There's always a reaction, an inflammatory response, sometimes good, sometimes better. It's not always the response you want to get, nor is it long term.

In my opinion, with all of the repetitive interventional treatment that didn't work, according to what she tells me as well as documented in the records, is another reason for ongoing pain. And many times we stop doing interventional treatment because we realize we're just adding -- we're not improving. We're creating a problem by putting -- making long, 5- and 6-inch needle tracks that has to heal. So we're adding to the problem; we're not improving the problem. In other words, we're not resolving; we're not solving;

we're aggravating.

Q. Okay. Thank you.

Also, on cross-examination, you had given testimony about -- you believed one of the sequelae or complications from the results from the surgery performed by Dr. Gross was a pseudarthrosis.

Do you recall that?

A. Yes. Yes.

Q. And then Mr. Smith asked you whether you believe that -- does that mean that Dr. Gross did something wrong. And you said, no, that wasn't your opinion. You had mentioned that you -- you had said there was something wrong in the construction -- construct of the configuration construct of the rods; right?

A. Yes.

Q. And then yesterday, you recall, by Mr. Strassburg, you were given an artistic rendition --

A. Yes.

Q. -- created by the plaintiffs in this case of the rods and screws.

A. Yes.

Q. Do you recall that?

A. Yes.

Q. And you referred to that as a rhomboid

structure of rods and screws?

A. Well, it's a -- if you look at it -- if he had created, put a crosspiece from the top of L5 on the right to the top of -- to L4, it would have been a rhomboid-shaped construct. But it never happened. In fact, Dr. Gross says in his op report that he had considered doing that.

Q. Sure. And -- and you're -- what do you mean, "it never happened"?

A. He didn't put a crosspiece.

Q. Okay. Fair enough.

A. That's another option, to create a rigid construct.

Q. And, Doctor, for the jurors' edification and for my own, a rhomboid has four sides, two sides that are parallel to one another?

MR. SMITH: Objection. This is outside the scope of cross.

THE COURT: I don't think so.

MR. MAZZEO: Thank you, Judge.

THE COURT: Overruled.

THE WITNESS: That's correct.

MR. MAZZEO: Okay. Judge, can I have the monitor for --

THE COURT: It's on the ELMO right now.

MR. MAZZEO: Oh. I guess -- it is on? Yes. It's on the -- yeah, it is. I guess I have to turn that on, Judge. Sometimes it goes on automatically and -- okay.

I don't think it's -- is it coming up on any monitors?

MR. STRASSBURG: No.

MR. MAZZEO: I'm not seeing that. I think it's a connection thing. Oh, here it is.

All right. Well, for some reason, the slide is not transferring over, but I -- I do have a connection here. Let's see. There we go.

BY MR. MAZZEO:

Q. All right. You recall looking at this slide yesterday, Doctor?

A. Yeah. But that's not what you're referring to. That's --

Q. No. I know. I was referring to a -- the artistic rendition of the construct rods and screws.

A. I remember that very well.

Q. Right. So --

MR. SMITH: Objection, Your Honor. May we approach?

THE COURT: Sure.

/////

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

THE COURT: Objection's overruled.

BY MR. MAZZEO:

Q. Dr. Klein, take a look at this post-op X ray of the -- this has two films, right, side by side?

A. Has an AP and a lateral.

Q. Okay. Which one is the AP? Which is the lateral?

A. The one on the left is the AP, and the one on the right is the lateral.

Q. Okay. And my question to you is about -- because you referred to the construct of the rods and rhomboid. Looking at this, is this a rendition or is this the actual construct of the rods and screws that are in Ms. Garcia's back following the surgery?

A. These are the actual position of the screws in the rods.

Q. And -- and I know you testified yesterday that the right -- the right side of Ms. Garcia's on the left side of the film.

A. Yes, that's correct.

Q. The left side of Ms. Garcia's on the right side of the film?

A. Because she's -- when the X ray is done,

she's laying on her back.
Q. Sure.
A. Okay.
Q. Would you consider this to be rhomboid construct of rods and screws?
A. No. This X ray is not representative at all of the anatomic diagram.
Q. Why not? In what way is it not?
A. One or two of these screws is not even contained within the pedicle.
Q. What are you referring to?
A. Well, on -- on the left side, the purpose is to maintain the biomechanical axis. You can see that screws are in the pedicles of 4-5 and 1. And the rod is straight up and down. If you look on her right side, on the left side of this film --
Q. Can you touch the screen?
A. Can I --
Q. You can touch it with your finger.
A. Can you see my finger?
Q. Yes. I can see the mark on the screen.
A. Okay. That screw there, on 5, doesn't appear to be contained within the pedicle. It's off to the side. It's not vertical. Should be in line with the pedicle of 4. It's probably an inch over. It's at an

angle. It's divergent. It's supposed to be parallel.

Q. So this is different than the artistic rendition yesterday that you looked at, which showed a -- more of a symmetrical alignment of the rods and screws?

A. Yes. Plus -- plus that screw is loose.

Q. Okay. Thank you, Doctor.

You had on -- according to the guidelines of NASS, when is surgery appropriate to treat a spondylolisthesis?

A. You want the lengthy answer or ...

Q. Well, you can -- either one.

A. In a patient -- in a patient who has a constellation of symptoms, whether it's traumatic or nontraumatic, that there's corroborating objective evidence, a clinical examination of back pain with or without radiculopathy, evidence of instability, ideally by flexion-extension X rays, or demonstration of progression. That's probably the biggest. In other words, where you have gone from a Grade I or Grade II. Progression is probably the -- the golden rule. Nonrefuteable if there's progression.

Those patients are the patients that are excellent candidates for a stabilization procedure. If you -- which we and the jury have heard the word

"fusion."

Q. Thank you, Doctor. Now --

A. And let me add one other thing.

Q. Oh, sure.

A. If you look in the guidelines, it doesn't say you have to put in screws and rods.

Q. What do you mean?

A. There isn't a -- you don't -- not all surgeons will do a fusion with instrumentation.

Q. Why? What other types of fusion --

A. Without instrumentation.

Q. Okay. Now, Mr. Smith, on cross-examination, had asked you about the articles, the Moller and the Ekman article, which had made references to the benefits of surgery -- surgical treatment versus conservative treatment for people with spondylolisthesis.

A. Yes.

Q. My question to you is, in light of the articles, in light of all the medical records you have reviewed in this case, was Ms. Garcia ever an appropriate candidate for fusion surgery for her Grade II spondylolisthesis?

A. In my opinion, she was not.

Q. Okay. Now, also on cross-examination, you

had told Mr. Smith, with regard to Ms. Garcia's reporting to you, that you believe that she was telling the truth when she talks about her history.

But based on your record review, did you observe and note inconsistencies in Ms. Garcia's reporting of the onset of symptoms to medical providers following this accident?

A. Yes.

Q. And do you find those inconsistencies to be significant or insignificant?

A. In my opinion, they're significant.

Q. Why?

A. I met her. I thought she was articulate, had a good memory. She does a lot of things, a multitasker with kids and working.

It didn't make sense to me that she wouldn't remember the exact sequence of events of the onset of her pain. The pain is fairly significant if it's functionally limiting. And she would remember when the pain started, how it increased, how it affected her.

That's just my opinion based on the review of the records.

MR. SMITH: Move to strike. Calls for speculation.

THE COURT: Overruled.

MR. MAZZEO: Thank you, Judge.

BY MR. MAZZEO:

Q. Now, also, Dr. Klein, you were asked by Mr. Smith about references you made regarding the section "Personal Activities, Activity of Limitations" on page 3 of your report.

A. I remember.

Q. And he asked you to turn that page. So I'll ask you to do the same.

A. Okay.

Q. And there is some exchange between you and Mr. Smith with regard to what period of time you're referring to when you're talking about those activities that Ms. Garcia's reporting to you that she's currently unable to do or has limitations in doing.

Do you recall that?

A. Yes.

Q. Okay. So -- and I'm not talking about "Current Symptoms" section. I'm talking about the "Personal Activity Limitations"; right?

A. Yes.

Q. Okay. So -- and how do you know, as you sit here today, that Ms. Garcia is reporting to you and that you had asked her about her current limitations with regard to those activities that are discussed in

that paragraph?

A. As I testified at trial under direct, when you asked me to describe what did she tell me during the interview, I said to her, as I said to all patients, "Tell me what's going on in the last three or four months."

What was going on a year ago really is not very significant to me. Last 90 to 120 days. That's how we started the evaluation.

And you can see under "Personal Activity Limitations" -- I'll slow down -- she stated her housework is limited, especially sweeping and mopping, due to the symptoms she was having.

Q. Having when? Currently or --

A. Over the last three to four months.

Q. Okay.

A. Okay.

Q. Thank you.

A. She has three daughters. Then I asked her, "How much, you know, of the cooking do you do?"

"I do 20 percent now. 30 percent of the laundry; 15 percent of the housekeeping." She still does 90 percent of the groceries. She said, "I don't carry the groceries."

Then when we went to current symptoms, I

again said, "What are the symptoms you're having for the last three to four months?" What she was doing a year ago, to me, is not of any -- to me, even to a physician. We want to know what's called current symptoms. A year ago is not current. Six months ago isn't current. You -- you could argue semantics, "Well, maybe the last 30 days."

So that's my approach because you don't do the same thing every day. So that gives me a -- a panorama or a spectrum of how she's functioning.

Q. And also -- thank you, Doctor.

What -- Mr. Smith had started his cross-examination yesterday with you asking about whether you're an expert in treating spinal injuries.

Do you recall that?

A. Yes.

Q. Go ahead and tell -- I don't know if you followed up with that. So why don't you tell the jury what -- why do you believe that you're an expert in treating spinal injuries?

A. Because I see people in my clinic with spinal injuries. I see, in the last three months, two young men in auto accidents that had a compression fracture, one thoracic, one lumbar. They can get seen by their primary care, still have back pain, and sent in from

one of the five primary care clinics.

I see postmenopausal women in their 70s, their 80s who have compression fractures due to their osteoporosis.

Young people have hurt themselves skiing. We have good snow this year in the Sierra. They fall down, they get compression fractures. They -- they're neurologically intact. They're not unstable, but they still have low back pain. They need some reassurance. They need a diagnosis.

So I have a basis of knowledge that the primary care doctor doesn't have. They -- they end up in my clinic, in -- in all honesty, because the spine physicians, they don't really want to see them. They're -- they have enough work just doing the spinal surgery. They end up in my clinic.

Q. Okay. Thank you, Judge -- or Doctor.

MR. MAZZEO: No further questions.

THE COURT: Mr. Strassburg?

MR. STRASSBURG: Not very many, Judge.

Can you give me the screen, Judge?

THE COURT: I've already given it to you. It's just not on there.

MR. STRASSBURG: This will just take a sec.

/////

RECROSS-EXAMINATION

BY MR. STRASSBURG:

Q. In your opinion, Doctor, the complications from the surgery probably account for Ms. Garcia's current pain symptoms?

A. Yes.

Q. You saw her on September 24th, 2014?

A. Correct.

Q. Twenty-one months postsurgery?

A. Yes.

Q. Was there time enough since the surgery for this fibrotic scar tissue to form in the vicinity of the nerve roots?

A. Yes.

Q. Was there time enough for micromotion to cause pain?

A. Yes.

Q. Loose screws?

A. Yes.

Q. Now, you have in front of you what we -- a slide of postoperative, the surgical construct, this rhomboid.

Do you see that?

A. Yes.

Q. And let me blow up this part.

This is the -- a front view. We're looking at the spine like this; is that right?

A. Yes. Ms. Garcia's laying on her back. On the left side of the spine, or to the left, is the screws on the right. This is the right side. This is the left side.

And it says the word "left." Do you see, in little words there, it says "left"?

Q. Okay.

A. I think that tells you.

Q. Let me add two lines here marking the width of the construct center to center.

Do you see those?

A. I do.

Q. And the top one is longer than the bottom one?

A. Yes. Because the -- the construct diverges. It's not parallel.

Q. And the divergence, you testified, is on the right side?

A. Correct.

Q. It's just on the left side because this is a mirror image?

A. Yes. If you just refer to the -- there's three screws and a longer rod on the left and then the

one on the right. The right -- the shorter one is the right side.

Q. And the top screw on the right side is the one you believe is outside the pedicle bone?

A. Yes, on L5. On the right side of the -- of her body.

Q. And if we draw lines marking the center of the rods, do you accept that this is accurate?

A. It is.

Q. Now, I want to show you what we talked about yesterday, the plaintiff's diagram. Let me get it up here.

And do you see that on your screen?

A. I do.

Q. All right. Now, let's do the same thing on the plaintiff's diagram. Let's draw a line marking the width.

Do you see that?

A. Correct.

Q. And those lines accurately mark the width?

A. Well, that's the way it should look on her body, but it doesn't.

Q. And then let's put in the lines that mark the line of the rods.

Can you see that?

A. I can.
Q. Would you join me down here, please.
A. (Witness complies.)
Q. So if we look at the actual medical image of the actual construct, we see that it is -- the -- the rods and screws are farther apart, displaced to the right, which on the screen is on the left; right?
A. Yes.
Q. But it's the opposite way in the plaintiff's depiction here, which shows that the rods are closer together at L5 when, in reality, we know that they are farther apart?
A. This is not an accurate depiction of what's present in her body.
Q. You're indicating the plaintiff's diagram?
A. Correct. This diagram is not indicative of what is represented on the post-op X ray.
Q. So true? False?
A. Well, inaccurate, rather than true, false. It's an artist's representation and maybe under Dr. Gross's direction. But this is not what's present in Ms. Garcia's body right now.
Q. And this depiction, this artwork by the plaintiff --
A. Yes.

Q. -- it leaves out this key fact that at -- on the right L5, the screw missed wide to the right?

A. There is no screw in 4, and this screw is too far to the right.

Q. You're indicating at L5 on the right?

A. The L5 pedicle. This is pedicle. This is the L4 pedicle. The L5 pedicle is here. And in the other X ray there's evidence that it's loose.

Q. Why don't you go back and sit down.

A. Okay.

Q. I don't want to delay you. Just one more second here.

Now, you just said that there is evidence that one of these screws that Dr. Gross installed is loose.

Do you remember just saying that?

A. I do.

Q. Does the looseness of this pedicle screw create any condition that is visible on an MRI?

A. No. The -- you get severe metal artifact when you do an MRI. So just -- unless you tell the radiologist or the neuroradiologist that there's metal and you want to do a subtraction technique, it's a very special MR study. And not all -- not all of these centers have that.

Q. Does the looseness of the screw -- has it created any condition on this image indicative of looseness?

A. Yes.

Q. Show us.

A. This is the screw up in the pedicle on the left side on 4. And you can see that this is a homogeneous body inside here, where the screw is inside, goes into the vertebral body.

If you look on L5 -- this is L4; this is L5 -- this halo here and around here. If you look down here in the sacrum, it's homogeneous. When you see this, which we call a wobble mark or a halo, in a patient who's still complaining of pain, this is indicative or suggestive of a pseudarthrosis, ongoing pain, this halo that you see here.

Q. And is a patient who has a pseudarthrosis, this loose screw, a candidate for spinal SCS, the spinal pain treatment procedure?

A. No, absolutely not.

Q. Explain.

A. Well, one of the MRs demonstrates a significant scar. You don't want to add more scar. This heals. As Mr. Smith asked me, do patients get scarring when you do this magnitude of surgery?

And you don't want -- keeping a spinal cord stimulator lead in place is almost an exercise in futility, just putting the leads in and getting through this dense scar. So the first thing, if you're suspicious you have a pseudarthrosis, then you need to do a CT scan, as I testified, and then you have to reoperate to resolve the pseudarthrosis.

Q. Thank you, sir.

You were asked questions regarding whether Dr. Gross's work satisfied the standard of care of a spine surgeon.

Do you recollect Mr. Smith asking you those questions?

A. I do.

Q. I wanted to ask you, whether or not Gross's technique satisfied the standard of care, does that in any way change your opinion that his surgery was addressing a condition that was not causally related to the collision?

A. In my opinion, she was not a candidate for a fusion in any way related to events that happened on 1/2/11. That's my opinion.

Q. So your answer would be yes?

A. Yes.

Q. It does not change --

A. It doesn't change my opinion at all.
Q. Now, you have mentioned bone spurs at L5-S1.
Do you recollect that?
A. Yes.
Q. And just so everybody can recollect with you ...
MR. SMITH: Outside the scope of cross.
THE COURT: I think it is, but I don't know what the question is yet.
MR. STRASSBURG: You know, Judge, he's right. I'll go on to something else.
THE COURT: Okay.
MR. STRASSBURG: Now, you know, Judge, I think that's enough out of me. So I'm going to sit down.
THE COURT: Okay. Mr. Smith?
Need a break?
MR. SMITH: I do.
THE COURT: How long you got?
MR. SMITH: Five to ten minutes.
THE COURT: Let's go ahead and take a quick break.
All right. During our break, folks, you're instructed not to talk with each other or with anyone else about any subject or issue connected with this

trial. You are not to read, watch, or listen to any report of or commentary on the trial by any person connected with this case or by any medium of information, including, without limitation, newspapers, television, the Internet, or radio.

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

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

Plan on ten minutes.

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

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

I know you didn't have much longer left, but I had one juror that was emphatically telling me that she needed a break.

Anything we need to take care of on the record?

MR. SMITH: I would like to put one thing on

the record.

THE COURT: You want him here or not?

MR. SMITH: Doesn't make a difference.

THE COURT: Okay. Go ahead.

MR. SMITH: We objected to the use and discussion of the June 27, 2014, X ray.

And what I said at the bench was that yesterday the Court limited Dr. Klein in talking about that X ray to say does this change your opinions. And if his answer was no, fine; if his answer was yes, the Court would strike his opinion.

The reason for that ruling was because Dr. Klein has never disclosed any opinions about the June 2014 X ray, and that X ray has obviously been around for a long time, including since before he wrote his initial report in October 2014.

On cross, we did not ask him about that X ray. We did not ask him about any postsurgical scans. And, in fact, we limited the questions on pseudarthrosis and scarring to whether those things are complications of surgery and whether they mean that Dr. Gross did something wrong in his treatment. That has nothing to do with the June 2014 X ray.

The Court allowed Dr. Klein to talk about it. And, as we saw, counsel then asked him a number of

questions that allowed him to provide brand-new opinions that we have not heard until right now. And that was clearly outside the scope of cross and outside the scope of everything that's in his reports.

THE COURT: I thought that the questions that you asked about the pseudarthrosis, the complications of surgery, and whether or not Dr. Gross did anything wrong -- I thought that that opened the door to use that. So --

MR. MAZZEO: And I --

THE COURT: -- that's why I allowed it.

MR. MAZZEO: Thank you, Judge. And I would agree because -- I don't need to -- do I need to say anything?

THE COURT: If you want to hear yourself talk.

MR. SMITH: I will say, for the record, we asked -- we asked Dr. Klein those same questions in his deposition. And in his deposition he never offered the opinions that he offered today. And his deposition was a long time ago, and he had an opportunity to amend his reports since then if he wanted to offer these opinions.

And having not offered them prior to today, knowing what questions I was going to ask, he should

have -- he should have offered those before walking in the door, and we shouldn't be subjected to new opinions at trial.

MR. MAZZEO: Well, the fact of the matter is Dr. Klein did testify at his deposition to the sequelae of symptoms. And the result for that was due to the pseudarthrosis.

And as he testified on cross-examination to Mr. Smith's questioning, he did talk about that that -- that pseudarthrosis was -- there was something wrong in the construct of the rods, thereby opening the door to let's look at the -- let's look at the film and compare that to the artistic rendition done by the plaintiffs.

THE COURT: Okay. You guys made your record. If I'm wrong, they'll tell me.

MR. MAZZEO: Thank you, Judge.

THE COURT: Anything else?

MR. SMITH: No, Judge.

THE COURT: All right. Off the record.

(Whereupon a short recess was taken.)

THE MARSHAL: Jury entering.

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

THE MARSHAL: Jury is present, Judge.

THE COURT: Thank you. Go ahead and be