Case No. 79424

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IN THE SUPREME COURT OF THE STATE OF NEVADA

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Elizabeth A. Brown
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DESIRE EVANS-WAIAU, individually; GUADALUPE PARRA-MENDEZ, individually,

Appellants,

vs.

BABYLYN TATE, individually,

Respondent.

APPEAL

From the Eighth Judicial District Court, Clark County
The Honorable Mary Kay Holthus, District Judge
District Court Case No. A-16-736457-C

APPELLANTS' APPENDIX
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years and can cause some overlying other symptoms such as depression, anxiety, some other symptoms that are in -- of a psychological nature. So pain that was originally originating from a organic cause, such as say inflammation, arthritis, extend over the years has become chronic and has then exerted an affect on the patient's psychological status as well.

Q Okay. And what are the ways that you manage those people; I mean, do you give them medications, do you provide injections, a combination of both, what sort of --

A Well --

Q -- methods do you treat those patients?

A Well, we are an interventional practice. And as we all know since the recent years we have the problem of the opioid crisis in our country and physicians have been too liberal and often careless in prescribing narcotic medication for patients with chronic pain.

Our approach is more so to find out what is causing the pain, the chronic pain. If we can treat that, we can diagnosis with injection therapy and then perhaps with a referral to a surgeon. But sometimes the pain -- the -- nature of the pain is not amenable to injections in terms of they won't get better with injections, they're not surgical candidates.

And then we have other modalities such as medication management, judicious and careful medication management or

other interventional modalities such as neural stimulation to essentially control the pain on a different level with the goal to enhance the patient's quality of life but still knowing that we can't really treat the pain completely.

Q Okay. When you say you're an interventional pain management specialist, what does it mean that you're an interventional pain specialist?

A What it means is that we use interventions such as injection therapy to isolate, to diagnose pain generators, so in other words, where the pain is coming from, but also in the hope with injections to cause an improvement of the patient's symptoms by reducing the inflammatory response because the pain perception or the development of pain is often a result of an inflammatory response as a result of a tissue damage.

So we are trying to diminish or decrease the inflammatory response with the injection therapy but also trying to isolate and find out where the pain is coming from to accurately labeling the cause of the pain or the diagnosis.

Q So what role do you play as an interventional pain specialist in diagnosing the process or the source of a patient's pain for to assist a surgeon in their management or approach?

A Well, my role -- I mean, I work in concert with the surgeon, is often to be the diagnostician, meaning, the surgeon requests perhaps a certain injection that targets a

suspected area where the pain might be coming from. I perform the injection and then we evaluate the response of the patient following the injection.

And if there is a positive response, meaning that the patient receive an improvement of the symptoms, then we have so-called narrowed down the area where the pain is coming from which is an important information for the surgeon because then he can make a surgical recommendation perhaps.

Q And in recent years, the field of pain management has grown. Is that to hopefully help control patients' pain better, maybe reduce the number of surgeries that are happening?

A Well, that is how I'll go. I always tell patients our pain -- unless his pain is coming from -- as a result of a heart attack or a ruptured appendix or a gall bladder, pain is not something where we're going to jump right into surgery.

We are trying to be as conservative as possible so we -- the patient kind of goes through several stages of treatment such as conservative treatment modalities, chiropractor care, physical therapy, and then pain management with interventional modalities. And then it culminates and reaches the level of surgery if everything else fails.

Q And we're going to be talking about the various injections including the ones that you've performed here. But before we kind of get into Desire specifically, Dr. Rosler,

tell us where you went to school and about your training.

A I was born and raised in Germany, grew up in Germany and went to medical school in Germany. And then I came to the United States after I've passed the qualification examinations to be able to go into a speciality training here in the United States.

I did my internship in -- in Michigan. I did my speciality training in anesthesiology and at the Indiana University in Indianapolis. And then I came to Las Vegas end of 2002, have been practicing in Las Vegas since beginning of 2003. I've been practicing pain medicine since the beginning of 2004. I was affiliated with Nevada Spine Clinic for about ten years -- my -- as an independent contractor in the diagnosis and treatment of pain symptoms.

And then about five years ago I opened up my own practice in intervention pain and spine institute where we -- where we focused on, as I pointed out earlier, in the diagnosis and the therapy of pain complaints emanating from the vertebral column.

I'm certified with the American Board of Anesthesiology and certified with the American Board of Pain Medicine and that's essentially it.

Q Okay. And kind of -- so you're an anesthesiologist by training, right?

A Yes.

Q And how many years was that training as anesthesiologist?

A Four years.

Q Four years? And you said you're board certified as an anesthesiologist?

A Yes.

Q Okay. And what does it mean to be board certified?

A Board certified means that you fulfill the requirements on -- and the standards of the board -- that's set forth by the board of your specialty. So every medical speciality like general surgery, like neural surgery, like orthopedics, like anesthesiology, there is a board standard.

And in order to reach that board standard you have to take a written and an oral test. And as of 1998, unfortunately, you have only a time limited board certification. So every ten years you have to renew your board certification license which is a very contentious thing.

Q Have you done that? Have you renewed?

A I have done that. I am -- as of now, I am board certified until 2024 in anesthesiology, and 2026 in pain medicine. And then I had to recertify for another ten years.

Q Okay. In addition to your training as an anesthesiologist, did you complete fellowship training as a pain -- in the area of pain management?

A What I did was a -- not an entire fellowship of

about one year I was invited to -- there was -- we call it -- at Indiana University the Department of Anesthesia a so-called mini pain fellowship that was specifically targeted in the diagnosis and treatment of patients with spinal complaints.

So I went back to the University and was trained into patients just presenting with spinal complaints, not so much with patients with -- who have other kind of complaints such as fibromyalgia, such as tumor kind of pain, or headaches and so forth.

Q Okay. And you said you're also board certified in the area of pain management?

A That's correct.

Q Why is it common that anesthesiologists are also pain management physicians, can you explain that?

A The field of pain -- or excuse me -- the field of pain medicine originated out of the field of anesthesiology and simply because in anesthesiology in and of itself as a training program also requires a certain amount of pain medicine.

First of all, anesthesiologists perform labor epidurals which is pain management during labor and delivery, anesthesiologists perform regional blocks if patients have surgery on their ankle, surgery on the shoulder. They learn how to do the regional blocks. That is kind of like the forte or the specialty of the anesthesiology specialty.

And then from there the field of pain medicine developed and then other -- other specialties such as physical medicine rehabilitation, they have kind of also encroached into this field. However, the interventional aspect has always come from the field of anesthesiology. And we can also or we are also able to treat side effects or potential adverse reactions that can occur with any spinal injection.

Q Okay. Now have you ever testified and qualified as an expert in the area of pain management here in Clark County, Nevada before?

A Numerous times.

Q Okay. And what I want to do now is -- and we're going to be talking about the clinical evidence in this case and your treatment and your role and Desire, and Guadalupe's care, but primarily Desire's. And I want to --

MR. PRINCE: Brandon, can you put up demonstrative 41.

BY MR. PRINCE:

Q And we have it on the monitor there. And can you see the monitor Dr. Rosler here or can you --

A Yeah, I can see it on my little monitor.

Q Okay. Perfect.

A Yeah.

Q All right. I want you to be able to see.

And when you're talking about your opinions in this

case, you're going to be presented to us, and when you formulated them, did you use clinical correlation methodology in formulating those opinions regarding what the cause of Desire's injuries were and her physical problems and the need for the treatment?

A Yes. This is, in general, a nice way to outline the different facets of us pain management physicians to come to a conclusion as to what kind of -- or what kind of clinical presentation the patient has and what kind of origin the patient is, what the pain the patient is stating is coming from.

Q Not only do you use clinical -- do you use clinical correlation not only in forming opinions as to what the cause of a patient's injuries were, do you also use clinical correlation in your practice to assist you in diagnosing and formulating a treatment plan?

A Certainly. When we -- as an example, if you have a pain that is emanating from your hand after a fall you obviously want to correlate this, so you get an x-ray to see is there perhaps a fracture there or is there perhaps a dislocation that could explain the patient's symptoms.

So we have multi layered approaches where we enact with a patient which is the most important or the basis, that's the patient's history, our physical examination. And then we are trying to obtain or gather other more objective

information focusing on the patient's complaints.

You will see this when you go to your primary care doctor and talk -- or call let them know you have a bad cough you'll get an x-ray. He wants to see hey is there a reason perhaps why my patient has a cough. So this is not just for pain management doctors important -- it's important for all medical doctors to -- to establish a correlation with clinical tests that kind of support what you hear from the patient as a subjective complaint.

Q Right. Here part half of the diagram or half of our puzzle, if you will, is comprised of the patient history. Is that a fair representation of how important a patient history is and, you know, formulating a diagnosis and a treatment plan for a patient?

A I would say the patient history is the basis of all of our interaction with the patient. And when I say the patient history, it's also the patient's complaint, voicing complaints. If you go to the emergency room and you state you have chest pain that is radiating into your arm, and you have sweats, you're going to be worked up for potential heart attack.

If you goto the emergency room and just say I have a little tingling in my hand you're not going to get worked up for a possible heart attack. So it's very important to get a good history because that is kind of the basis from where you

take off and initiate further testing and further treatment.

Q Why are examination findings and [indiscernible] why are those important, Dr. Rosler?

A The physical examination is to verify that patient's complaints, meaning, you examine the area of complaint and there are orthopedic tests and over the years there have become more and more specialty tests.

And again, what we are trying to do is kind of objectify or correlate certain -- certain tests with the complaints of the patient.

Q Okay. And next on our chart is response to treatment. Why is response to treatment an important part of the clinical correlation process?

A Well, when we -- once we have taken the history, once we have done a physical examination, perhaps once we had the chance to come up -- well, to look at other diagnostic tools such as an x-ray, an MRI scan, or an EKG we come up with an impression. And then we have a treatment recommendation that allows us to either confirm our impression or to state well, this is not -- obviously not the case. We may have to do something else.

So the treatment is important for us to establish our diagnosis and hopefully treatment the patient at the same time.

Q Okay. And next we have diagnostic [indiscernible]

x-rays and MRIs you talked about. Other testing; could that include like the, you know, site specific interventional injections that you provide?

A That could be. The site specific injections that are being diagnostic and also to a certain degree therapeutic in nature, yes.

Q Okay. And now you had the opportunity to treat my client, Desire Evans-Waiau, correct?

A That is correct.

Q Do you remember Ms. Waiau?

A Not very well.

Q You just mostly -- you rely upon the records -- your records?

A That is correct.

Q All right. In front of you I have open is Tab 40, Exhibit 47 are the records from your facility.

A Yes.

Q Okay. And that -- and those have already been admitted into evidence. And the first time you saw her --

MR. PRINCE: And Brandon, that's Bate No. 196.

BY MR. PRINCE:

Q And based upon your recollection who referred Desire to you for a pain management consultation? You can look at your own chart if you brought that, if that will help you.

A Yeah, that is a little more helpful.

It's my understanding that the patient was referred by the chiropractor.

Q Okay. Is -- do chiropractors, not just at Align Chiropractic -- do chiropractors refer patients to you?

A Chiropractor, physical therapists, primary care doctors, kind of like the first treater, that is very common.

Q Do surgeons also refer patients to you for --

A Surgeons also refer patients to me, that is correct.

Q Okay. And when -- now when Ms. Evans was referred to you did you take a history from her?

A Yes, sir.

MR. PRINCE: Brandon can you show -- go to the chief complaints.

THE WITNESS: I'm sorry?

MR. PRINCE: I'm showing to the jury now --

BY MR. PRINCE:

Q What were her complaints when she initially came to see you on December 16th, 2015?

A Her chief complaints were headaches left side and neck pain and left shoulder and left parascapular pain with shooting pain and numbness down into the left arm and the left hand.

Q Okay. And in your -- when you saw her based upon that history, was there something more to that history than simply a soft tissue injury to you based upon her description

of her symptoms?

A Well, the definition of soft tissue injuries, injury to the musculature, to the ligaments, to some tendons, whenever there is a what we call a potential for a radicular symptomology which is shooting pain, numbness or tingling going down an arm or down the leg, sciatica for example down the leg, then this is something where we can't just say this is a soft tissue injury. That has to be evaluated for potential nerve irritation.

Q Okay. And now did you also take a history of what they call a present illness --

A Yes.

Q -- from Desire? And if we could --

MR. PRINCE: Brendan, if you can highlight that on the screen.

BY MR. PRINCE:

Q What significant history did you obtain from Desire at the time of your initial evaluation as to when her symptoms started and what was the cause of the symptoms starting?

A It was a narrative history taken from the patient and the information that we gathered was that the patient was involved in a motor vehicle collision in October of 2015, and subsequently, developed symptoms of such she was complaining of.

Q Okay. Was he symptoms consistent with being

involved in a motor vehicle collision on October 30th, 2015 as she described? Were they consistent with that mechanism?

A Those were consistent with that mechanism. There was a temporal onset of her symptoms as a result of that motor vehicle collision.

Q Okay. Did she tell you that she -- whether or not she'd been receiving medical care before she came to see you? Obviously, she had been with a chiropractor because that's who referred her to you.

A That is correct.

Q All right. And just because the chiropractor referred her, did he in any way try to -- Dr. McCauley influence you because Desire may have had a lawyer involved and what treatment you should provide, what your diagnosis ought to be, or are you independently assessing her at this point?

A Well, I'm a specialist so I appreciate chiropractors and physical therapists, but obviously they wouldn't send patients to me if the chiropractic treatment had been successful.

So at that point, it is the level of care steps up to the level of a specialist and therefore I conduct my own investigation, my own examination and so forth.

Q Right. And your note says she's complaining of ongoing headaches, left sided neck pain, shoulder pain,

shooting pain down the left arm and numbness into the left hand; do you see that?

A Yes.

Q Was that concerning to you clinically based upon, you know, she's about -- just shy of two months since her motor vehicle collision?

A It was a finding that one would not necessarily expect if you have just a soft tissue sprain/strain symptoms as we all know that sprain/strain symptoms when you pull the hamstring playing soccer or football, a typically self-limiting meaning after a period of time depending on age, four to six to eight weeks, those symptoms resolve. And as I pointed out, those symptoms typically do not present as shooting pain, numbness, tingling going down an extremity.

So it was my understanding that the patient's symptoms are due to an underlying structural problem in the spine rather than the soft tissue.

Q Okay. And did you have any medical evidence or any history that in the -- immediately before this collision of October 30th, 2015, that she was experiencing any of these symptoms of neck pain, headaches, left arm symptoms, numbness into the hand and fingers?

A When we asked the patient whether he -- or whether she had those similar such symptoms she was presenting with prior; we learned that she had a motor vehicle collision back

in 2010 and she had experienced low back pain but that conservative treatment that she had completed helped and it relieved her pain symptoms.

Q Okay. And was that 2010 incident, does that in any way explain any of these issues going on here?

A No.

Q Okay. And at the time of your physical exam -- and did you also do a physical examination at that time?

A Yes, sir.

Q Well, before we get there; was she on medication when she came to see you?

A She was taking a few medications such as Tramadol which is a very mild opioid narcotic medication. She was taking Flexural which is a muscle relaxer. She was taking Omeprazole which is a proton pump inhibitor for increased gastric acid production and she was taking -- she was taking Ibuprofen which is Motrin is an anti inflammatory.

Q Okay. And those are medications, they are what -- what is Tramadol again?

A Tramadol is a very mild narcotic pain medication.

Q Okay. And Flexural?

A Flexural is a muscle relaxer.

Q Okay. Does that help control symptoms even while you're getting conservative care like chiropractor treatment?

A It's intended to be adjuvant therapy to help with

the symptoms, yes.

Q Okay. And what's the Omeprazole?

A Omeprazole is a proton pump inhibitor. I assume the patient is a little sensitive with her stomach and Ibuprofen can cause some increased gastric acid production and irritate -- can cause some gastritis like symptoms. So often, patients who take an anti inflammatory such as an Ibuprofen, they have been prescribed Pepcid, for example, which is an antacid, or omeprazole which is a proton pump inhibitor limiting the production of gastric acid.

Q Okay. And when she came to you, did she also have some diagnostic imaging, correct?

A That is correct.

Q And you looked at the imaging. Now, have you looked at the images yourself or [inaudible] reports?

A I am not sure whether I looked at the images -- imaging myself. At some point I looked at the imagining but I don't know if I looked at it at that first visit.

Q I mean, during the course of your care, did you look at imaging?

A Yes.

Q Okay. Would you have looked at it before you did your injections? The jury learned you've done a couple sets of injections [inaudible] my opening statement.

A Yes.

Q Okay. So now let's talk about -- before we do that, what I'd like to do is talk about anatomy of the spine a little bit before -- then we're going to look at the imaging.

Can you step down and I want you to educate the jury on the anatomy of the spine, the various components of the spine and then we're going to come back and talk about the MRI of the cervical spine.

A Certainly.

MR. PRINCE: Is it okay with your Clerk?

THE CLERK: It's okay.

THE WITNESS: So this is a model of the vertebral column and let's see if you can see; this is actually the back of your head and the first part, the first set of vertebra comprising the cervical spine or the neck, the next 12 vertebrae, the thoracic spine and the last 5 vertebrae the lumbar spine.

As you look at the size of those vertebrae you can probably appreciate those vertebrae are getting larger the further down we go in the spine. The reason being is the lower parts of the vertebral column has to absorb -- deal with a lot more stresses from the weight.

So the vertebral bodies, the bones are bigger than in the neck. But also what are bigger are the -- the discs. And what are discs? Discs are simple shock absorbers in between the bones, in between the vertebral bodies.

So the discs obviously in the cervical spine are much smaller than the discs in the thoracic spine and certainly a lot smaller than discs in the lumbar spine.

BY MR. PRINCE:

Q Why is that?

A As I pointed out, it has to do with the stresses, with the daily stresses that are being exerted onto the vertebral column, the stresses in the lower back are a lot higher because the lumbar segments carry essentially the upper torso whereas the cervical segments more or less just carry the head so there's a lot less weight and stress on those.

What we also see is these ilio structures here. These are the spinal nerves. The spinal nerves, you'll notice that they're coming off the spinal cord and they're very important because those are the spinal nerves. They run into our shoulder, into our arm, into our hands and/or in the mid back run across our torso in the lower back they run into our lower extremities.

And they provide motor function and they provide sensations such sensation to touch, but they can also provide pain if we get, you know, somebody steps on our toe or when we -- when we cook and burn our hand, so they are essentially also a relay for pain that goes into the spinal cord and then up to the brain.

Q Okay. And we're going to talk -- I want you to

while we're here, while you have that in your hand --

MR. PRINCE: Brendan, can you put up Demonstrative 34?

BY MR. PRINCE:

Q We want to talk about the anatomy of a disc, the structure of a disc.

A Yes. As I pointed out --

MR. PRINCE: You can't get a -- put up a demonstrative [inaudible].

BY MR. PRINCE:

Q Okay. Tell us what we see.

A As I pointed out, this is -- this is a model of a disc. And again, the disc is for shock absorber. But actually part of the shock absorber is the nucleus pulposis. This is like the jelly pad.

And this is the area that absorbs the energy whereas the annulus fibrosis is the ring structure and that kind of holds the nucleus pulposis, the jelly pad into place.

And the annulus is -- can be injured and that means that part --

MR. PRINCE: 36, put up 36.

THE WITNESS: -- part --

BY MR. PRINCE:

Q I'm going to show you another one. Maybe you can use this to help demonstrate [inaudible].

A Yes. So what we see here is, again, the annulus and where we see that the integrity of the annulus is compromised and the nucleus that the picture before it was nicely and the middle of the disc it's now herniating through the annulus that has tears and the nucleus follows the path of least resistence because keeping in mind there's always like this pressure sensation coming from above.

So it squeeze on, and an intact annulus keeps the nucleus in place and it can -- this form and kind of absorb the stresses. But if the annulus not intact it's being squeezed out here into the annulus. And you can see it's coming out here outside the annulus.

What you see here is the spinal nerve. This is the spinal cord in the spine canal, the spinal cord will be this kind of thick structure that runs from top all the way to the lower segment in the lumbar spine.

And off these spinal cords --

MR. WINNER: I'm sorry to interrupt and maybe I need a clarification. I don't know if the doctor is just sort of discussing things generally, but I don't believe the doctor had an opinion about herniation and I don't --

MR. PRINCE: [Inaudible].

MR. WINNER: -- believe he looked at the MRIs based on what he --

MR. PRINCE: He said he did -- he said he did during

the course of his treatment. And right now we're just explaining anatomy right now.

MR. WINNER: I think he did not, but if we're just explaining anatomy and not the particular patient, then that's explained.

MR. PRINCE: Well, we're going to talk about this.

BY MR. PRINCE:

Q Did you look at, at some point, Desire Evans-Waiau's MRIs?

A Yes.

Q Okay. During your care?

A Yes.

Q Okay. All right. Keep going then, please.

THE COURT: Overruled. If that was an objection, I'm not really sure, but.

THE WITNESS: So this is first of all just an education of presentation.

Yeah, so once the annulus is -- loses its integrity the nucleus or part of the nucleus can kind of be squeezed out of the annulus onto the adjacent spinal nerve.

And what you see here that's red is inflammation. And we have found out in the laboratory when you put nuclear material on [inaudible] nerves and under the microscope and we had found out that this material is very inflammatory.

So the causes what we call like a chemical

irritation inflammatory response of that [inaudible].

Q Okay. And even if the nucleus material doesn't always leak out, can the -- with the annulus can it become protruded or bulging and that cause nerve root irrigation?

A Yes, it can.

Q Okay. And why is inflammation so significant? Are you talking about nerve root irritation or inflammation?

A Inflammation per se causes pain and nerve root inflammation causes the inflammatory response in the nerve root and it causes symptoms such as pain, shooting pain, numbness, tingling motor weakness, all of the above.

Q Okay. And so now we're going to go back to your chart, Doctor, which is Bate No. 197 of Exhibit No. 47.

And we're going to be at the bottom it says MRI cervical spine, C5-6 disc bulge and a C6-7 bilateral disc protrusion effacing the C7 nerve roots. Tell us what you're talking about there.

A This bulge is just more or less a slight out pouching of an intact disc, of an intact annulus. Many people can get that over time and it doesn't have to be necessarily significant.

A disc protrusion is where there are some loss in integrity off the annulus where the nucleus, the core of the disc, the jelly pad protrudes into the annulus that is not intact. And the effacement of the nerve that's been seen is

essentially that this protruded part comes very close to the adjacent nerve root.

Q Okay. And that disc protrusion caused by the -- like you said, the jelly pad, kind of herniating out towards the edges of it can that cause nerve root irritation producing symptoms down the arm and into the hand?

A It can -- it can cause nerve root irritation especially what we like to see is a correlation with the patient's symptom with a distribution --

Q Right.

A -- of that nerve root irritation, that complaint, how far the pain is going down into the extremity and then try to correlate it with the abnormality on the discs in a cervical spine. Just as rule of thumb, the higher the problem is in the cervical spine the higher the discs are that are affected, the less far those symptoms travel down into the arm, but the lower -- the discs are that are affected, the lower travel the symptoms into the upper extremity.

Q Right. Now, looking at the MRI of the left shoulder and it says that there's bone contusion of the lesser tuberosity. What was significant to you about the fact that she had a bone contusion on her left shoulder? What is that indicative of to you?

A A bone contusion in layman's terms is a bone bruise so when you play soccer and you get a kick at your chin it

gets bruised. That's a bone contusion. It's pretty painful. It usually resolves on its own. And but it's a sign of a impact of a more of an acute impact in that area.

Q Like a blunt force, like a blunt impact?

A Yes.

Q Okay. Would that be consistent with Ms. -- with Desire [inaudible] sudden impact with something inside of the car to cause a bone contusion?

A That could be, yes.

Q Okay. Is there any other history, a recent history in November of 2015, of any other trauma which would cause a bone contusion would make it more likely other than a motor vehicle accident?

A Not to my knowledge.

Q Okay. And Mr. Winner said in his opening statement that the MRI showed some kind of an impingement syndrom. Is there any impingement syndrome that you saw on the imaging at least as -- even as reported by the radiologist?

A While I'm not a orthopedic surgeon, I did not see that, an impingement syndrom. It was certainly an intact rotator cuff. There were no tears in the rotator cuff muscles.

Q Okay. And he also said that ligament structures around the rotator cuff in the joint, no problems there, right?

A Those seem to be intact, yes.
Q And that the labrum was also intact?
A The labrum was -- there was no sign of any labral tear or slap tear.
Q Okay. Now, based on the history and the MRI, we're kind of building our puzzle, our clinical correlation, is there history of neck pain and pain into the arm and notice into the hand, is that consistent with a disc protrusion effacing the nerve roots at C7?
A That could be consistent. And I just want to point out, this finding is -- we have the -- the clinical complaints, we have the MRI finding that shows an abnormality at that level, and also we have the physical exam finding, so we're kind of tying these findings or these different pieces of the puzzle together. And then want to come up with a treatment plan to diagnose is it indeed that level that where we think the pathology is, is it indeed that area that causes the pain, and that's why we're doing the interventional injection.
Q Right. And so we talked about the complaints that she came in with, we've talked now about the imaging, right, about the -- you see the disc protrusion at C6-7. Now I want to talk about your exam findings, kind of putting our pieces of the puzzle together, okay?
A Yes.

Q We're going to go to 197.

MR. PRINCE: Brandon go to the cervical thoracic exam.

BY MR. PRINCE:

Q And can you tell the jury about your cervical physical examination and the findings on your examination?

A So the physical examination was obviously targeted to the chief complaints, the neck and the left shoulder. The neck revealed a restricted range of motion in all directions. She had tenderness in the area over the paraspinal muscles, the muscles in -- in the neck. She had some palpable spasms appreciated. There was a --

Q What does it mean to have a palpable spasm? What does that mean?

A You can feel a spasm, a tightness of a muscle versus a muscle that is not in spasm.

Q Okay.

A Because the muscle is contracted.

Q Okay.

A There was a positive axial compression test, meaning when we ask or when we push down on the head of the patient, it was causing pain in the neck, and that is often indicative of pain emanating from a structural part of the cervical spine such as a disc or a joint. She had a positive Spurling's sign. A Spurling's sign is a nerve root tension test, meaning

it's a test that is performed or used to see if there's nerve root irritation, such as pain, numbness, and tingling, and the way you do this is you ask the patient to look up and turn the head to either side, and then you push on top of the head.

And what you do is the idea is the nerve travels anatomically through a tight space. It's called the neural foramen. And if there is a narrowing from a protruded disc off that nerve and you performed this test, you create even a smaller space for that nerve. And if that nerve is irritated, then it reproduces the patient's symptoms of shooting symptoms down the arm. And that test was positive on the left side where she had the shooting pain down the arm, indicating that there was nerve root irritation.

Q Okay. Now, you did an axial compression test, which is you applied the pressure. Is that consistent with the pain or symptoms coming from a disc?

A Yes.

Q And then you did the Spurling's test, which is what you just described where you kind of do something to narrow the hole where the nerve comes out. And that was positive on the left, consistent with her presenting complaint?

A Right.

Q Now, you also examined the shoulder; right?

A Yes.

Q Okay. Well, you know, let me stay on -- before you

go into this exam, I want to stay on did you do a neurological exam, as well?

A Yes.

MR. PRINCE: Okay. Let's go Bates No. 180, Brandon. The sensory exam.

BY MR. PRINCE:

Q Okay. And I want to focus on your sensory examination. It says perception of light touch and pin prick was diminished in the left C7 dermatome, pain follows the left C7 dermatomal distribution. What are you talking about there, Dr. Rosler?

A So each spinal nerve innervates a certain pattern on -- in our extremity. We call it a dermatome.

Q Here, I have the dermatome chart.

MR. PRINCE: Let's use 38, Brandon. Demonstrative 38.

BY MR. PRINCE:

Q Here you can explain the dermatome. I'll go ahead and put it up so you can explain what that is. We're going to put up the dermatome charge.

A So this is a famous dermatome chart.

Q You can even stand up, if you wish, and maybe show the jury what you're talking about, I would presume.

A So these are the dermatomes that are innervated by spinal nerves. So this one would be --

Q What is a dermatome first?

A Dermatome is the area that is being innervated and affected by a spinal nerve.

Q Okay. Is it equal on both sides?

A Yes, it's equal. Plus we have spinal nerves coming out from both sides. So the dermatome No. 3 is up here, No. 4, No. 5 goes into the upper trapezius, sometimes it goes a little bit into the biceps area. The C6 dermatome travels further down up into the thumb, forearm into the thumb. The C7 dermatome, the dermatome that we are talking about, travels all the way down the back of your arm into the -- into the index and middle finger and part of the fourth finger. And the C8 dermatome goes alongside the medial aspect of the arm, and it goes into the pinky and in part of the fourth finger. So this is kind of a dermatomal distribution.

And when you do a physical exam, you -- examination, the area of complaint, I have pain, I have tingling down my arm, you try to elicit any loss of sensation to a pinprick, and you also try to map out the pain, the shooting pain that's going on there. So that gives you an understanding, a rough understanding of the dermatome, and then you correlate this and try to correlate this with the abnormality of the MRI scan. Is there something that would irritate a nerve that follows that specific dermatome.

Q Now, when you -- you do a sensory exam, and here you

indicated your note says perception of line touch and pinprick was diminished in the left C7 dermatome. What -- what are you telling us?

A You essentially test a pinprick in this area of the C7 dermatome right here, right here. You touch it slightly. You use a little sharp object with little pinprick. And then you compare it to the other side because you have to have a comparison. And if patient states, yeah, I feel less on this side versus on the other side, then you know that there is a diminished sensation of -- to touch and pinprick.

Q Okay. And in this case you indicated that she had a decreased sensation following the C7 nerve root.

A Correct.

Q Is that consistent with the MRI image?

A It is consistent with the MRI image which show a disc protrusion effacing the C7 nerve root. It's consistent also with the fact that the patient had a positive Spurling's sign, indicating that there is something going on with the nerve root.

Q So it's not just her complaints. You're looking at imaging, your exam findings, and also now the -- the decrease in sensation in that same distribution?

A Yes.

Q Okay. Now, did you also examine the shoulder?

A Yes.

Q Did you, as part of your examination and history, were you able to rule out that the shoulder was the explanation for these symptoms into the arm?

A Well, the only way to rule it out is, in fact, to do a nerve block; right? And if the patient gets better with a nerve block that is affecting the C7 nerve, then you know you rule out the shoulder.

Q Okay.

A The shoulder can sometimes cause some symptoms, often nonspecific symptoms of radiating pain down the arm, but not very specific symptoms following a dermatome.

Q Okay. So you're saying that as part of your -- the injection that you perform, these injections you perform, you can differentiate is it coming from the shoulder, is it coming from a nerve, coming from the neck?

A That is correct.

Q Is that one of the purposes of the testing?

A That is one of the purposes. Right.

Q Okay. And what I'd like to do is let's look at your impressions and your recommendations at the time of your initial evaluation. That's Bates No. 198. And let's go to the first impression. It says cervical sprain-strain status post motor vehicle accident with left mechanical neck pain, intrascapular pain, parascapular pain, with upper extremity radiculitis. Can you tell us what that means?

A Well, what it means is the patient has certainly a sprain-strain symptomatology, head sprain-strain symptomatology, but there was still ongoing underlying what we call mechanical neck pain and that would -- which was also causing some radiating symptoms into the left upper extremity which we called radiculitis. Radiculitis means an inflammation, painful inflammation of a nerve root.

Q Okay. And -- I want to talk about can you have a soft tissue injury to, you know, the muscles, tendons, and ligaments, and also a structural injury to the spine in connection with a motor vehicle collision, such as the one Desire described to you?

A Typically, when the forces are enough to cause a structural injury, certainly causing the overlying sprain-strain symptoms, there's no doubt about it.

Q Is it common that when you initially are treating a patient that you would, you know, initially treat them conservatively as if it's a sprain-strain. If it doesn't improve with time, then you kind of look at more structural issues or something more serious?

A In general you do this unless there is a real significant finding right away that alerts you to something more serious right off the bat.

Q Okay. Now, what was your second impression?

A My second impression was that the patient was having

a sprain-strain of her shoulder, and also as a result of a traumatic event and, again, keeping in mind we know that there was a contusion, bone contusion, and that's typically the result of some blunt force.

Q And with regard to your findings, do you believe that those are consistent with the motor vehicle accident, your impressions, that Desire described to you that she was involved in October 30, 2015?

A Yes.

Q Okay. In terms of the onset of symptoms, the mere fact -- and as part of your practices and your training and experience, do you treat patients who have developed disc injuries that they don't report any symptoms or injury, let's say, at the scene of a motor vehicle collision? Do you see that in your practice?

A Well, we see that, you know, often. Even we see that in -- in sports where people break -- break a bone and they keep playing because of the adrenalin. Or the most extreme I always say is soldiers being shot in the -- in the field and they don't even know about it, and just lay there once the adrenalin kind of goes down and the stress goes down, then they become aware of the injury. So it's not uncommon that the patient does not feel the pain right away.

Q Okay. And part of your education, training, and experience, as well as treating people who have been involved

in either work related incidents or motor vehicle collisions or falls or otherwise, have you seen situations where they may not feel symptoms for hour or even a day or two before the full development of these symptoms occur?

A That is -- that is correct. And, again, what is pain? Pain is an unpleasant response as a result of a tissue injury. And there -- if there is a tissue injury, certain -- certain biomechanical processes have to happen. We call it the inflammatory cascade, and that has to be initiated. And it takes -- sometimes it takes, you know, it can take hours to a few days where this -- the inflammatory cascade is being initiated and then the patient becomes aware. Again, the example, you play football on Sunday, you feel okay, and on Monday you're hurting all over. It just sometimes takes time for it to develop.

Q Okay. So the mere fact that someone doesn’t report an injury at the scene or go by -- to the emergency room from the scene or go by ambulance, does that mean that they're not injured or don’t have some sort of -- develop a discogenic injury that we’re talking about in Desire’s case?

A That is correct.

Q Okay. Now, let’s talk about your recommendations. You said, number one, continue conservative treatment. What are you talking about there?

A With the chiropractic treatment.

Q Okay. And you thought that in addition to your own management that she should continue with that?

A Yes.

Q Okay. And it says schedule patient for left CSNRV, rule out cervical discogenic symptomatology. What are you talking about there?

A Well, my suspicion was that there was an irritation of the C7 nerve root that was responsible for her symptoms going down into her arm, into her hand, also correlating with the MRI finding. So my recommendation was to evaluate with an interventional injection if, indeed, this nerve root is, in fact, the pain generator, the culprit.

Q Okay. Is this kind of your way of investigating where the pain was coming from so you can determine what's the -- what are the next steps for Desire?

A Correct.

Q Okay. And why did you select, number one, a left-sided C7 selective memory block?

A Her symptoms were predominantly -- extremity symptoms were predominantly left-sided. She complained of left-sided pain and numbness, and the neurological examination showed diminished sensation to pinprick and touch and -- and pain following that left C7 dermatome we saw on the MRI scan. There is some disc pathology abnormality at that level, so it was reasonable to investigate is this indeed the culprit is

the C7 nerve root, and, therefore, the C6-7 intervertebral disc indeed pain generator based upon her symptoms.

Q Right. Were you doing this to diagnose a disc issue or provide a therapeutic benefit or, you know, control pain?

A It's more a hybrid. It's -- you obviously want the diagnosis, so you -- you use it as a diagnostic part, but also you hope with the addition of some small amount of corticosteroid to -- to provide some reduction in the inflammation, hopefully some improvement of pain to give her a therapeutic benefit from the injection.

Q Right. I'm going to put up a demonstrative slide I used during the opening statement. The two goals of spine injection is, one, to determine the source for the diagnostic part of it, and then the second part is the therapeutic part. Hopefully it reduces pain and inflammation and you can improve your quality of your life, improve your function.

A Yes.

Q Are those the two goals of the type of injections you were -- the type of injection you were recommending to Desire?

A Yes.

MR. PRINCE: Okay. And I'm going to Bates No. -- Demonstrative 54, Brandon.

BY MR. PRINCE:

Q Can you maybe stand up and explain to us what --

what you're doing when you do a selective nerve root black and what it entails, then we're going to go -- then we'll go specifically to Desire's case.

A Well, the selective nerve root block, as it already says, selective, you go selectively after the nerve root that you suspect is the culprit. And you go after the nerve root with a needle, the spinal needle, we have specialized needles that are very thin and sharp, and from fluoroscopic guidance and place a small amount of medication right on that nerve root, mainly a numbing medication that you get when you go to the dentist, we call it lidocaine. And then a corticosteroid, again, that's a therapeutic component that hopes to diminish the inflammation around the nerve.

Q Okay. I want to kind of break this down for a second because it's in a courtroom. You talked about lidocaine. That's the numbing agent?

A Yes.

Q Why are you using lidocaine? Is that the diagnostic part of it?

A The numbing medication, as you know, when you go to the dentist it works right away. So that gives us a diagnostic result. The corticosteroid often takes about a day to start working because what it does, it doesn't number the area, it diminishes the inflammatory response so it has to kind of diffuse into the structure that is inflamed and cause

the anti-inflammatory action there. And that typically takes -- takes about a day and a few days to reach its peak effect.

Q How long does the -- does the numbing agent with the shutting off of the nerve, how long does that typically stay in effect?

A Typically it stays anywhere between, you know, 90 minutes to a couple of hours. And, you know, we all went to the dentist and we got it and, you know, sometimes it takes until the evening, but a few hours I would say.

Q Now, the steroid agent, the steroid, you said that that usually kicks in within about a day or so. How long can that last, Dr. Rosler?

A Well, that is -- that is from each individual different, you know. It's probably -- I've had steroid injections in the joints. Perhaps it can last, you know, days, weeks, months, you know. It's -- there's no clear --

Q Is it highly variable between patients --

A It is.

Q -- about whether you get any benefit, you may get weeks or months of benefit --

A Yes.

Q -- and then sometimes nothing?

A Yes.

Q Okay. All right. Perfect. Thank you for doing that. Now, I want to talk about your -- your initial

injection, which was January 7, 2016.

MR. PRINCE: Brandon, that's part of Exhibit 47, Bates No. 199.

BY MR. PRINCE:

Q Now, you can -- the perioperative diagnosis and kind of down to the procedure --

MR. PRINCE: Brandon, right there. Perfect.

BY MR. PRINCE:

Q Now, first off, are you doing this to evaluate or to treat her soft tissue injuries to her cervical or lumbar or thoracic region?

A No, that would be malpractice.

Q Right. This is -- this is -- what is this directed at?

A This is directed to assess a underlying structural problem emanating from the spine, not from the soft tissue.

Q So even though you said she has a cervical sprain and strain, you're now investigating whether she has a discogenic problem; right?

A Correct.

Q So she has both?

A Correct.

Q All right. Now, tell us where this -- this -- the surgery center is known as Surgical Heart Center. So you have her go to a surgical center?

A Yes.

Q Okay. Describe the process for performing a selective nerve root block and what happens when the patient gets there from the time they arrive through the procedure.

A Well, when you go to a surgery center, you're obviously being -- all the demographics is being, you know, taken and, you know, meet the preoperative nurse, go over your health, you know, make sure you're not on any medication that would be conflicting what we are doing, make sure your blood pressure is okay, your blood sure is okay if you're diabetic and so forth. And then we write the consent and, you know, you then --

Q What are the risks associated with a selective nerve root block such as this?

A Well, the most common risks or most common named risks are bleeding infection. Whenever you get a needle stuck in your body, that’s always the risk of bleeding and infection. There’s the risk of a nerve injury. Perhaps if you stick the needle right into the nerve and inject and you're not careful, there is the risk of vascular damage, of injecting into the vertebral artery and that could potentially cause stroke. There’s the risk of injecting into the spinal cord, which would be detrimental. That could cause paralysis, tetraplegia. There is the risk if you inject too much numbing medication in -- in the area that it migrates up to the brain

and the patient loses consciousness and needs to be reanimated. So there -- these are procedures that should not be done and typically not be done by novices.

Q Okay. And here the preoperative diagnosis was the cervical straining with left-sided mechanical neck pain and left upper extremity radiculitis. Why did you record the preoperative score of 8 out of 10?

A Well, I --

Q Why is that important?

A Well, I -- it is important for us to know how the patient does the day before the injection. Now, I do not report that. That's been reported by the preoperative nurse because I want to be blinded. I don't want to know. I just want to get the facts, so the preoperative nurse documents the -- the preoperative pain score when she takes the patient in and -- and assesses the patient and asks the patient about her medication.

And also after the procedure, the postoperative nurse that is about to discharge the patient, and every surgery center, just like every hospital, has to fulfill certain discharge criteria to make sure the patient is hemodynamically stable, that the patient is not in severe pain, that the patient is oriented to time, place, and person. And only then the patient will be discharged into the hands of her driver. And at this time when the patient meets all these

criteria, the patient is being asked how are your symptoms now compared to when you came in? So that would be the postoperative pain score.

Q Okay. And tell us what you did that day.

A I did a left C7 selective nerve root block.

Q Okay. And it says you used sedation. Tell us what you mean by sedation.

A Sedation is -- I tell my patients sedation is voluntary. It doesn't have to be done. There's no -- to us it doesn't make a difference whether the patient has sedation or not. Some patients are just afraid. They said I freak out when I get stuck with a needle in my neck or back, kind of similar to a colonoscopy. You don't really need sedation for a colonoscopy. It's just very uncomfortable. So we offer this to the patient while we clearly stress that it is not necessary. But if the patient requests to be sedated, we're certainly not telling the patient, no, you can't be sedated, you have to undergo this and you have to endure it.

Q What does the -- what does the sedation do for them?

A The sedation typically kind of gets the patient in a twilight state where the patient is very, very relaxed and doesn't fell all that much of the procedure.

Q Okay. What sedation do you use as part of your practice?

A We typically use -- well, that differs, too, but you

typically use a sedative called propofol. Again, if people had colonoscopies in the past, it's that milky solution that's being injected. The advantage of that is that the patient -- it has a very short half-life, so the patient comes to very quickly. It also doesn't interfere with the pain perception of the patient. It's not what we call an analgesic. It just simply kind of dims down the -- the brain, the perception of the patient, what's going on.

Q Does it relax them and reduce the anxiety so that you can perform the procedure safely?

A Right. Right.

Q Right. And as part of your training in the area of pain management, did you receive training on uses of sedation when it's -- when a patient might be anxious or might be nervous about the procedure?

A Absolutely.

Q Okay. Is it in widespread use?

A It is in widespread use here in our -- in our town. A lot of my colleagues use it. But, again, we use it at the request of the patient. We are not saying you have to have sedation, you have to do this, you know, there are patients that are just fine without -- without any sedation, but everyone is different.

Q Okay. And you said the sedation, the propofol, doesn't have any analgesic or any pain relieving effects?

A That is correct.

Q All right. So, then, after she's done with the procedure, now the score is down to 8, what does that tell you diagnostically her pain went from 8 to zero, Dr. Rosler?

A That means -- what it means, there was no pain at the end, and that is contributed to a local anesthetic that was injected. Because what it does, the local anesthetic changes for a very short period of time the chemical composition of the nerve, so it causes a conduction block, meaning there is no pain transmitted on the -- in that nerve, and that causes the immediate relief of symptoms. But it only -- it only does that if you obviously target the right structure.

Q Okay. And in this case, did you believe that that confirmed that the C6-7 disc was a source and cause of Desire's pain and symptoms into her neck and her arm.

A That was my impression, yes.

Q Okay. Was that based upon all the available clinical data or what she told, the history, examination, MRI findings, as well as now your results of your selective nerve root block?

A Correct.

Q Did you form an opinion what was the cause of that -- the soft tissue injuries, as well as the discogenic injury, did you form an opinion as to what the cause was?

A Well, based upon the knowledge that I gathered, it was my understanding that the patient sustained a disc -- traumatic induced disc injury with subsequent nerve root irritation which we call radiculitis, which was then successfully diagnosed with an injection.

Q Okay. Caused by the motor vehicle collision of October 30, 2015?

A That's my understanding. Yes.

Q And now that you have the -- the selective nerve root block performed, is the shoulder an explanation for these arm symptoms based upon your selective nerve root block? Did you rule that out?

A You rule that out and certainly, again, the shoulder does not explain a C7 radicular symptoms, it's just -- anatomically it's just not. As I pointed out before, the actual -- the pain, you can have some nonspecific pain going down into the arm, but that would not respond to an isolated C7 selective nerve root block.

Q Okay. And I guess there were some statements made during the opening statement that the shoulder could be the explanation for the symptoms down the arm and into the hand. Based on the selective nerve root block, did you rule the shoulder out as the cause?

A Yes.

Q Okay. Can you state that to a reasonable degree of

medical probability?

A Yes.

Q And beyond that are you certain?

A Yes.

Q All right. I want to now go to January 14, 2016, a return visit to you after the selective nerve root block.

MR. PRINCE: Bates No. 201. Brandon.

BY MR. PRINCE:

Q This is exactly a week later.

A Yes.

Q Okay. It says Desire returned to her follow up. She underwent a left C7 selective nerve root block, pre-procedure, 8 out of 10, post-procedure was zero out of 10. Patient reports she has cervical discomfort 1 to 2 out of 10.

A Yes.

Q What's significant about that to you, Dr. Rosler? She's come back, she's a week later, and she's -- her pain is very low now.

A She has sustained some therapeutic benefit from the injection that is not due to the lidocaine anymore, the numbing medication, because that has worn off, but that's due to the corticosteroid component of the injection solution.

Q And does that mean that the disc protrusion, that that's now repaired or fixed because you did the injection? Does that fix the underlying issue?

A It didn't fix the underlying issue, but what it did, it reduced the inflammation that was caused by the underlying issue.

Q Okay. Now, let's go to Bates No. 202. Let's look at the cervical thoracic exam. And it says cervical range of motion was full flexion, extension, bilateral rotation, bilateral bending, mild paraspinal discomfort. Is that an improvement, you know, from your initial exam findings in December after the injection on January 7th?

A It was.

Q Do you think there's a direct correlation to that improvement, now she's got a full range of motion, minimal discomfort, is that consistent with the steroid now taking effect and improving pain and function?

A Yes.

Q Okay. Do you see that in your practice?

A We do see that.

Q When you're -- when you're giving your patients their -- and discussing their options, medical options, do you discuss with them before you perform one of these procedures that there's a chance or a probability that your symptoms may return in either days, weeks, or months?

A Yeah, well, we -- we -- we tell patients the injection can return the next day, the symptoms after the injection can return the next day, but at the very least we

have a diagnostic value and a diagnostic impression as to where the pain is coming from. So we can't guarantee that with this injection your pain will be gone for good. That's just not possible.

Q Right. Do you -- do you discuss with them or at least counsel them that there's a risk that it's going to return?

A Well, I tell the patient it's expected to return at some point.

Q Okay.

A Because --

Q Why do you tell them that?

A Because I want to be up-front with my patients and not give them any false hopes. But I say, you know, there's -- there's a good chance, and I expect that at some point the pain -- the pain will return because what we are doing, we're not fixing an underlying problem. We are not fixing a structural problem. We are dive -- we are trying to diagnose where the pain is coming from, and in the process of diagnose, saying we are trying to provide also a therapeutic benefit and that varies from patient to patient.

Q Okay. Let's go to your February 18, 2016, visit.

MR. PRINCE: 204. Can you get the date, Brandon, in there? And the -- just the whole -- there you go.

BY MR. PRINCE:

Q All right. So now we're a little more than a month, we're about a month and a week after you did your selective nerve root block. She comes back and she says, doctor, I'm symptom free in my cervical spine. You must have been pleased with that at that point.

A Yes.

Q Okay. Does that in your mind, even though she's symptom free, at that point did you believe in your mind, oh, I cured the disc problem, the underlying structural disc problem?

A Well, I have not because I have, in my recommendations, I have clearly expressed to the patient come back when the -- if the symptoms return.

Q Okay. And so in your examination that day --

MR. PRINCE: Go to Bates No. 205. Brandon, go through the cervical, thoracic, all the way down to the motor exam, Brandon. 205.

BY MR. PRINCE:

Q Okay. And how was she doing on the cervical exam that day after -- after undergoing the injection about five weeks earlier?

A She had essentially a normal physical examination finding which I was pleased to see that.

Q Okay. And how about the sensory exam?

A The sensory exam also then showed a reduction in the

inflammation and, therefore, a normal neurological examination.

Q So you're saying that the -- did the steroid reduce the inflammation which was causing the nerve root irritation, which was inducting her sensation down her arm under the dermatome we talked about earlier?

A Yes, and it took a little bit longer. In the visit before she reported significant improvement of her neck with some residual discomfort, but there was still some -- still some neurological findings in the -- in the nerve. But then with -- then the corticosteroid further exerted the anti-inflammatory action on those, on this particular nerve, and those nerve findings then subsided.

Q Okay. And what was your recommendation at that point?

MR. PRINCE: Brandon, go to the recommendation.

THE WITNESS: It was pointed out there was nothing else for me to do at this point. The patient seemed to be and was in good condition, and I told the patient to return if the symptoms return.

BY MR. PRINCE:

Q Okay. Now, I want you to go to your March 29, 2016, visit. It’s the one that’s about six weeks later.

MR. PRINCE: That’s Bates No. 206. If you get -- pull in the date for the history and compress all this. All

right.
BY MR. PRINCE:
Q All right. Now Desire is back. And what was her symptoms when she came back to see you on March 29, 2016?
A I think on -- unfortunately her symptoms returned with neck pain and also her arm symptoms also returned.
Q And the numbness?
A Arm symptoms, such as pain and numbness, yes.
Q Okay. And was that surprising to you that she came back with a return of these symptoms?
A It was not, as I pointed out earlier, I stated return, if those symptoms return, so it would not half surprise me at that point when she was fine that at some point those symptoms come back because we're dealing with a structural problem. We are not -- unfortunately not able to cure that. We are calling it a palliative treatment --
Q Okay.
A -- where we treat the pain, but not the underlying structural problem.
Q Right. Is it common or do you see it in your -- in your -- based on your training and experience and work in this area, is it -- do you see patients who initially had a good response to an injection like a selective nerve root block, and then a month or two later they come back to the clinic and the symptoms have returned?

A I have seen that, yes.
Q Do you see that common -- frequently?
A It's -- it's frequently. It's due to the fact that we're just with injections not correctly the -- the underlying problem, the structural problem, but rather we are treating the -- the symptoms.
Q Right. Is there any evidence between, you know, February 18th and March 29th of any intervening trauma, any new injury, any -- anything new --
A Not to my knowledge.
Q -- that would explain the - the recurrence of these symptoms?
A Not to my knowledge.
Q In your opinion, are these symptoms that she's returning with in March 29, 2016, still once caused by the motor vehicle collision of October 30, 2015?
MR. WINNER: Foundation.
BY MR. PRINCE:
Q Based upon all the evidence that you -- all the data, your examination, the history, and everything?
A Based -- based upon the data, based upon --
MR. WINNER: Foundation objection.
THE WITNESS: Based upon the --
THE COURT: Approach please.
(Bench conference)

THE COURT: What's the question again? Well, I guess wait until he gets here. Come on. Come on. Is this going to finish by 7:00?

MR. PRINCE: No. I'm going to go another 15 minutes, we'll stop, and he'll have to come back another day, so -- so the -- because I have to deal now with the 2010 issue. Now, he knew not to say it, but I've got to come back and deal with that. So I could have done -- that's over now. I've got to figure out how we can talk about -- when this guy I guess is going to come in, I'm going to have to do it with Garber, too. But on this issue, my question was the symptoms that she returned with in March 29, 20156, were those the ones caused by the motor vehicle accident that we were talking about, October 30, 2015.

THE COURT: And your objection is foundation?

MR. WINNER: Foundation. Just that --

THE COURT: Explain it to me just a little bit more because --

MR. WINNER: Well, he said based on all of the evidence and all of the data about the return of symptoms. My foundation was he had limited data, it was kind of what she reported to him. Had the question been phrased a different way, I wouldn't have objected, but it was all of the evidence --

THE COURT: Can you just --

MR. WINNER: -- and all of the data.

THE COURT: -- rephrase it. If we're not finishing, is there any reason to not break right now at 6:30? Because you're going to keep going tomorrow?

MR. PRINCE: Not with him. I have to start a new witness. He'll have to come back another day. He can't come back tomorrow. So we're going to stop and --

MR. WINNER: My cross isn't going to be that long.

MR. PRINCE: He can't come back tomorrow.

MR. WINNER: But, I mean, my cross isn't going to be that long. If you could wrap it up, I'll do a pretty quick cross tonight.

MR. PRINCE: I won't be done by 7:00, so --

MR. WINNER: You said --

THE COURT: You won't be --

MR. WINNER: -- you had 15 --

THE COURT: -- done by 7:00?

MR. WINNER: -- minutes left; right?

MR. PRINCE: No, I said I wanted to go another 15 minutes and then just break. I'm not going to be done in 30 minutes, so --

THE COURT: Well, if we have to bring him back another day, then I'm just going to break. The sergeant is looking for my marshal. And so I thought -- my goal was to get him on and off --

MR. PRINCE: Yeah, no.
THE COURT: -- so you didn't --
MR. PRINCE: Not going to.
THE COURT: -- have to bring him back.
MR. PRINCE: No.
THE COURT: So unless there's any compelling reason not to, I'm just going to call it for the day.
MR. PRINCE: Well, let me just finish this question and then we can --
THE COURT: Okay.
MR. PRINCE: -- we can -- I'm fine to break.
MR. WINNER: I need the question to be rephrased. Not to object to it, but it was based on all of the evidence, all of this, and all of this.
THE COURT: Just rephrase it.
MR. WINNER: It clearly doesn't have --
MR. PRINCE: All right.
MR. WINNER: Yeah.
(End of bench conference)
THE COURT: All right. I'll sustain it. Just rephrase the question, please.
BY MR. PRINCE:
Q Doctor, let me rephrase just to help us. Dr. Rosler, based upon your history of the present illness described to you by Desire Evans being involved in this motor

vehicle collision, her examination of findings, her response to treatment, chiropractic treatment, the selective nerve root block, the MRI imaging, the physical examination findings, is it your opinion that the return of these symptoms as of March 29, 2016, that was caused by the motor vehicle collision we're talking about of October 30, 2015?

MR. WINNER: Based on what was reported to him, I withdraw my objection based on that.

THE COURT: You can answer.

THE WITNESS: Okay. Yes, it is my opinion the motor vehicle collision is caused, as I pointed out earlier, this traumatic disc injury that we diagnosed and treated to a certain degree successfully with the injection that lasted for a month, and then the pain came back. And what is important is the same symptoms came back, the same symptoms that she was presented with to me the first time around, those were not other symptoms that she was complaining. So more likely than not, these were the same.

MR. PRINCE: Judge, can I just -- I need to finish this note and we can be done.

THE COURT: Go ahead.

BY MR. PRINCE:

Q And then can we go to Bates No. 207, which is the -- your exam findings of that day, March 29, 2016. And it says the -- these are exam findings changed from your visit in

February where she reported she was pain free and had -- you know, could move her neck freely with no pain?

A Those exam findings changed again. Yes, sir.

Q Did they change clinically significant in your mind?

A They changed and kind of reverted to the exam findings that she had prior during the first injection.

Q Okay. And did she have -- did she have restricted range of motion?

A That was documented.

Q And then so you had actual compression testing, which is the loading we talked about you did, was that present again?

A Yes.

Q And the Spurling’s test, positive to the left, which is similar to her symptoms, was that also -- did that -- had that returned?

A Yes.

Q All right. And let’s look at the sensory exam under your neurological examination. Was there now a change in her sensory exam from where she was in February after your initial injection?

A Yes.

Q And what did you find on March 29, 2016?

A Essentially, the same finding, that the perception to pinprick and touch was diminished and pain was following

the same dermatome, the C7 dermatome on the left.

Q And what was your recommendation to her that day?

A My recommendation was based upon her good response, initial good response from the injection, I recommended consideration for a repeat injection, the very same injection again, in the hopes that we perhaps obtain a longer therapeutic benefit.

Q Okay. And did you perform that injection on March -- April 11, 2016? Bates No. 209.

A Yes.

MR. PRINCE: Okay. Can you go to that Brandon. And we'll stop after this, Judge.

MR. WINNER: Did you say 2009?

MR. PRINCE: 209.

MR. WINNER: Oh.

MR. PRINCE: That's the Bates number.

BY MR. PRINCE:

Q And the -- what was the pre-procedure pain score?

A It was an 8.

Q What did it reduce down to after the procedure?

A To a zero.

Q What did that indicate to you?

A It confirmed what it indicated the first time around, that the lidocaine, the numbing medication was, again, accurately pinpointing the -- the area where the pain was

coming from.

Q Okay. And at this point --

MR. PRINCE: I need to just follow up with one -- one more note, Judge.

BY MR. PRINCE:

Q Go to your April 26, 2016, note. Bates No. 211.

A Yes.

Q And this is 15 days or two weeks after you perform your procedure. How is she doing there? Did she have the same type of response that she did the first time?

A She -- unfortunately not. She had some relief of pain. I mean, initial from 8 to a zero from the local anesthetic, then the pain went down to a 5. She still have left arm symptoms.

Q Okay. So she didn't have the same amount of therapeutic benefit as the first time?

A Correct.

Q Okay. And if we can go to Bates No. 212. I want to talk about your recommendations now, how they change, and then we can stop here after this. And it says, number one, neurosurgical consult for discogenic neck pain. Why are you recommending her to go see a neurosurgeon?

A The patient had obviously a discogenic symptomatology, discogenic neck pain. It's often warrant -- often warrants a surgical consultation in an attempt to

perhaps relieve that pain emanating from that particular disc through surgical means, and that obviously has to be evaluated and recommended by a surgeon. So my recommendation was at this point in time there is nothing else that I can offer in terms of interventional treatment. It would not make sense, another injection there. So, again, it's a stepwise process in the care of the patients. And my recommendation was have the patient -- refer the patient on to a neurosurgeon, see what he has to say, and go from there.

Q Did the chiropractor suggest that you refer her to a neurosurgeon, or was that your own independent judgment?

A No, it was my independent judgment based upon the diagnostic data that I have gathered based upon my experience.

Q Right. And certainly the lawyers don't influence your -- whether you make some -- refer someone to a neurosurgeon or not; right? You make that independent judgment?

A That is my independent judgment because it's part of my medical practice and my responsibility to do the best for the patient.

MR. PRINCE: All right. Okay. We're at a good breaking point, Judge.

THE COURT: Okay. Ladies and gentlemen, it looks like -- we were going to push until 7:00 in the hopes of finishing this witness, but even if we stay until 7:00, we're

not going to finish, so we're going to call it.

MR. PRINCE: Dr. Rosler is going to come back. And he won't be coming back tomorrow, but another day sometime this week, or early next --

THE COURT: Okay.

MR. PRINCE: -- to finish up.

THE WITNESS: Next week I'm out of the country.

MR. PRINCE: Okay. We'll talk.

MR. WINNER: Can you not finish?

MR. PRINCE: With Dr. Rosler?

MR. WINNER: Yeah.

MR. PRINCE: No.

THE COURT: And my understanding from counsel, both counsel, you wouldn't even finish by 7:00.

MR. PRINCE: No.

THE COURT: Let alone cross. Okay.

MR. WINNER: My cross will be short.

THE COURT: Well, but if he's not done until 7:00, that -- you're not going to get cross because he's going to get --

MR. WINNER: I understand you have to -- well, I'll defer to the Court, but if we want to finish --

THE COURT: Well, I said 7:00. If 7:00 doesn't finish it --

MR. PRINCE: It doesn't.

THE COURT: -- and Mr. Prince indicated to me that he was going to go past 7:00 alone.

MR. PRINCE: Right. That’s true.

THE WITNESS: I can't come back. I have patients scheduled. I was supposed to be here yesterday. I have patients scheduled.

THE COURT: All right. Counsel approach.

(Bench conference)

MR. PRINCE: Can you come back Thursday?

THE WITNESS: [Indiscernible] procedures in the afternoon. I already cut my procedures short on Monday.

THE COURT: I'm not keeping them past 7:00.

MR. PRINCE: Okay.

MR. WINNER: Okay.

THE COURT: I told them -- they're glazing over anyway.

MR. PRINCE: Okay.

MS. LORELLI: Can we go 20 minutes of cross if he can't come back.

MR. PRINCE: There’s no way he can. Can you come on Thursday?

MR. HENRIOD: Can we ask the --

THE COURT: What?

MR. HENRIOD: -- the jurors if they’d be willing to?

THE COURT: To what, stay longer?

MS. LORELLI: Or can we do our 20 minutes of cross before he's not available and out of the country?

MR. PRINCE: Well, let me -- I'm just not going to be done, Judge. I don't know what to say. I don't know.

THE COURT: I don't either. I was told that if we stayed until 7:00 you would be able to finish this witness. I'm not sure what I'm supposed to do here.

MR. PRINCE: Well, let me -- let me -- how much cross-examination do you have?

MR. WINNER: 15 minutes.

(End of bench conference)

THE COURT: Ladies and gentlemen, if you had to stay after 7:00, would that be a hardship for someone?

JUROR: Yeah.

THE COURT: Okay. That's -- that's good enough. I not going to do it.

(Bench conference)

THE COURT: So you all figure it out.

MR. PRINCE: Can you do what you can to help with that?

THE COURT: Can't we just order him and let -- they don't do that here?

MR. WINNER: Can you just order him what?

THE COURT: Order him to come back.

MR. PRINCE: He's got to deal with his patients.

THE COURT: I heard he has a deposition. I can order him to reschedule that, can I not?

MR. RAY: I have patients tomorrow after deposition Thursday.

MR. PRINCE: What time is your deposition tomorrow?

THE WITNESS: In the morning. In the morning after that I have patients scheduled.

MR. WINNER: Is it with me? I'll cancel it.

THE WITNESS: I had your deposition today.

MR. PRINCE: Well, can you -- can you come Thursday? What time is your deposition on Thursday?

THE WITNESS: From 8:00 -- from 7:00 to 8:00.

MR. PRINCE: Yeah, no we start -- what's your availability on Thursday?

MR. WINNER: 7:00 a.m. to 8:00 a.m.?

THE WITNESS: 7:00 a.m. to 8:00 a.m.

MR. WINNER: Oh. Okay.

THE WITNESS: So I have to be at the surgery center at 1:00.

THE COURT: What if we come in at 11:00 on Thursday, and you guys will only get two hours. And you're going to get --

MR. PRINCE: Yeah, we will. We will for sure. Yeah.

MR. WINNER: 11:00 a.m. Thursday?

THE WITNESS: I can come in tomorrow at 11:00.
THE COURT: Okay.
MR. PRINCE: Fine.
THE COURT: Well, if the jury --
(End of bench conference)
THE COURT: Ladies and gentlemen, can you come back at 11:00 tomorrow? Yeah? Okay.
JUROR NO. 4: So I do have a conflicting thing sort of, but I wouldn't want to suck up everybody else's time that agreed to be here. My daughter is doing like a 5th grade promotional ceremony.
THE COURT: What time is that?
JUROR NO. 4: It's at 2:00.
THE COURT: At 2:00 tomorrow? But you weren't going to be there anyway. I mean, I don't --
JUROR NO. 4: It's okay. I was just asking. I will be here.
THE COURT: Oh, you're killing me. Well, we didn't know about that, did we?
JUROR NO. 4: No. It's okay. I was just asking. So I will still be here.
THE COURT: How far away do you live or is the school?
JUROR NO. 4: Silverado Ranch area.
THE COURT: I am --

JUROR NO. 4: It’s okay.

THE COURT: -- so sorry.

JUROR NO. 4: It’s okay. It’s okay for me to miss it. I've been at everything else. I already talked to her ahead of time so she knows that I am committed to this and probably can't be there tomorrow. It’s not high school graduation. It’s not college graduation. It’s okay.

THE COURT: All right. Well, I -- if I had known ahead of time, we could have worked around it or something, but the way we’re doing it right now, we just --

JUROR NO. 4: It is totally okay.

THE COURT: Okay. So 11:00 doesn’t hurt you any more than 1:00 does.

JUROR NO. 4: That’s fine.

THE COURT: All right. So we’re going to take our evening recess right now. We’re going to ask you all to be back here -- I’d like you to be back by 10:45-ish so we can hit -- hit it at 11:00. I mean, if you're not, I'm not going to bring you in until 11:00, so I'm telling you that, but I'm really saying 10:45, meaning I want to get in our chairs by 11:00, okay.

So during the recess you're admonished not to talk or converse amongst yourselves or with anyone else on any subject connected to this trial, or read, watch, or listen to any report of or commentary on the trial of any person

connected with this trial by any medium of information, including, without limitation, newspapers, television, the Internet, and radio, or form or express any opinion on any subject connected to the trial until the case is finally submitted to you. Okay.

(Jury recessed at 6:46 P.M.)

THE COURT: All right. Here's the deal, though, tomorrow. I would appreciate it if, Mr. Prince, you would finish up so that we can --

MR. PRINCE: We will.

THE COURT: You need to leave by what time, Doctor, tomorrow?

THE WITNESS: By noon so I can get my 1:00 clinic.

THE COURT: Noon? I thought you said 2:00.

MR. WINNER: I'm sorry. Did you say by 1:00?

THE WITNESS: By noon.

MR. WINNER: Oh.

THE COURT: I thought you said 2:00.

THE WITNESS: Well, maybe 12:30.

THE COURT: Here's the deal. I'm going to keep you until they finish as long as they're reasonable, okay.

THE WITNESS: Okay.

THE COURT: So just make whatever --

THE WITNESS: Well, my 1:00, my clinic starts at 1:00.

MR. PRINCE: We're going to do our best to get you there, Dr. Rosler.

THE COURT: Make whatever accommodations you need, but I can't give Mr. Prince five hours and 20 minutes to the other side.

THE WITNESS: Absolutely. Absolutely.

THE COURT: So if he keeps going, we're going to have a problem.

THE WITNESS: [Indiscernible].

THE COURT: No, I'm going to keep you here. Once you're here -- where's my marshal guy?

THE WITNESS: And he promised to protect me from my patients.

THE COURT: Talk fast. That what I'm saying.

MR. PRINCE: Okay.

THE COURT: All right. We'll see you all tomorrow. Do we need to -- well, I can't come back early because I have a calendar. So I don't know if anybody is filing any briefs or whatnot, but --

MR. HENRIOD: I mean, do we -- do we need to file one on the 2010 --

MR. PRINCE: No, that's over now.

MR. HENRIOD: -- accident?

MR. PRINCE: It's dead. I don't know how to even deal with that now after he says that; right?

THE COURT: That's up to you. I just sit here.

MR. HENRIOD: I don't -- I'm not filing [indiscernible].

THE COURT: My only question was if you were going to brief the issue of the second surgery. That's what I want to know about. Or are you all rolling over on -- have you come to an agreement?

MR. HENRIOD: On another $300,000? No.

THE COURT: A girl can dream; right? All right. So when are we going to have those briefs?

MR. HENRIOD: Midday tomorrow. I mean, if you need them earlier, they --

THE COURT: Well, no, as long as I don't have to make any rulings on anything before then. We -- we have enough to keep going all day tomorrow and Thursday without addressing that issue, the second surgery?

MR. PRINCE: Well, tomorrow we have to address it because there doctor is going to talk about it.

THE COURT: Which doctor?

MR. HENRIOD: Okay. So then -- all right.

MS. LORELLI: Garber.

THE COURT: Not this guy?

MR. PRINCE: Garber. Garber.

THE COURT: What time does Garber go?

MR. PRINCE: Right after 1:00. As soon as we're

ready. If we were going to take a lunch break, then he'll be in.

THE COURT: Oh, I'm going to have to give my -- my people a lunch break because we'll be here all day.

MR. PRINCE: As soon as -- as soon as we're -- the next witness after.

THE COURT: Finish him and then we'll take a break. So I need my stuff before them, yeah.

MR. PRINCE: The only issue is the cost. I mean, part of the prognosis is about the three-level. I mean, she's going to undergo that in her lifetime. Pain, suffering, all the pain stuff, that's part of what he does as a treating physician. It's just a cost issue.

THE COURT: I don't know. If it's an expert I need -- if it's an expert, I need to see it in a report that was turned over. If it's -- was my understanding.

MR. PRINCE: But he's also a treating physician. They don't have that in a document in a report.

THE COURT: I understand that, but if you're going to get to compensation, my understanding is it's got to be put up front.

MR. PRINCE: The numeric value of like the surgical cost. That's -- that's --

MR. HENRIOD: I think those overlap a little bit. We can brief it.

THE COURT: Agreed. You know what, it’s going to be a ten-page max on those, guys. And that’s with exhibits, so choose your selections carefully. I'm reading the first ten pages.

(Court recessed at 6:50 P.M., until Wednesday, May 22, 2019, at 11:00 A.M.)

I N D E X

WITNESSES

* * * * *

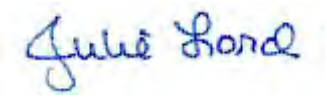
EXHIBITS

DESCRIPTION	ADMITTED

(No exhibits admitted)

* * * * *

ATTEST: Pursuant to Rule 3C(d) of the Nevada Rules of Appellate Procedure, I acknowledge that this is a rough draft transcript, expeditiously prepared, not proofread, corrected or certified to be an accurate transcript.



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RTRAN

DISTRICT COURT
CLARK COUNTY, NEVADA
* * * * *

DESIRE EVANS-WAIAU, et al., Plaintiffs, vs. BABYLYN TATE, Defendant.	)	CASE NO. A-16-736457-C DEPT. NO. XVIII

BEFORE THE HONORABLE MARY KAY HOLTHUS, DISTRICT COURT JUDGE

WEDNESDAY, MAY 22, 2019

RECORDER'S ROUGH DRAFT TRANSCRIPT OF:
JURY TRIAL - DAY 7

APPEARANCES:

FOR THE PLAINTIFFS: DENNIS M. PRINCE, ESQ.
JACK F. DEGREE, ESQ.

FOR THE DEFENDANT: THOMAS E. WINNER, ESQ.
JOEL D. HENRIOD, ESQ.
CAITLIN J. LORELLI, ESQ.

RECORDED BY: YVETTE SISON, COURT RECORDER
TRANSCRIBED BY: VERBATIM DIGITAL REPORTING, LLC

LAS VEGAS, NEVADA, WEDNESDAY, MAY 22, 2019

(Case called at 11:03 A.M.)

(Outside the presence of the jury)

THE COURT: Okay, ready?

MR. PRINCE: Yeah.

THE COURT: We'll talk about that stuff later. We're going to do the jury and the expert now.

MR. PRINCE: Okay.

THE COURT: I assume this is not coming up in this, right? The second surgery is not -- has nothing to do with this witness?

MR. PRINCE: He is going to address the 2010 issue now. We actually -- we've given the exhibit -- we're now marked as Exhibit 81 and we're going to just move for the admission of those exhibits -- those records.

THE COURT: Any objection?

MR. WINNER: No, that's all the 2010 records?

MR. PRINCE: I took out the medical lien and a couple other things from the 2010, I mean, that sort of thing, like her identification, and that sort of thing. But had [inaudible] identification on it.

MR. WINNER: But all the --

MR. PRINCE: All the --

MR. WINNER: -- medical records?

MR. PRINCE: All the medical records, yes.

MR. WINNER: Okay. So the radiculopathy and the -- that stuff.

MR. PRINCE: Possible, yes.

MR. WINNER: Possible radiculopathy. Okay.

MR. PRINCE: Yes. Yes, the answer is yes.

(Pause in the proceedings)

THE COURT: Are you ready?

MR. PRINCE: We're ready.

THE COURT: Okay.

(Pause in the proceedings)

THE MARSHAL: All rise for the entering jury.

(Jury enters at 11:05 A.M.)

THE COURT: Do parties stipulate to the presence of the jury?

MR. PRINCE: Yes.

THE COURT: Mr. Winner?

MR. WINNER: Yes, thank you.

THE COURT: Welcome back, ladies and gentlemen. Everybody ready? Let's go. Mr. Prince?

MR. PRINCE: Yes.

All right.

THE COURT: I'll remind you, you're still under oath.

THE WITNESS: Yes.

//

(Pause in the proceedings)

DR. HANS JORG ROSLER, PLAINTIFFS' WITNESS, PREVIOUSLY SWORN

DIRECT EXAMINATION (RESUMED)

BY MR. PRINCE:

Q Okay. Dr. Rosler, thank you for your time and coming back today. And let's -- I kind of want to recap since we kind of went late last night. And let me just make sure everybody -- we're all on the same page.

You did -- on January 7th, 2016, you did a selective nerve root block which took away all of Desire's neck and arm pain?

A Yes.

Q And how long did that last for?

A Well, on a follow-up visit on 1/14 she had very minimal cervical discomfort.

Q Okay.

A That's a month later. Two months later on 2/18/2018 she had -- she was essentially symptom-free in her cervical spine. And was recommended to return as needed.

Q Okay.

A And then on March 29th, 2016, she returned back having the symptoms again with radiating pain into her left arm and hand with numbness.

Q Okay. And when her symptoms returned on March 29th, 2016, did that come as a surprise to you or is that something

you see frequently in your practice after you do a selective nerve root block that you'll see a return of symptoms?

A We do see this commonly and it is contributed to the wearing off of the actual therapeutic agent, corticosteroid.

Q Okay. And when we were talking last we kind of -- I'm just going to make sure we recap to ourself.

When she came back on March 29th, 2016 --

MR. PRINCE: That's Bate No. 206, Brendon of Exhibit 47.

BY MR. PRINCE:

Q You did an examination that day, correct?

MR. PRINCE: Brendon, pick the date of the present illness.

THE WITNESS: That is correct.

BY MR. PRINCE:

Q Okay. And with respect to her examination findings, which is on page number 207

MR. PRINCE: Use the whole -- all the way through the motor, Brendon, [inaudible].

BY MR. PRINCE:

Q Okay. So let's kind of just briefly summarize; did you have positive findings of the neck on that day?

A She presented with a -- again, with positive findings of restricted range of motion, the tenderness to palpation in the neck area as well as a positive axial

compression test and positive Spurling sign to the left side which are orthopedic tests.

Q Right. Did she again present with a sensory deficit?

A She presented again with diminished sensation to light touch and pin prick following the C7 dermatome --

Q Okay.

A -- on the left.

Q Now, is that similar to the findings you had at the time of your initial visit?

A Yes.

Q Would you have tested both arms on March 29, 2016, like you talked about before so you have some kind of a control level to see where you're at?

A Yeah. Neurological examination is for both extremities but you obviously document the positive finding of the affected extremity.

Q And you talked about just kind of as part of a recap, on April 11th, 2016, you also performed another set of selective nerve root blocks on --

MR. PRINCE: It's Bates No. 209, Brendon.

BY MR. PRINCE:

Q And she went -- she had went from a preoperative score of 8 down to zero.

A Correct.

Q Was that, again, diagnostic of a discogenic problem at the C6-7 level?

A It was kind of a confirmatory diagnostic value or a result that confirmed the initial response from the first injection.

Q Okay. And I think when we left off we were talking about your April 26th, 2016 visit, which is about two weeks later after that second of a confirmatory injection and she was telling you that --

MR. PRINCE: It's Bate No. 211, Brendon.

BY MR. PRINCE:

Q -- that she came back and her pain level was about a 5 out of 10 with left arm pain.

A Correct.

Q Okay. So she didn't have the same therapeutic benefit that she did before?

A That is correct.

Q Okay. Now, as of that -- the April 26th, 2016, had you confirmed or ruled in through your diagnostic injections imagining, meaning, MRI, examination and history, a discogenic problem at the C6-7 level?

A That was confirmed with the -- with the two diagnostic injections, yes.

Q And do you have an opinion as to what caused the discogenic problem with the neck pain and the arm pain that

we've been talking about?

A Based upon my knowledge, it was caused from a traumatic disc injury that subsequently developed the pain symptomatology.

Q What caused the traumatic disc injury, this motor vehicle collision?

A The motor vehicle collision.

Q Okay. And Doctor, you said yesterday, but that you referred her for a neurosurgical consultation that day.

A Correct.

Q And realizing that she's only 24-years old, in April of 2016, was that a decision that you have struggled with in terms of like, hey, I'm sending a 24-year old to a surgeon because she potentially has a surgical problem?

A Well, obviously, you consider the age of a patient in your decision-making. We have diagnosed and was confident with my diagnosis of discogenic neck pain. We -- she was provided with two injections that unfortunately were not providing her sustained therapeutic benefit.

The next step in further treatment course of the patient is a surgical, neurosurgical evaluation that doesn't necessarily mean that you want to turf off that patient to a surgeon, but you want to get another set of eyes from another specialist onto this case and go from there.

Q Right. And just so we're clear, why not just -- now

you've confirmed she's got a structural disc injury at C6-7. Why not just send her back to the chiropractor for more chiropractic treatment or she -- it sounds like she got some benefit, at least for some period of time from that. Why didn't you just send her back to the chiropractor? Is that going to fix this problem?

A Chiropractic treatment and physical therapy is intended to address soft tissue injuries. We are talking about a structural problem, a disc that is protruding, that is irritating causing a radiculitis, radiculopathy, meaning, a nerve root irritation with inflammation that is not amenable to chiropractic care. It's a structural problem.

And therefore, it would have been not -- of any value or benefit for the patient to go back to the chiropractor. In fact, one would have just protracted the course of the symptoms.

Q Would chiropractor care do anything other than provide maybe temporary relief or short periods of relief?

A Yeah, what --

Q For this structural type of problem?

A What chiropractic care does, it doesn't address the structural problem. But what it does, it often relieves the tension in the -- of the supporting muscles, the overlying muscles. It feels good when you get a massage or you get some electrostimulation. It feels good if you get ice and heat

treatment. But it doesn't get to the source of the problem. So even if you get some improvement it is of a very short nature.

Q Okay. And so with that in mind you refer her to a neurosurgeon. What neurosurgeon did you refer her to?

A I referred her to Dr. Khavkin.

Q Okay. Is Dr. Khavkin someone that you have trust and confidence in in treating your patients?

A I had the pleasure to work with Dr. Khavkin in my past in an office at Nevada Spine Clinic for three years and I worked closely with Dr. Khavkin on numerous patients and successfully worked with him.

Q Okay. Is he board certified in neurosurgery?

A He's board certified in neurosurgery, that is correct.

Q Is he also fellowship trained in neurosurgery?

A Yes, sir.

Q Okay. Now, you said yesterday, I mean, now we going to talk about that you believe that the cause of her pain and her problems in her arm was a traumatic disc injury of the resultant motor vehicle collision; right?

A Correct.

Q You talked about a two thousand -- you mentioned yesterday a 2010 motor vehicle incident?

A Yes.

Q Have you read those -- have you had a chance to read those records?

A Yes.

Q Okay. Based on -- we're going to talk about those based upon your review of those medical records, is that -- was that incident from May of 2010, does that in any way explain or were the cause of any of these symptoms we've been talking about over the last two days?

A No.

Q And in fact, have you been able to rule that out as a causative factor?

A Yes.

Q Okay. Can you say that to a reasonable degree of medical probability?

A Yes.

Q And beyond that are you certain?

A I am certain, yes.

Q Have you also read the defendant's experts. Doctors Wang and Schifini, their expert reports which discuss the 2010 records?

A Yes.

Q And Dr. Wang is a surgeon and Dr. Schifini is a local pain physician. Do they in any way attribute Desire's symptoms, problems or conditions to that 2010 incident?

A There was no mention of that.

Q Now, let's look at -- I'm going to show you one of the -- some of the records from that just so we can -- we're clear.

We're going to go to Bate No. -- Exhibit 81, 964. And the hard copy is in the second binder there. I'm going to put them on the monitor also.

Okay. I'm showing her pain diagram from that day. Is there any documentation of any symptoms down into the arms?

A No.

Q Is that different than her presentation after this motor vehicle collision?

A Yes, it is.

Q Is that significant to you?

A It is significant in the sense that it describes that patient's pain complaints and that's the reason or that's what we are focusing on as treating physicians.

Q All right. If we can look at the -- go down to the "rate the severity of the pain and location".

MR. PRINCE: Go down there Brendon.

BY MR. PRINCE:

Q This is from May 26th, 2010, date of her initial visit, all the way down.

Do you see there where it says, elbows, hands, leg, do you see that --

A Yes.

Q -- and arms. Does she have any symptoms like -- like the pain radiating down her arm? See where it says, arm zero, elbows, wrist, hand, how everything is zero?

A Correct.

Q All right. Is that -- that's different than the presentation she had with you, right?

A That is correct.

Q Is that clinically significant to you in determining that the -- in ruling this out as a causative factor in her symptoms after October 30th, 2015?

A That is correct.

Q Okay. Now, do you recall that she was also sent for an MRI?

A That is correct.

Q And let's --

MR. PRINCE: That's on page 955 of Exhibit No. 81. Brendon, I want you to go to the levels, under the findings. Go to findings all the way down to impressions. All the way, one more.

BY MR. PRINCE:

Q Okay. And what were the results of this MRI from July 2010?

A I would call this -- given her age, an age appropriate MRI, an MRI that you would expect in a young, healthy 19-year old. It was a negative in the sense that it

-- with no pathologies identified on the MRI scan.

Q It's an entirely normal MRI; correct?

A It's a normal MRI you would expect in a young person, yes.

Q I think you told me before we started, it's pristine.

A Yes.

Q Okay. What do you mean by the term "pristine"?

A Pristine means that it's -- there is not a blip of a -- a pathology. It's a textbook normal MRI scan, so to speak.

Q Okay. Now, when we compare it to the one in this case --

MR. PRINCE: 155, Brendon.

BY MR. PRINCE:

Q We're going to show you the MRI report from Align Med.

MR. PRINCE: Go to 45 to 155. If you'd just go down to the findings right there, it's fine.

BY MR. PRINCE:

Q Looking at C6-7, where it says, bilateral, or posterolateral disc protrusion extending 2 to 3 millimeters into the, you know, recess affecting the nerve roots as well as the C5-67 problem, that's significant different than what it was in 2010, correct?

A That is correct.

Q And you attribute that pathology to C6-7 to this -- the trauma of this motor vehicle collision of October 30th, 2015?

A More likely than not, correct.

Q Okay. That's your opinion to a reasonable degree of medical probability?

A Yes.

Q And this -- the 2010 MRI we just looked at that you characterized as pristine or entirely normal?

A Yes.

Q Does that support your position that the -- this was a traumatic cause to the C6-7 disc in this case?

A It does.

Q Okay. There's one medical doctor visit from June 16th, 2010, with a -- it looks a doctor by the name of Kathleen Smith as part of Exhibit No. 81.

MR. PRINCE: And if we can look at page 9 -- page 958. Okay, Brendon, about halfway, right there. Just take it there all the way through "impression".

BY MR. PRINCE:

Q And there is a lot of words here. I want to start with where it says, The patient also experiences pain between the shoulder blades and rhomboides, major muscle areas bilaterally with abduction and -- abduction of her arm, do you see that?

A Yes.

Q Okay. And it says here, The patient has possible radiculopathy and post-traumatic headaches which I believe was sustained as a result of this May 10th, 2010, motor vehicle collision. Do you see that?

A Yes.

Q Was that radiculopathy ever confirmed?

A No, it wasn't.

Q Right. Does the MRI rule that out since it was normal?

A The lack of any MRI findings rules out a radiculopathy.

Q Okay. Is that your opinion to a reasonable degree of medical probability?

A Yes.

Q Okay. I'm also going to show you a pain diagram of also that same day, June 16th, 2010. The date of that's -- no, this is from the chiropractor now.

MR. PRINCE: Bates No. 950. All the way down through the -- through the -- all the way down to the pain stuff, Brendon.

BY MR. PRINCE:

Q Is there any on this -- on June 16th, 2010, is there any symptoms down the arm as we saw in this case from the chiropractor himself, or Dr. Khavkin and Dr. Garber?

A No.

Q Okay. And also, when asking to rate the pain in the arm, shoulders, wrist, hand, elbow, etcetera, and both arms, is there any symptoms noted or documented even in the by pain a score?

A No, there isn't.

Q Is that a significantly different presentation from when she came to you after this motor vehicle collision?

A Yes.

Q Okay. And as of --

MR. PRINCE: Let's go to the discharge summary from the chiropractor, July 13th 2010. This is Bate No. 939, so I'm going to reference that so there's -- the jury understands where I'm getting it from. 939.

BY MR. PRINCE:

Q And it says --

MR. PRINCE: If you could go there at the top, Brendon, just show me that.

BY MR. PRINCE:

Q It's says the date of the final visit. Okay. And it says July 13th 2010; do you see that?

A Yes.

Q I counted up 14 visits with the chiropractor between May 26th and July 13th. Is that consistent with your review?

A It's about right.

Q Okay. Is that consistent with a soft tissue injury going for a few visits like that?

A It's within the, you know, time frame you would expect for a soft tissue injury.

Q Okay. And looking at the physical examination under the neurological examination, you can -- we're going to start on page -- on 940.

MR. PRINCE: Actually, let's go to 941, Brendon.

BY MR. PRINCE:

Q And it says there, using sensory kind of comparing your sensory exam [inaudible] over here on the specific dermatome pattern, was there any sensory deficit similar to findings like you had?

A No.

Q Okay. Was there any motor weakness, anything on examination by the chiropractor?

A The motor weakness appear to be normal, the motor strength appeared to be normal, no motor weakness was documented there.

Q Okay. And if we look at the diagnostic impression on Exhibit 941 by the chiropractor, there's a number of things is radiculopathy -- cervical radiculopathy, any of those diagnoses?

A Those are not listed there.

Q Okay. So it's not present as of the date of the

last chart note?

A That is correct.

Q Okay. And are those -- well, then would you characterize that as a sprain/strain type of diagnoses?

A Yes.

Q Okay. Is there any medical evidence of any neck pain problems, limitations, between July 2010, and when you -- and October 30th, 2015?

A Not to my knowledge, no.

Q Okay. And using that information, were you able to rule out 2010, everything you talked about, rule out that that was the cause or even a contributing factor to her ongoing -- her presentation when she came to see you after her motor vehicle collision?

A Yes.

Q Okay. Is that your opinion to a reasonable degree of medical probability?

A Yes.

Q And beyond that are you certain?

A Yes.

Q Okay. All right. Now, you sent Desire to Dr. Khavkin, catching back up with our story now. And she saw Dr. Khavkin on May 17th, 2016.

Do you think it was reasonable for Desire to follow your recommendation and go see a neurosurgeon?

A I think it was certainly reasonable, given her -- the persistence of her symptoms, number one. And number two, given the diagnostic workup that we were able to achieve, it was reasonable for the patient to see the neurosurgeon and to have a consultation.

Q Okay. And when you were treating her, was Desire a compliant patient? Meaning, she made her appointments, followed your recommendations?

A Yeah, there were -- there was no reason to think that she was not compliant with us.

Q Did she appear to have a positive attitude throughout in terms of, you know, her treatment and, you know, the hopes of getting better?

A I would say so; yes, sir.

Q Okay. And is there any type of behavior that was concerning to you during like, you know, any breach of your -- well, strike that. Let me just ask a foundational question first.

Do you have patients sign agreements with you regarding your prescription drug policies and practices?

A Yes.

Q Okay. Did -- was there ever any violation of your opioid policy or your agreements you have with your patients concerning your prescription practices?

A Ever or with this --

Q No, just with her.
A -- patient?
Q Just with Desire?
A No, there was not.
Q No, I'm only talking about Desire.
A Okay.
Q Yeah. And we're only -- did she appear to be motivated to getting better and --
A Yes, she did.
Q -- was there any -- any problems with her compliance with your recommendations --
A No.
Q -- Desire's? Okay. Any concerns that you had with her, that you had to sit down with her with, concerning any aspect of your care or prescription practices?
A No. This care was very straightforward.
Q Any efforts of drug seeking behavior or anything unusual that you saw in her presentation at any time?
A Certainly not.
Q Okay. All right. And now, you -- she goes to see Dr. Khavkin and then she comes back to see you on May 24th, 2016.

MR. PRINCE: And let's go to that, the history of present illness.

//

BY MR. PRINCE:

Q Okay. It says she does her returns. Patient complains of left sided neck pain, 8 out 10. She is evaluated by Dr. Khavkin who recommended neck surgery. She wishes to proceed with surgery and will be undergoing a workup. She states that pain is progressively worsening.

And did you become aware of Dr. Khavkin's surgical recommendation?

A Yes.

Q What was he recommending?

A He was recommending an anterior cervical disc fusion at two levels; at the C6-7 level that we had evaluated, and also including the C5-6 level.

Q Okay. Was there anything more that you could do with her, or offer her short of a surgery as of May 24th, 2016?

A No, there was no further treatment recommendations that I had or that I was able to provide to -- to help her in that respect and hence the referral to the surgeon.

Q Okay. And what was her options as of May 24th, 2016, other than surgery; just to live with it?

A Well, and that is always an option, you don't have -- that's not -- it's up to the patient. It's not an emergency procedure or urgent procedure. It's up to the patient. Either you live with the pain or you consider the

surgery.

Q And honestly, by 2016, prescribing practice or for opioids it's obviously changed; right?

A It has significantly --

Q [Inaudible].

A -- changed in particular starting January of 2018.

Q Right. And other than just giving her pills, there was really nothing ever left for her other than surgery; right?

A Knowing that the pills are not a remedy for --

Q Right.

A -- long-term; that is correct.

Q And have -- and they have their own problems; right?

A They have as we unfortunately know, with the many opioid deaths in this country, they have significant problems.

Q And you have indicated that you were having her follow up with Dr. Khavkin and you were switching her to Norco for better analgesic control and Flexural at night. What are you doing there?

A Well, she appeared that her pain was bothering her more and she's a surgical candidate. And we were switching her to a somewhat stronger pain medication, Hydrocodone, which was in several years ago still a Schedule III drug. Now it was moved up with the opioid crisis as a Schedule II drug.

It is a intermediate strong narcotic medication. It

is not as strong as morphine, for example, or Oxycodone, Percocet, but it's stronger than Tylenol No. 3, it's stronger than Tramadol, for example.

So we try to kind of dial in the medication therapy a little bit to kind of give her some relief until she can the surgery.

Q Okay. All right. Now, I want to go to your June 21st, 2016 note, Bate No. 215. And I want to -- because we're going to compare and contrast something.

What was her neck pain as of June 21st, 2016?

A It was about a 9 out of 10.

Q Okay. And so the lower back, she has lower back at 5 out of 10; do you see that?

A That is correct.

Q Did you ever recommend anything for her lower back?

A No.

Q Okay. And where was the really -- the main source of her pain?

A We were no focusing on the lower back at all. The main focus lied on the neck, the cervical spine.

Q All right. And according to your notes, she's awaiting the surgery with Dr. Khavkin and she comes back to see you on July 26th, 2016.

A Correct.

Q Okay.

MR. PRINCE: Bate No. 217.

BY MR. PRINCE:

Q And it says she returns for follow-up. The patient complains of neck pain 8 out of 10 and it's worse, the lower back pain 10 out of 10. She reports a new MVA which occurred on 7/10/2016, she was a front seat passenger; do you see that?

A Yes.

Q Okay. And with respect to the neck, based upon, you know, her complaints to you, your examination, was there any significant clinical change in her condition from where she was on June 21st, 2016?

A There was no change in her pain score, her pain intensity and her presentation.

Q How about on physical examination, did her examination change in any significant way?

A Physical examination was consistent with --

Q For the neck --

A -- the prior --

Q -- [inaudible].

A -- for the cervical spine, yes.

Q Right. It looks like she had some -- obviously, some increase in lower back pain.

A That is correct.

Q That obviously is not related to our accident on June -- or October 2015?

A That is correct.
Q Right. Did you treat the lower back pain for anything other than the soft tissue?
A Correct. We obviously as physicians we have to examine the lower back but there were no treatment -- interventional treatment recommendations --
Q Did you make --
A -- made.
Q Did you make -- did you offer any injections to her lower back?
A I did not.
Q Okay. And other than with regard to the neck now, did you have her reimaged? Did you have her -- order an updated MRI? Was there any necessity for that?
A I did not. I thought we ordered an updated MRI scan of the cervical spine but there was no MRI scan performed.
Q No, did you -- you didn't -- did you order -- was that in your plan? Did you order one?
A Considered an --
Q Right.
A -- updated MRI scan.
Q And was there any significant change in her presentation that you felt you needed to get one?
A No.
Q Okay. Was there anything on physical examination

for which you needed -- you offered her any new injections, any treatment, any intervention that you could offer?

A Nothing -- nothing changed.

Q Did that change her surgical consideration as a surgical candidate that obviously predated that July 10th, 2016 motor vehicle collision?

A Well, she was diagnosed with discogenic neck pain and was seen by Dr. Khavkin who recommended surgery. So the surgical recommendation was made based upon the condition that was prior to the second motor vehicle collision.

Q Okay. Did the -- in your opinion did the July 10th, 2016 motor vehicle collision result in any new structural injury to her cervical spine?

A Her symptoms were the same so I do not believe in my opinion is it did not.

Q All right. And now it indicates that she also saw Dr. Garber for a second opinion. Do you know Dr. Garber?

A I do know him.

Q Who is Dr. Garber?

A Dr. Garber is also a neurosurgeon.

Q Okay. Did you refer her to Dr. Garber or give Desire the name of Dr. Garber for a second opinion?

A Yes.

Q Okay. And what -- do you think it was reasonable for her to seek a second opinion?

A It is not uncommon that patients, especially when they've been referred and recommended to have surgery that they just want to get a second opinion just to be more certain that this is, indeed, something that would benefit from surgery.

Q Okay. Were you in any way critical for her wanting a second opinion?

A No, I think it's absolutely reasonable.

Q Okay. Is Dr. Garber someone that you send patients to?

A I do work with Dr. Garber on a regular basis as well.

Q Do you believe -- is Dr. Garber somebody you have trust and confidence in to provide treatment and surgery to your patients?

A Certainly.

Q Okay. Does he refer patients to you?

A He does.

Q Okay. And she came back to see you in October -- August 3rd, 2016, and she was talking about, you know, she's having surgery on September 1st; did you learn that she was having surgery on September 1st, with Dr. Garber?

A That was -- that's what I learned at that visit, yes.

Q Okay. And what kind of surgery does Dr. Garber

perform on her?

A Dr. Garber also recommended and ACDF, an interior cervical disc fusion but just limit it to the C6-7 level, the level that we diagnosed as the culprit the pain generator.

Q Okay. Now, obviously, Desire consented to undergo that surgery?

A That is correct.

Q Right. Do you think that was a reasonable decision for someone her age, 25-years old, that she was at the point she could no longer tolerate those symptoms?

A I think this is always up to the patient and we never force patients to have surgery or talk patients into surgery. But what I tell patients is, if you feel like you're -- have more bad days than good days, if you feel like your quality of life, your activity of daily living, are significantly impaired and it -- your whole outlook on life has significantly changed to the bad, to the worse, then it is reasonable to undertake the surgery for those reasons.

Q Okay. And defense obviously underwent the surgery.

A That is correct.

Q Okay. How would you characterize her outcome after the surgery?

A It had helped her quite a bit.

Q Okay. And was the outcome of the surgery since it helped improve her symptoms, her neck and her arm pain, was

that consistent with your findings following your selective nerve root blocks at the C6-7 level?

A That was essentially confirming the diagnostic workup to be appropriate and to isolate the pain generator, correct.

MR. PRINCE: Brendon, can you put up Exhibit No. -- or Demonstrative 41?

BY MR. PRINCE:

Q And looking -- just kind of using our clinical correlation chart here, the response to treatment, meaning response to surgery, did that support, you know, the history of Desire and the onset of her symptoms with her neck and her left arm, the examination findings that you as well as others had of pain in the neck, limitation of range of motion and symptoms under the arm, the MRI finding of a disc protrusion at C6-7 and as well as your diagnostic injections; did that all fit together and confirm the diagnosis of a C6-7 discogenic problem?

A Yes, it did.

Q Okay. And if there's -- and are you -- in forming your opinions are you solely relying on what Desire told you or are you looking at more factors that we've been talking about?

A Well, as we've pointed out, the history taking is an important part of the puzzle but it's not the only part of the

puzzle there are several other parts that come in such as your physical examination, imaging scans, diagnostic testing, injection therapy, and all this together hopefully allows us to come up with a diagnosis and a treatment plan.

And it appears here that everything kind of came together and we made the right diagnosis and the right treatment plan with the surgery, was then instituted and the patient's symptoms improved.

Q Okay. And with regard to her low back pain, remember, we talked it was after July accident it went up to about a 10 out of 10; did that eventually go down to a -- or essentially go away?

A That settled, yes.

Q Okay. Did that resolve itself?

A Yes.

Q Okay. And do you treat patients who have spinal surgery?

A Yes, I was --

Q Or after they --

A -- I was --

Q -- have surgery?

A Yes, I was in practice for about ten years with a colleague who was an orthopedic spine surgeon, it's on a very frequent basis patients, and I do still see those, who had in the past spinal surgery.

Q Okay. And do you treat patients who become symptomatic and as well an adjacent segment disease?

A Yes, I do.

Q Okay. And is that something you see in your practice how frequently?

A I see that on patients who had previous spine surgery, fusion surgery, yes.

Q Right. Do you help provide pain management patients who become symptomatic for -- as a result of adjacent segment disease?

A That's why they are coming to me as a pain management doctor to provide therapy but also diagnostics.

Q What's adjacent segment disease, briefly?

A The adjacent segment, we look at the normal spine as I pointed out, we are talking about a motion segment that allows us to turn our head or turn our back.

And the motion segment is comprised of two vertebral bodies connected with -- or in between the intervertebral disc, the shock absorber, and then there are joints, we call those facet joints, which allow us to flex, extend to a certain degree, to rotate. And this is a motion segment.

Now when you fuse a motion segment that is not a natural condition, meaning, one reason why we have the motion segments is to transform forces from the top to the bottom from one vertebra to the other and that's the reason why the

vertebral bodies in the discs in the lower back are much larger than in the neck because they take up larger forces, the body weight.

Over time, if you have a fused segment, that segment doesn't act as a normal motion segment. So from a biomechanical standpoint the segment above or adjacent to that fusion segment now takes up more stresses.

And it takes up more stresses than it's biologically built for, so to speak, or meant to do so, because below it's a fused segment.

So over time what can happen or what will happen is that there are more stresses acting on a segment that is not made to take these stresses and those -- unfortunately, those segments, the adjacent segment undergo an accelerated, degenerative change. We also call that an accelerated breakdown, meaning, the -- there are stresses now on that particular segment that affects the discs, the joints, or both.

And these segments that were previously normal and not painful can become painful due to the biomechanical and anatomical changes.

Q And do patients who start to develop this adjacent segment disease and become symptomatic, do they come to you for pain management control, injections, before they eventually undergo another surgery?

A Yes, in a typical scenario is that the patient had years ago surgery and was doing well and then over time pain came back and they are being referred to us pain specialists, myself. And we obtain, obviously, again, we are working up the patient, we obtain imaging scans in particular, to look at the adjacent segment and see that there are some signs of accelerated degenerational breakdown.

And then we evaluate and investigate that particular segment to see if that's, indeed, the pain generator through injection therapy.

Q So the process kind of starts all over again?

A It starts -- it starts all over again; yes, that is correct.

Q All right. Now, in this case, do you have an opinion whether Desire, given her age and the type of a fusion surgery we have, will she have developed a case of segment disease for which she'll go on to become symptomatic and require surgery, in your opinion, as a pain management --

MR. WINNER: Excuse me, Your Honor.

Q -- specialist?

MR. WINNER: This is outside the scope of his treatment and outside the scope of his records and a new opinion not been tendered to the Court.

MR. PRINCE: He's a treating --

THE COURT: Sustained.

MR. PRINCE: Well, he's a treating physician.
BY MR. PRINCE:
Q Well, do you believe that as a result of adjacent segment disease, Desire will become symptomatic at the C5-6 level?
MR. WINNER: Same objection.
THE COURT: Sustained.
THE WITNESS: Yes, it is my belief --
BY MR. PRINCE:
Q No -- well, hang on a second -- do you treat patients -- do patients come to your clinic after a spinal surgery whether cervical or lumbar, who have adjacent symptoms as a result of adjacent segment disease?
A Yes, I have mentioned it earlier.
Q Do you, as part of your education, training and experience, do you diagnose patients with adjacent segment disease? You may not do the surgery on it, but you diagnose it?
A Yes.
Q And how do you diagnose it?
A We diagnose it with, again, with history taking, with physical exam taking, with the help of imaging scans, maybe MRI scans, or CT scans. And then with site specific injections to isolate if, indeed, this segment, adjacent segment is a pain generator and if it is, then we come up with

a diagnosis of adjacent segment pain.

Q Okay. And in Desire's case, as part of your treatment of her during the course of your treatment did you feel her prognosis was, at some point in her life, she was going to become symptomatic as a result of adjacent segment disease due to the fusion surgery she had when she was only 25-years old?

MR. WINNER: Same objection.

THE COURT: Sustained.

THE WITNESS: Um --

MR. PRINCE: Can we approach, Your Honor?

THE COURT: Yep.

(Bench conference)

MR. PRINCE: I guess another standing objection.

MR. WINNER: It's not contained in his prognosis.

MR. PRINCE: It doesn't have to be in the records. It only has to be just formed in the course of your care. It does not have to be in any record.

MR. WINNER: Well he also wrote a record review. You asked him to do it and he didn't include it in there either.

MR. PRINCE: No, but that's part of his prognosis and the opinion he formed during the course of his care.

THE COURT: I thought when we discussed this we weren't going to -- this particular witness wasn't going to be

getting into the future surgery thing, I thought this was just a pain management --

MR. PRINCE: He's talking about becoming symptomatic.

THE COURT: Don't you have two other people to talk about it?

MR. PRINCE: I have two doctors but he's -- he also is going to be involved in the treatment of her if she has symptoms return. There's also adjacent segment disease.

I'm not going to ask about is she going to need surgery. I'll be asking will she become symptomatic.

THE COURT: Didn't you just ask that?

MR. PRINCE: Huh?

THE COURT: I thought you just asked that.

MR. PRINCE: No, I asked -- and you sustained it, and then I said, will she become symptomatic as a result of a case of segment disease in his opinion. He says he treats it. He treats people who are surgical candidates, who have already had fusion surgery.

THE COURT: Okay. So what more do you need from him?

MR. PRINCE: Just that one -- that one question, does he believe that she'll become symptomatic as a result of adjacent segment disease. That's --

MR. WINNER: That's -- that's not --

THE COURT: Which --

MR. WINNER: -- his prognosis --

MR. PRINCE: It doesn't have to be in his notes. He can -- he doesn't have -- not everything has to be charted by a treating physician. That's the part of FCH1 [phonetic] that's part of Pizarro-Ortega, you don't have to that that in. If I ask him, did you form that opinion during the course of your care, that's the relevance standard.

THE COURT: I know, I know.

MR. WINNER: Yes, but the opinions need to be reasonably ascertainable to somebody reading his notes. You had to form such an opinion that was not contained in any of his notes and the plaintiff decided to use it as a rebuttal expert to rebut what my experts were saying. He went through and looked through the records, wrote an actual forensic expert report and he didn't say anything in that about this either.

MR. PRINCE: Well, he can form opinions regarding what the expert's criticism of him and the nature of his treatment and his opinions of her injuries --

MR. WINNER: Which he did a rebuttal report.

MR. PRINCE: -- but it's a -- right, that's only because Dr. Schifini was critical of him for the way he did his injections. But with respect to this issue, this is part of a treating physician opinion.

THE COURT: Okay. Then that's the -- my understanding is treating physicians have a lot more latitude.

MR. PRINCE: They do.

MR. WINNER: They do.

MR. HENRIOD: And not [inaudible].

THE COURT: All right. Ask this --

MR. PRINCE: But they're trying to say ask --

THE COURT: -- question and we're done.

I'm going to overrule it --

MR. PRINCE: Okay.

THE COURT: -- now ask him and we're done.

MR. PRINCE: All right.

(End of bench conference)

BY MR. PRINCE:

Q All right. Doctor, I'm going to reask the question. In your opinion, based upon your care and treatment of Desire, your education, training and experience of treating patients who have had a cervical spine fusion, do you have an opinion whether Desire will become symptomatic, developed symptoms of pain and other symptoms, either adjacent segment disease at one or more levels?

MR. WINNER: I'd ask my objection to be noted, I understand your ruling.

THE COURT: We'll do.

BY MR. PRINCE:

Q Go ahead.

A Yeah, given her young age, more likely than not she will develop what we call adjacent segment breakdown because there will be all the years to come that unfortunately will affect the adjacent segment.

Q Okay. Now, from -- All right. Now, with regard to your own care, do you have an opinion whether all of the care that you have provided up through 2017 was reasonable and causally related to the motor vehicle accident of October 30th of 2015?

A Yes.

Q And I want to -- if you can look at your charges.

MR. PRINCE: Let's put up a summary format, [inaudible] fifty-four, page number or Bate No. 328. Number 2, if you could [inaudible].

BY MR. PRINCE:

Q Interventional, you know, your charges from December 16th, 2017 through July of -- excuse me -- December 2015 through July of 2017, your charges for all of your treatment and procedures, $11,660; do you see that?

A Yes.

Q And do you have an opinion whether those charges are usual and customary for the services?

A Yes, they are.

Q Are they caused as a result of this motor vehicle

collision in October 2015?
A Yes.
Q Okay. Is that opinion to a reasonable degree of medical probability?
A Yes.
Q And you performed the procedures at Surgical Art Center?
A Yes.
Q And the charges --
MR. PRINCE: Bring up number eight.
MR. WINNER: Counsel, I'm sorry, I can't see your screen. Excuse me.
(Counsel conferring)
MR. WINNER: Excuse me. Excuse, I'm sorry, no objection.
MR. PRINCE: Okay.
BY MR. PRINCE:
Q The charges for Surgical Art Center for the procedures you performed there, $4,610; do you see that?
A Yes.
Q Are those usual and customary for the procedures you performed?
A Yes.
Q And did you -- did you treat Desire on a lien basis?
A I did.

Q Okay. What does the lien mean?
A A lien is where you have a -- well, put a lien on any potential settlement to get paid. We expect to get paid for our medical services.
Q Okay. And obviously, if there's a judgment in favor of Desire you would expect to be paid for your bill, right?
A That is correct.
Q And now, are medical liens common? Is there anything unlawful about them or illegal about them?
A They're fairly common here in this community.
Q Okay. And Dr. Schifini, you know, are you familiar with Dr. Schifini?
A I am.
Q And has he reviewed cases of yours in the past for defense firms like Mr. Winner's?
A Yes, he has.
Q And do you know if this -- are you aware of him treatment patients on a lien basis?
A I can't say that for sure.
Q Okay. Well, I'll ask him when he gets here, because I -- he's a pain specialist.
All right. Now, just because you're on a lien, even if the jury doesn't decide, do you fully expect Desire to have to pay you in full for your services?
A As I pointed out, we expect to pay -- paid for our

services just like any other person, too, yes.

Q Correct. You just waited to be paid out of any -- if the jury finds that we prove our case, and they find in her favor and you can expect to be paid out of those proceeds?

A That is correct.

Q Right. Okay. Now, one last thing. When you talked to Desire, she told you she was involved in a 2010 incident where she hurt her lower back; do you remember that?

A Correct.

Q Did she talk about her neck to you at all?

A Not to my recollection.

Q Right. The fact that she didn't say anything or you didn't document anything about her neck, is that after reviewing those records in 2010, our discussion, does that have any significance to you at all in terms of your opinions you've offered in this case?

A That doesn't affect my opinions.

Q In your opinion, was the injury from 2010, anything more than a soft tissue injury, the 14 chiropractic visits?

A Which subsided, yes.

Q All right. Does the MRI actually support your position in this case since we're now [inaudible] about a disc herniation at C6-7?

A Yes.

Q That that was traumatically caused from this

collision and not from before?
A That is correct.
Q Okay. Have all the opinions you've offered here been stated to a reasonable degree of medical probability?
A Yes.
Q Okay. Thank you.
MR. PRINCE: I have no additional questions.
THE COURT: Okay. Mr. Winner?
MR. WINNER: Thank you.
THE COURT: Oh.
MR. DEGREE: I'm going to be brief.
THE COURT: Okay.

PLAINTIFF PARRA'S DIRECT EXAMINATION

BY MR. DEGREE:
Q Good morning, Dr. Rosler.
A Good afternoon.
Q We also represent Guadalupe Parra in this case. She's also a prior patient of yours?
A Yes.
Q And if you need your records you have plaintiffs' exhibit binder number two, Exhibit 68 up there with you?
A Yes.
Q Okay. And those are your medical records for the care and treatment you provided for Guadalupe in the two to three months following the October 2015 collision?

A Yes.
Q I see you treated her on two separate occasions in those two to three months, once on December 18th of 2015, and then one follow up appointment on January 20 of 2016; is that right?
A That is correct.
Q Did you use clinical correlation in the course of treating her as well?
A I treat everyone the same way and certainly I use clinical correlation in every patient.
Q Okay. You also used clinical correlation in forming your opinion as to what caused her symptomatology as well?
A Certainly.
Q When she -- now, do you find that patient are affected physically by trauma differently?
A Well, we are individuals. We are all reacting, responding differently. That is -- that is well established.
Q And I guess in other words, you can have two individuals involved in the same motor vehicle collision they're going to be affected by the trauma differently?
A If patients, they survive a plane crash and some -- and most patients don't, and they went through the same trauma.
Q Do patients respond to treatment differently?
A That is correct, as well.

Q Is the response to treatment also an important part of clinical correlation?
A Certainly.
Q Fair to say you each -- each and every one of your patients are unique?
A And should be treated so, yes.
Q When Guadalupe came under your care did you know that she was receiving chiropractic care at Align Med for neck and back pain?
A Yes.
Q Was she referred to you by Align Med?
A Yes.
Q That first visit was December 18th, of 2015, correct?
A That is correct.
Q When she first presented, what was her chief complaint?
A Her chief complaint --
Q Or complaints?
A Her chief complaints were neck pain, low back pain and numbness in her left hand.
Q The numbness in the left hand, was that described as constant or intermittent?
A That was mostly intermittent.
Q Okay. Does that affect your treatment plan whether

the left upper extremity pain is of constant nature or more intermittent?

A Well, it certainly changes a little bit what you're thinking so it can affect your treatment plan, yes.

Q How so?

A Because more so often intermittent symptomology that could be part of a recovery, part of a healing process, that it was first constant, then it becomes intermittent. So often you give it a little bit more time and see if that intermittent symptomology eventually subsides.

Q Okay. On that first visit did you take a medical history or a history of present illness from her?

A Yes, I did.

Q Did she indicate to you where on the body she was feeling pain?

A Yes, I did.

Q Is that --

A Yes, she did.

Q Is that what you were talking about when you referenced the chief complaints you just described?

A Yes.

Q Was the low back pain occasional, frequent?

A Her lower back was -- when present occasional, yes.

Q What about the neck pain?

A The neck pain was -- contrary to the low back pain

was more of a constant symptom.

Q How was she describing the symptomology?

A She described her symptoms as more aching, tender and numb.

Q Okay. Did she report the October 30th, 2015 collision as the inciting factor as to what triggered the pain?

A Yes, she did.

Q Did she tell you how that collision occurred?

A Yes, she did.

Q The presentation that she had on that initial visit December of 2015, is that initial symptomology consistent with the soft tissue injury?

A It is certainly consistent with a soft tissue injury and the question is if that -- there were symptoms remain persistent or if those symptoms improve with -- over a period of time.

Q Okay. Did she have any overlapping symptoms upon that initial presentation which could be indicative of something more than a soft tissue injury, just on that initial visit?

A Well, she saw us about six weeks after the incident and she was still having symptoms so it was -- and she underwent an MRI scan of the lumbar spine. So there were findings that potentially could also produce pain. But it was

my -- and later on it's -- she was improving so it was not my opinion that she had a pain symptomology from a structural problem but rather a soft tissue problem.

Q And that's more from your second visit, correct?

A That is correct.

Q Okay. To your knowledge, had she experienced any prior symptoms, injuries or pain like she described to you prior to this October 2015 collision?

A Not to my knowledge.

Q Did you also perform a physical exam on the first visit?

A Certainly.

Q Can you briefly describe some of those findings?

A The physical exam findings were that she had some restricted range of motion in the neck with some palpable tenderness. She had a positive orthopedic sign meaning the axial compression test was producing pain, however she had no nerve root tension signs, meaning, the Spurling's test, the tests whether there's a pinched nerve or irritated spinal nerve, that was negative.

In her lower -- or lumbar spine, rather she had restricted range of motion with tenderness in the lumbar area.

Q And you already mentioned that she had undergone a low back MRI prior to coming to you on this first visit; correct?

A That is correct.
Q Did you have the benefit of reviewing that report?
A Yes.
Q Did it affect your treatment plan?
A It affected my treatment plan in a sense that I wanted to send the patient out for a surgical consultation just based upon the MRI finding, not so much based upon the -- the symptoms, the severity of her symptoms. But I just wanted to cover my bases, hey, is it not something that may or may not require some surgery down the road.
Q And you talked a little bit about the image and you talked about her presentation, how she's describing her symptomology. Focusing on the MRI, do these MRI reports and images, do they detect pain?
A No, they do not. You can have MRI findings that don't necessarily tell you that there's pain.
Q Okay. In other words, for example, can you have a finding on MRI of a 3 or 4 millimeter bulge that's symptomatic in one person, but a finding on MRI that's a 3 or 4 millimeter bulge that's asymptomatic or pain free in somebody else?
A You can, and that's what I always tell my patients that we do not treat MRI findings, we treat symptoms, and try to correlate those with the MRI findings.
Q Can a trauma such as a motor vehicle collision or a fall cause an asymptomatic or otherwise pain free disc and

become symptomatic?
A Yes.
Q All right. Imaging studies are not the only piece used in clinical correlation; correct?
A That is correct.
Q Overall, what were your impressions after that first visit?
A That the patient was having some cervical sprain/strain with some what appeared to be mechanical -- osteomechanical neck pain and possible some intermittent left arm radicular symptoms, although not diagnosed, as well as lumbar sprain/strain with ongoing mechanical pain that was of varying degrees.
Q Do you consider that an initial working diagnosis?
A That is just an impression. It's not a clear cut diagnosis. We haven't done any tests to confirm that.
Q Through time and through treatment is the goal to either rule in or rule out that diagnosis?
A If the symptoms persist then that is correct.
Q If you look to your first impression concerning the neck sprain/strain, you also referenced possible dynamic left upper extremity radiculopathy. Why did you choose to use the word "possible"?
A Because I wasn't sure. It could be, could be not.
Q And how do you figure out or confirm whether that's

present or not?

A Well, for one, you want to get an imaging scan. Number two, you want to see if it's a persistent phenomenon. And number three, other diagnostic tests.

Q What were your recommendations for Guadalupe following this December 2015 visit?

A It was my recommendation based upon the -- of a significant MRI finding in the lower back with that herniated -- large herniated disc, have a surgeon take a look at it, just make sure everything is okay from that standpoint.

And also, I would -- was recommending an MRI of the cervical spine.

Q What was it about her symptomology on the first visit that made you want to obtain a neck MRI?

A Well, the persistence of the neck pain and also the potential radicular component to it.

Q And what was it about her symptomology that made you -- or was there symptomology or was it just the findings from the lumbar MRI that made you -- that thought you should be -- that she should be evaluated by a surgeon?

A Not so much the symptomology but the -- but the MRI scan of the rather, you know, significant disc extrusion. I wanted to do -- have a surgeon just take a look at it --

Q Okay.

A -- and go from there.

Q Tell us why you think she would benefit from continuing with the chiropractic care that she'd been receiving.

A Because a soft tissue injury which -- and she was kind of not in that extreme pain and it appeared that she was benefitting from it. So I said it's a reasonable thing to continue with a chiropractor.

Q Okay. And you just testified yesterday and today that you recommended diagnostic and therapeutic injections for Desire, but you didn't make that same recommendation for Guadalupe. Can you tell us why?

A When the patient returned to us for the follow-up visit, she essentially was symptom-fee in her cervical lumbar spine. Again, we do not treat MRI findings, we treat symptoms and there was no reason for me to get involved with any interventional therapy, that therefore there were none recommended.

Q Unlike Desire, was your medical opinion that Guadalupe was not clinically indicated for injections?

A That is correct.

Q And you moved on to the follow-up appointment which was the second time you saw her, January 20th of 2016, right?

A Yes.

Q That's the last time that you saw her as a result of the injuries sustained in this collision, correct?

A Yes.
Q Did you know that in that intervening period from December to January that she'd been continuing with that chiropractic care at your recommendation since the last time you saw her?
A I'm not sure.
Q When she presented to you, how was she doing that day?
A When she presented --
Q January --
A -- to me --
Q January 20th of 2016.
A She, as I stated, she was symptom-free.
Q Okay. And you were able to review the neck MRI by that time?
A Yes.
Q Were you able to perform another physical exam on that date as well?
A I was.
Q Can you briefly describe the differences between your findings upon physically examining her the second time, in comparison to your findings from the first time?
A The cervical spine she had regained full range of motion, and there was very mild tenderness, you know, the orthopedic tests, the axial compression test was negative.

Q All right.
A So there was -- we were able to corroborate the patient's subjective telling us she's doing better with a physical exam and the same for the lumbar spine.
Q Okay. And then as for cervical spine, I believe it references that she had range of motion was near full in all directions and that she had mild tenderness on palpation. Does that mean she's still having some difficulty and limitations albeit mild at that time?
A Yes. I mean, she was symptom-free in a sense but when we poked around a little bit so to speak it was causing her a little bit discomfort.
Q Okay. Fair to say that she had improved by the time she returned to you the second time in comparison to the first time?
A Yes, she has.
Q Looking at your list of impressions, a sprain/strain on this final visit. They're the same as the first. Why is that?
A Because that was in a sense the diagnosis.
Q Okay. You also advised her to continue with the chiropractic care as she'd been doing; why so?
A It was helping her and according to the chiropractic protocol and then certainly we encourage patients also to do home exercises as part of her conservative treatment.

Q Okay. By the time she'd returned to you the second and final time, you also removed the recommendation for a surgical consult. What was it about her presentation on that final visit that convinced you that that was no longer necessary for her?

A Because her symptoms resolved.

Q Okay. Did you advise her to come back if her symptoms persist?

A Return as -- if symptoms return, yes.

Q And she never returned to you as a result of this collision; correct?

A That is correct.

Q Okay. Doctor, in light of the fact that she continued with chiropractic care, reportedly received good benefit from it, was no longer experiencing the left upper extremity symptomology, intermittent, and didn't need to return for pain from this, did that help you rule in, or rule out a neck and low back sprain?

A It was more likely than not she sustained a soft tissue injury, sprain/strain injury of the neck and the low back that was successfully treated with chiropractic care.

Q And you testified earlier that you treated during the course of your care of treating Desire, you treated her for both soft tissue injury, but also for the structural disc injury, correct?

A Well, the soft tissue injury was more treated by the chiropractor and the underlying mechanical symptoms and radicular symptoms were treated by us.

Q That's right. And you also obviously treated Guadalupe for soft tissue injury as well, correct?

A For symptoms that were then diagnosed as soft tissue injuries, correct.

Q And does it -- would it surprise you in any way that the soft tissue injury portion of Desire's injury and the soft tissue injury that Guadalupe sustained, that they resolved near or around the same time period in February of 2016, approximately three months after this motor vehicle collision?

A Well, as I pointed out earlier, soft tissue injuries are self-limiting and usually, you know, resolve with time.

Q And Guadalupe, I'll represent to you, her last day of treatment was February 12th of 2016, so about three-and-a-half months following this collision. Is that well within a reasonable time frame of what you would expect for a soft tissue to resolve?

A Certainly.

Q Doctor, in your medical opinion, is all the care and treatment that you provided for Guadalupe reasonable and necessary for treating her soft tissue injury?

A Yes.

Q In your medical opinion is all the care and

treatment you provided for her on those -- provided for her on those two occasions directly and causally related to the October 2015 collision?

A That's -- that's my opinion.

Q And the costs for your medical care are listed on Exhibit 69, and they're in the amount of $1,190. Doctor, is the costs of the medical care that you provided Guadalupe usual and customary for the Southern Nevada medical community?

A Yes, it is.

Q Okay. Lastly, Doctor, of all the opinions you've expressed here today as they relate to not just Desire but also to Guadalupe been stated to a reasonable degree of medical probability?

A Yes.

Q Thank you.

MR. WINNER: If you want to offer that, no objection.

THE COURT: I'm sorry?

MR. WINNER: If you want to offer that, no objection.

MR. DEGREE: I'm sorry?

MR. WINNER: If you want to offer that, no objection.

MR. PRINCE: I'm sorry, for what? For what? What did he say?

MR. WINNER: The exhibit, is it stipulated in?
MR. PRINCE: Oh, okay.
MR. DEGREE: Oh, yeah. Thank you.
MR. PRINCE: It's stipulated in.
THE COURT: Okay. So it's the operative admitted --
MR. PRINCE: It's already -- it's already in.
MR. DEGREE: It's already in.
MR. PRINCE: It's already in.
THE COURT: Do you know what exhibit they're talking about?
THE CLERK: [Inaudible].
THE COURT: Can we get a number on that?
MR. PRINCE: 69.
THE COURT: (To Clerk) Just confirm that it's been admitted, please. [Inaudible].
THE CLERK: Yes.
THE COURT: Thank you. Mr. Winner?
MR. WINNER: And if it's possible, I might need the ELMO.

(Pause in the proceedings)

CROSS-EXAMINATION

BY MR. WINNER:

Q Dr. Rosler, you and I have met before, haven't we?
A Yes, we have.
Q Okay. I want to ask you to go back to what some of

the records Mr. Prince asked you about.

You did an injection on this plaintiff on June 7th, 2016, correct?

A Yes, sir.

Q And on June 7th, 2016, your notes said, your notes said she showed up on June 7th with 8 over 10 pain in the neck, and after the, I don't know, 30 minutes or something, it was down to zero out of 10 after the lidocaine was injected?

A Yes.

Q Okay. And following that visit, I think she had another visit with you on January 14th at which time she had minimal cervical discomfort?

A Yes, sir.

Q What's minimal; 2 out of 10?

A Yeah, I would say so.

Q Okay.

THE COURT: I'm sorry to interrupt. But which plaintiff are we referencing?

MR. WINNER: Pardon me, Judge?

THE COURT: Which plaintiff are you talking about?

MR. WINNER: I'm talking about Evans-Waiau.

THE COURT: Thank you.

BY MR. WINNER:

Q You told us when we took you -- your deposition in this case -- do you remember giving a deposition in this case?

A Yes, sir.
Q Have you reviewed your deposition transcript from this case?
A I have.
Q Did you do that in preparation for today or do you remember what your answers were?
A No, that was a while ago.
Q Okay. You said at the time of your deposition that you didn't really go through -- you really didn't go through one-by-one through the chiropractic records, you just saw that she had been to 30 chiropractic treatments and met with her, and she told you she had 8 over 10 pain.
A Correct.
Q Okay. If -- if the patient hadn't reported to the chiropractor 8 over 10 pain in several months, and in fact a couple of days before her visit to you she had minimal neck pain of 2 or 3 out of 10, is that inconsistent with what she told you?
A Are you referring to the first visit --
Q Yes.
A -- when she saw me? There appears to be an inconsistency of the pain score. I'd like to see what -- what the chiropractor actually documented and what was this a pain score immediately taken after chiropractic treatment after we see this discrepancy when patients have their chiropractic

treatment taken, they feel pretty good, its soft tissue related treatment, they feel pretty good. But then the pain comes back within a day or so.

Q Okay. Well if the patient is reporting that chiropractic helping a lot, my symptoms are going away, I can do my activities of daily living, chiropractic has been successful, I'm happy with the chiropractic treatment, and the symptoms went from 6 or 7 out of 10 over the course of a couple of months, down to 3 out of 10, 2 out of 10, 1 out of 10, that's successful chiropractic treatment, isn't it?

MR. PRINCE: Objection, argumentative and compound.

THE COURT: Overruled.

THE WITNESS: There appears to be that there is some improvement, yes.

BY MR. WINNER:

Q Yeah. Why do you suppose that when she comes to see you that one time, she tells you my pain is at 8 out of 10?

A I think that's a question you need to ask the patient that's what we --

Q Yes.

A -- documented that was -- what the patient presented with.

Q So 2 out of 10 pain, you would -- and I agree with you, I'm not arguing with you -- 2 out of 10 pain, 3 out of 10 pain, you would -- you would consider that to be minimal

cervical discomfort?

A Mild cervical discomfort, yes.

Q Okay. And if the patient reported mild or minimal cervical discomfort to the chiropractor just before coming in to see you, would you have any reason to disagree with that?

A If the chiropractor documents that, I would not disagree with that.

Q Okay. I skipped over some of this, we're getting late in the morning. Did you happen to see MRIs from both of the plaintiffs from Guadalupe Parra and from Desire Evans-Waiau?

A I saw the MRI of Desire Evans, I don't recall seeing the MRI of the other patient.

Q Well, you mentioned that Guadalupe Parra had a 9 millimeter disc herniation in the lumbar spine I thought when you were answering questions about her.

A That was by the report, so.

Q Okay. So you looked at the reports?

A Yes, sir.

Q Do you know if you actually looked at the reports or if you looked at the actual MRIs?

A I do not, on Guadalupe.

Q Okay. At the time of your deposition you indicated you couldn't remember if you'd seen the actual MRIs on either.

A Yes.

Q Did you look at the actual film since that time?
A Yes, I looked at the actual film on Desire Evans.
Q Okay. And I want to ask you something else just to follow up from yesterday.
You indicated, of course, there's a difference between -- in the way you use it, and there's a difference between a bulge and a protrusion and a herniation; a bulge would be just sort of a patching out -- or a pouching out?
A That's correct.
Q A protrusion would be a pouching out where there might be some movement of nuclear material within the disc but it doesn't go outside the annulus and a full blown herniation goes outside the annulus?
A Yes. The disc protrusion is where the nucleus protrudes into some inner layers of the annulus where we have some interrupted fibers, annular fibers. The herniation is where the annulus is entirely interrupted and the nucleus herniates out, outside the limits of the annulus.
Q Or to maybe put it in Mr. Prince's more colorful language where the inside part of the jelly donut goes all the way outside the spare tire, goes all the way outside the disc?
A That's a good point, yes.
Q Okay. And in fairness, you did not see any herniation in Desire Evans, correct?
A That is correct.

Q You saw some protrusion?
A There was protrusion and some effacement of the nerve roots, the adjacent nerve roots.
Q Okay. Protrusions, Doctor, and I know we've talked about this many times before -- but protrusions are very common, aren't they?
A They are common. Certainly, we have to look at it with the respect of the age of the patient. They are obviously more common in middle aged patients than in --
Q Yeah.
A -- younger patients.
Q All right. Disc protrusions, disc bulges are common even among patients in their teens and 20s, correct?
A They are common as we know in this particular here, is the patient was -- had an MRI scan done as a 19-year old teenager and that was a pristine MRI scan. So we can see those, but you would again, more so expect protrusions in -- since it is wear and tear over time --
Q Okay.
A -- more so in patients of older age.
Q Okay. Or wear and tear over time based on repetitive activity?
A Correct.
Q So a 25 or a 30-year old who works as an auto mechanic might have more protrusions, whether he knows it or

not, in his neck and back, then would --

A An attorney, yes.

Q -- Tom Winner who sits at his desk?

A Right.

Q Okay. Gotcha.

Are you aware between -- you never saw the actual MRI films from 2010, did you?

A I did not, sir.

Q Okay. And you did at some point see the films from 2015?

A Yes, sir.

Q Okay. Are you familiar with Dr. Keith Lewis from Align MRI?

A I am familiar with him. I have not met him personally, but I am familiar with him.

Q Okay.

A With his readings.

Q Are you familiar with his testimony that he's given in other cases? I know you've dealt with him in other cases, haven't you?

A Yes, sir.

Q Okay. Are you familiar with his testimony that in any given MRI there's a 2 to 3 millimeter margin of error built into those MRIs because of the way the magnetic imaging tries to transfer to photograph images?

A I'm not aware of this statement and I would defer to a radiologist. Certainly, I'm not a radiologist.

Q Well, I know that you look at MRIs, and you look at spinal MRIs.

A Yes.

Q Would you have any reason to disagree with that? Is that consistent with your experience?

A Well, the radiologist has the ability, the advantage, he has a program where he can actually measure the size of the protrusion, herniation, bulge for building software program. We don't have that. When we pull up the MRI scan on our -- on our laptop, or on our computers we cannot exactly measure the size.

So I'm sure there is some variability but I don't know how big that one is.

Q Can we agree that in most individuals, most adult individuals, myself included, probably everybody in this room all of us can have disc bulges, all of us can have disc protrusions, all of us can have disc herniations and not even know it; they don't cause any symptoms?

A Yes.

Q Okay. Is it possible for somebody to have a soft tissue injury just a whiplash injury that takes -- sometimes it takes a few weeks, sometimes it takes a few months. Is it possible for somebody to have a soft tissue injury

superimposed on a neck or a back that happens to already have some protrusions in it?

A Yes, it is possible.

Q So if somebody has a soft tissue injury, a little whiplash after a car accident, and a chiropractor decides to send that person for a bunch of MRIs, there's a good chance the MRI place is going to find something wrong in all of those MRIs; isn't there?

A It depends on the age of patient, certainly. But that can be a possibility.

Q Okay. Do soft tissue injuries typically need to be sent for MRIs, simple soft tissue injuries?

A Is this a question?

Q Yeah, I'm asking generally.

A If simple soft tissue injuries should be sent for an MRI is that what I'm understanding?

Q Is that typically necessary for a soft tissue injury?

A Oh, if it's a clear soft tissue injury, that I would not get an MRI scan right away, I would wait for a period of time and if the pain persists then I would get an MRI scan.

Q Okay. Is it typically necessary for a soft tissue to refer a patient out for injections with a doctor such as yourself?

A As I pointed out earlier, I would not do injections,

spinal injections on patients with soft tissue injuries.

Q Okay. And just to reiterate, in Desire Waiau Evans you found -- the radiologist found no herniation, you found no herniation, what you found was a bulge or a protrusion, meaning, not a herniation?

A We -- correct. We found disc protrusion with effacement of the C7 nerves and that correlated with the patient's complaints of radicular symptoms down the left arm.

Q Okay. And someone in her 20s, that might engage in physical labor, might be more likely to show signs of disc protrusions, disc bulges, maybe even disc herniations without even knowing it just because that person is involved in physical labor; correct?

A That is correct.

Q Okay. Were you aware that five years before the 2010 incident and the 2015 incident what Desire Waiau Evans did for a living?

A Off the top of my head, no. I believe she was a homemaker.

Q If I were to tell you in the five years before this accident happened she worked for a warehouse lifting 15-pound boxes every hour, every day, would that be news to you or might that affect your opinions at all?

A It would be news to me. I would like to know if those activities have caused her any pain, any symptoms she

was presenting with to us. If she had seen any medical doctor or physical therapist for symptoms.

Q In your experience, do you ever look at reports written by different radiologists?

A If I have these reports available, then I look at those, that is correct.

Q Yeah, I -- I know, given what you do, you look at a lot of spines. Do you sometimes see a radiologist's report on one patient's spine and then see a different radiologist's report on the same patient's spine?

A Yeah, there's some interperson variability; yes, that's correct.

Q There's a difference between machines, there's a difference between radiologists, right?

A That is correct.

Q And is it common, is it very common for one radiologist to read an MRI as completely normal and a different radiologist to look at the same spine and see some abnormality?

A I wouldn't say that this is very common.

Q Okay. You've seen this happen?

A I have seen this happen. I've seen this happen in my practice where I called up the radiologist and he then made an addendum based upon that.

Q Okay. You did review the chiropractic records and

you took a history from Ms. Waiau Tate [sic], correct?

A Yes, sir.

Q You said 50 percent of -- 50 percent of all the opinions you give is based on what the patient tells you, or what the patient chooses to tell you; correct?

A Yeah, we rely on the history of the patient, that is correct.

Q Okay. Is a patient -- are patients you've seen ever told you things that aren't true?

A I have.

Q Do you ever get fooled by patients?

A They try to. I think over time you develop a certain experience with that. But certainly, that can happen.

Q Well, and I -- believe me, I'm not criticizing. Even the smartest doctors can get fooled by patients. You want to be an advocate for your patient, try to help your patient, right?

A That is correct.

Q Okay. Ms. Waiau Evans, when you interviewed her, on her first visit she told you a couple of things; right? She told you that the pain -- the pain in her neck and her arm began immediately after the accident; correct? Isn't that what she told you?

A Correct.

Q And when you asked her about her medical history and

whether she had prior spine problems she had said she had some problems in her low back five years before; correct?

A Correct.

Q She denied ever having had problems in her neck before 2015; correct?

A That's what awe documented, correct.

Q Okay. So she did not tell you that she had neck pain significant enough to go get an MRI back in 2015; correct?

MR. PRINCE: No, the objection's -- well, move to strike, it's 2010, not '15.

MR. WINNER: I'm sorry.

THE WITNESS: 2015.

BY MR. WINNER:

Q She did not tell you that she had gone to get an MRI for her neck back in [inaudible]; did she?

A That is correct.

Q Okay. She did not tell you that she had pain significant to warrant an MRI back in 2010; correct?

A Correct.

Q She did not tell you that she had been seen by the Bonanza Pain Clinic for neck and back pain back in 2010; correct?

A Correct.

Q She did not tell you that had been to see Dr.

Kathleen Smith for neck and back pain back in 2010; did she?

A Correct.

Q She did not tell you that she had been to a local chiropractic office for neck and back pain and suspected --

MR. PRINCE: Well, objection. I'm going to move to strike that because she did tell him that she did see a doctor for back pain. So he did know about that. So he's misstating the record.

THE COURT: Overruled.

BY MR. WINNER:

Q She did not tell you that she had seen a chiropractor, Vegas Valley Chiropractic was the name of the place for, among other things, neck pain back in 2010; did she?

A No.

Q Okay. Do you think Ms. Evans forgot that she had gone to get an MRI of her neck?

A Well, we learned that she had low back pain in the past from 2010, that symptomology resolved with conservative treatment and there was no reason for us to kind of dive more into it, and we didn't ask anymore questions because for us, it was a non-issue, what we learned was the symptom back in 2010 of back pain. We were not aware of neck pain.

Had we learned that she had some neck pain we would've obviously asked, did you have any treatment for it

and so forth. We didn't know about it, we didn't ask.

Q Okay. We do know a couple of things though. And you learned about these things later, these records were provided to you much, much later; correct?

A That is correct, sir.

Q Okay. What we do know is that in 2010, she had at least suspected radiculopathy, suspected radiculopathy and neck pain strong enough to be sent to take an MRI. That she had been seen by Bonanza Pain Clinic.

MR. PRINCE: No, objection. That's a chiropractic clinic. It's not a pain clinic.

MR. WINNER: Excuse me, I thought it said Bonanza.

MR. PRINCE: No, it doesn't. There's Bonanza Back Center.

MR. WINNER: Hum?

MR. PRINCE: Bonanza Back Center.

MR. WINNER: Bonanza Back Center? I stand corrected.

BY MR. WINNER:

Q Bonanza Back Center, and she has been seen by Green Valley Chiropractic Clinic for, among other things, her neck; correct?

MR. PRINCE: Objection, move to strike that she was seen by Green Valley Chiropractic Clinic. There's no records of Green Valley Chiropractic Clinic.

BY MR. WINNER:

Q She'd been seen by a chiropractor, by a pain place, by an MRI facility. She already knew a chiropractor, she already knew a pain place, she already apparently knew an MRI facility and she knew at least two, if not three, physicians who had treated her for neck pain before 2015; correct?

MR. PRINCE: Your Honor, can we approach, please?

THE COURT: Sure.

(Bench conference)

MR. PRINCE: Number one, the question's argumentative and he's completely misstating it. He's not even using the evidence correctly. She went to Bonanza Back Center. She didn't go to any Green Valley Chiropractic. She didn't go to a pain center.

MR. WINNER: Bonanza Back, you're right.

MR. PRINCE: She didn't to go -- she didn't to -- there's no pain physicians involved here. She went to a Cameron Medical Center and she was seen by a medical doctor who's not -- there's no indication it was a pain physician.

So you can't say she went to all these places, that he's just misstating the record. Use the actual records, because he's misstating -- he's not allowed to misstate it.

THE COURT: Well, I think when you --

MR. PRINCE: He's falsely stating it.

THE COURT: -- mention things he's corrected, and

you will also have the opportunity to redirect. So you can clean up whatever --

MR. WINNER: I accept what Mr. Prince says and I'll correct it.

MR. PRINCE: Yeah. Okay.

(End of bench conference)

UNIDENTIFIED SPEAKER: I'm going to run to the bathroom real quick.

MR. WINNER: Oh, I'll withdraw the question.

THE MARSHAL: Judge, we also have a juror that -- can they use the restroom no problem?

THE COURT: All right. Let's take five.

MR. WINNER: Thank you.

THE COURT: During the recess, you're admonished not to talk to or converse among yourselves or with anyone else on any subject connected to this trial or read, watch or listen to any report of or commentary on the trial by any person connected with this trial, by any medium of information, including without limitation to newspapers, television, the Internet and radio, or form or express any opinion on any subject connected with the trial until the case is finally submitted to you.

Five.

THE MARSHAL: All rise for exiting jury.

(Jury recessed at 12:38 P.M.)

THE COURT: Mr. Winner, no pressure, but do you have an idea of how long you're going to be?

MR. WINNER: Five or ten minutes. I'm almost done.

THE COURT: Oh. Do we have our next witness then?

MR. WINNER: I don't know. Jack do you have your next witness or can we take a lunch break and [inaudible]?

THE COURT: Do you have your next witness, Mr. Prince?

MR. PRINCE: I do.

THE COURT: Okay.

MR. PRINCE: He's going to sit in. He's an expert so he's going to listen to the testimony.

THE COURT: Okay. So he's -- Mr. Winner indicates only about five more minutes. Do you have a lot of redirect either you or Mr. Degree?

MR. PRINCE: About probably five to ten minutes. He only has five minutes? Then I'll go five to ten minutes.

THE COURT: So do you want to --

MR. PRINCE: Fifteen, ten.

THE COURT: -- do one more witness before we take a lunch break?

MR. WINNER: Oh, you mean redirect. Gotcha.

MR. PRINCE: I'm sorry? I'd rather take the lunch break and start over. I mean, I don't think we'll get too far other than qualifying. If you'd like me to start to qualify

him and then come back, you --

THE COURT: I mean, I don't want to make it too late a lunch break but I also don't want to just have them come back from the restroom and then ten minutes later break.

MR. PRINCE: Well, I'm going to have -- I'll have about ten or 15 minutes worth of questions, yeah, until about --

THE COURT: All right. Well, I guess we'll just -- we'll see where we are.

MR. PRINCE: Okay. Yeah, whatever you decide, Judge, I'm fine with.

MR. WINNER: So you want to take a lunch break during Garber? Just qualify him and then take a break?

MR. PRINCE: We could -- whatever the Court's preference is. I could call him qualify him, get him ready and go.

THE COURT: Well, let's see what the jury wants to do.

MR. WINNER: Whatever you want to do is fine.

(Court recessed at 12:39 P.M., until 12:45 P.M.)

(Outside the presence of the jury)

THE COURT: And Mr. Prince, would you just for the record, that's your expert present in the courtroom?

MR. PRINCE: That's Dr. Jason Garber.

THE COURT: Okay.

MR. PRINCE: And so the exclusionary rule doesn't apply to the experts.

THE COURT: Okay, thank you.

(Pause in the proceedings)

THE MARSHAL: All rise for the entering jury.

(Jury enters at 12:47 P.M.)

THE MARSHAL: All present, Your Honor.

THE COURT: Do the parties stipulate to the presence of the jury?

MR. PRINCE: Yes.

MR. WINNER: Yes.

THE COURT: Thank you.

BY MR. WINNER:

Q Okay. I'm sorry, if I'm reiterating, but you found no herniation on that 2015 MRI at any level, but you did find a bulge, a pouching as you called it, and some protrusion, but no herniation outside the annulus?

A That is correct.

Q Okay. And either of those conditions in any given patient can be completely asymptomatic and can be benign, correct?

A Well, benign, any -- any finding on the MRI scan can be asymptomatic; that is correct.

Q Yeah. So I'm -- I'm not 25, but if somebody took -- if somebody took an MRI of my back and somebody took an MRI of

my neck and I got bumped in a car accident, and a chiropractor sent me for an MRI, chances are there are going to be a lot of things to find in it?

A At our age, yes. That is correct.

Q Okay. Dr. McCauley worked at Align Chiropractic; is that right?

A That's my understanding.

Q Okay. At the time you gave your deposition you've indicated you got about 20 referrals a month from Align Chiropractic; is that still the case?

A Yeah, it's -- it's off and on. It's a larger Chiropractic outfit. We get referrals from different chiropractic outfits and it's -- it's up and down.

Q Okay. You get referrals from other chiropractic offices?

A Yes.

Q Those referrals you get from chiropractors, are most of those on liens?

A I would say the most of them, yes.

Q Okay. Most of those are car accidents represented by lawyers?

A I would say, yes.

Q Okay. Is that true of the other chiropractic clinics you get referrals from?

A As a general, that is correct.

MR. WINNER: I'll identify this just for counsel and the Court's benefit. This is Exhibit L, Bates Stamp 21. This will be the initial intake at Align Chiropractic from November 2, 2015.

MR. PRINCE: We agree that we're going to use the defense -- the medical records by the plaintiff so that's not in evidence.

MR. WINNER: Is that an objection?

MR. PRINCE: Yes.

MR. WINNER: Okay.

THE COURT: What's the objection?

MR. PRINCE: The objection is it's not admitted into evidence. We have the -- the records are already admitted in as part of Exhibit No. 44.

MR. WINNER: Okay. It is the same exhibit.

BY MR. WINNER:

Q Doctor, are you able to see the intake sheet from Align Chiropractic dated 11/2 of 2015?

A I am, sir.

Q Okay. Is this down here, the pain diagram?

A That is correct.

Q Does that look any different from what Mr. Prince showed you from 2010?

A Yes, it does.

Q In what respect?

A That --
Q [Inaudible]?
A That the 2010 showed some marking of the back of the head. There were no marks going down the left arm.
Q Okay.
THE COURT: So, counsel, you're showing the jury something that --
MR. PRINCE: It's --
THE COURT: I know you're representing that it's --
MR. PRINCE: It's in --
THE COURT: -- identical to 44?
MR. WINNER: Yes, it is.
THE COURT: Okay.
MR. PRINCE: Okay.
MR. WINNER: Court's indulgence a moment, Your Honor.
THE COURT: Will counsel approach, please?
MR. WINNER: Yes.
(Bench conference)
THE COURT: Because I can't make out stuff on my screen, if you are going to use an exhibit that's in, would you use the actual exhibit --
MR. PRINCE: Yeah.
THE COURT: -- so that whatever you're showing the jury --

MR. PRINCE: Yeah, we -- we agreed to use the plaintiff -- the medical records from the plaintiff. His exhibits, they've never -- they've never cleaned them up, they never redacted them.

THE COURT: I'm -- no, I'm just saying --

MR. PRINCE: Anyway --

THE COURT: -- I can't monitor it.

MR. WINNER: Well, they have to redact the --

THE COURT: You could be writing little -- little subliminal notes in there or highlighting, I can't monitor it.

MR. WINNER: Okay.

THE COURT: So the only way I can [inaudible] is if you get the exhibits from the Clerk and [inaudible].

MR. WINNER: Okay. Understood.

THE COURT: Okay. Thank you.

MR. PRINCE: And the only -- the only medical records that are admitted are the plaintiffs'. There's no defense exhibits even admitted.

THE COURT: Okay.

MR. HENRIOD: As a professional courtesy, we agreed to do that.

THE COURT: Thank you.

MR. PRINCE: What do you mean it was a professional -- that's what -- that's what we agreed to.

(End of bench conference)

MR. WINNER: Can I approach, Your Honor?
THE COURT: Sure.
MR. PRINCE: Do you have a copy?
MR. WINNER: No.
MR. PRINCE: Then I don't agree.
MR. WINNER: Hum?
MR. PRINCE: Then I don't -- I don't agree. I need a copy of that.
MS. LORELLI: [Inaudible] his depo?
MR. WINNER: It's attached to his deposition [inaudible].
MR. PRINCE: Do you have a copy for me though?
MR. WINNER: I'm not offering it, I'm just approaching.
MR. PRINCE: Oh, okay.
MR. WINNER: It's attached to his deposition.
MR. PRINCE: I'm asking -- I'm asking do you have any copy for me to have?
MS. LORELLI: We do not have an extra copy at this moment.
MR. PRINCE: Okay. Then I guess I have an issue with that then, because I don't know if it's complete, I don't know what it is. And that has writing all over it so I'm not agreeing to that.
MR. WINNER: Okay, I'm not offering it but --

MR. PRINCE: I'm not --
MR. WINNER: -- I'm showing it to him.
MR. PRINCE: I'm not even -- want you to do that.
THE COURT: Counsel, will you approach the bench?
MR. PRINCE: Yeah, let's go up to the front. Yes.
(Bench conference)
MR. PRINCE: He's trying to show the witness a document. Number one, I don't have a copy of it. He's not giving me a copy of it. He's got writing on it so I don't know what its completeness, I have no idea.
THE COURT: Okay. Well, what's the purpose of showing it?
MR. PRINCE: Yeah.
MR. WINNER: The number of times testified he went through that on his opening statement. This was what was attached to his deposition. I'm going to show it to him and ask, is this your testifying history, and I did some math and added up the number of times. Those are my pen marks. I'm not offering it, I'm showing it to the witness and I'm asking him if this is accurate.
MR. PRINCE: Well, I don't --
THE COURT: Can you ask him --
MR. PRINCE: -- a copy of it.
THE COURT: -- first, do you know how many times you've testified and can you lay the -- are you -- I'm

essentially going to refresh his recollection which will kind of point -- because to show him the document and say, what is this, and what does it say, I think you can ask him, how many times have you testified --

MR. WINNER: Okay.

THE COURT: -- and -- and then if you need to -- and then if you need to refresh his recollection, you can show him whatever you want, a banana if that's helps.

MR. WINNER: Okay. Understood.

(End of bench conference)

BY MR. WINNER:

Q Doctor, do you know how many times you've testified in trial or deposition according to your deposition history?

A Oh, hundreds of times in depositions.

Q What's that?

A Hundreds of times in depositions.

Q Okay. Would looking at your testifying history refresh your recollection at all?

A Certainly.

Q Okay.

MR. WINNER: May I approach, Your Honor?

THE COURT: Um-hum. You've seen it, right, counsel? I understand you may not have a copy but you've seen it?

MR. PRINCE: Yeah, I don't have a copy and he's got writing on it.

BY MR. WINNER:

Q And the pen writing on it is mine, not yours, Doctor. But I tried to do some math.

A Okay. Well, there's quite a bit missing, because I certainly was deposed in 2018 as well.

Q Okay.

A So it's not complete.

Q My math, and please correct me if that looks wrong; my math is that according to that list which ended, I think, in 2017, you had testified over 300 times?

A Yeah, I haven't counted it, but like I said there's several hundred times that --

Q Okay.

A -- it's about right.

Q And that number would actually be higher?

A Yes.

Q Okay. In the last decade or so, have you ever asked -- been asked to testify on behalf of a defendant in a personal injury --

A I have --

Q -- case?

A I have been asked to do defense expert work but I'm -- typically involved as the treating physician and then being an expert as a treating physician and I'm -- have a busy practice so I have not taken out more time to do testifying

for defendants.

Q Doctor, do you remember testifying at a deposition in this case?

A I do.

Q And do you remember testifying at the depositions in this case that you saw that a lumbar MRI had been ordered on Desire Evans, but you wanted a cervical MRI performed before she went to get the surgery, an additional cervical MRI?

A As I pointed out, we had recommended a cervical MRI but I don't believe a cervical MRI was done; yes, sir.

Q Yeah. So if you ordered a cervical MRI on July 26th a few weeks before she had the surgery that was -- does that comport with your memory and your records?

A Well, I can't tell for sure the date. Let me double-check. But on July 26th, we had recommend ed an updated MRI scan, that is correct, sir.

Q And it appears that that was never done?

A Yeah, I never saw that in my [indiscernible].

Q Okay. And between the MRI that you looked at from 2015, November of 2015, and following that July 10th, 2016 accident, there was never a repeat MRI after that July 2016 accident, to your knowledge?

A To my knowledge, correct.

Q Do you believe -- we -- we talked about this a little bit already -- you've said patients have occasionally

exaggerated symptoms to you and sometimes you've caught them doing that?

A Yes.

Q You've seen patients who've edited their medical history a little bit and sometimes you've caught them doing that?

A I have.

Q Okay. Do you suspect you don't always catch them at doing that?

A Like with everything, we don't always catch things; that is correct.

Q No matter how smart you are --

A That is correct.

Q -- the smartest physician can be fooled?

A Yes.

Q Okay. We do know that she -- this particular patient, this particular plaintiff had been seen by Bonanza Back Clinic, had been seen by Green Valley Chiropractic, had been seen by an MRI facility and at least one physician had to suspected radiculopathy back in 2010; correct?

A That is correct, sir.

Q And I think there was an objection sustained; do you think she forgot about all that when she gave you her medical history and gave her medical history to the chiropractor that her lawyer sent her to?

MR. PRINCE: Objection, argumentative.

THE COURT: Overruled.

THE WITNESS: I think that's a question you have to ask a patient.

BY MR. WINNER:

Q Can you think of any reason why a patient would go see a chiropractor who had never seen her before at the recommendation of her lawyer and leave all that information out?

A Well, I would hope that I'd get the information. But you know, I can't read into people and I, you know, think that needs to be clarified with the person.

Q Also, the difference between 2010 and 2015, is in 2015, there was an MRI of the right shoulder, correct? I'm sorry, the left shoulder?

A That is correct, sir.

Q Okay. The left shoulder -- as a pain doctor, I assume you can speak more intelligently about this than I can, but a left shoulder impingement and left shoulder bursitis and what appears to be a bone bruise, that can cause symptoms in the left shoulder and in the left arm; correct?

A When we talk -- that is correct as a general statement. But it doesn't show radicular pattern or a dermatomal pattern. We call that a revert pain and it's not typically going into the hand.

Q At any point -- at any point -- at any point during your treatment of Ms. Waiau-Tate [sic], at any point --

MR. PRINCE: Tate is your client.

MR. WINNER: I'm sorry. I apologize.

BY MR. WINNER:

Q At at any point during your treatment of Ms. Waiau, Evans-Waiau, did she complain of symptoms in her legs?

A Not to my knowledge, sir.

Q Okay. At any point before April of 2016, was there anything suspected or mentioned about her right arm?

A No, sir.

Q Thank you.

THE COURT: Mr. Prince?

MR. PRINCE: Yeah.

REDIRECT EXAMINATION

BY MR. PRINCE:

Q Doctor, just so we're clear, did any question that Mr. Winner asked you change your opinions or thoughts or feelings about this case at all?

A No, if I had known, obviously I would like to know as much information I can. If I had known about that the incident in 2010 caused some neck pain I -- it will say probable radiculopathy, it was -- it was -- at that time the patient was evaluated by a primary care doctor. There were no evidence on the MRI scan of nerve irritation, of any disc

pathology. The -- in fact, the reason for -- to think of a probable radiculopathy was simply based upon some weakness in the bicep strength, in the arm strength.

A month later there was a comprehensive examination performed at that Bonanza Clinic where the patient had no sensory deficits whatsoever, so radiculopathy was certainly not the case. So it doesn't at all change my opinion whether I know that or not.

Q So --

A So I would like to get as much information as possible.

Q Okay. Well, you got all -- before you come to court you got all the information though, you have the records, right?

A That is exactly.

Q Whether she told you about the neck or didn't tell you about the neck, now you have the records and you saw what happened?

A Yes.

Q Does that change your thoughts or your feelings or opinions at all?

A No.

Q And in fact, does it support your opinions now that you've received that information, it actually strengthen your opinions in some way, that it was this motor vehicle collision

from October 30th, 2015, and the onset of the neck pain, the left arm symptoms, and the disc pathology that we see on the MRI after this collision?

A That is correct.

Q Okay. Is that your opinion to a reasonable degree of medical probability?

A Yes, it is.

Q Do you feel in any manner that you were fooled by or taken advantage of by Desire?

A No.

Q Right. And at times, ever patients, if there's a remote history say, 2, 3, 4, 5 years, 10 years even, because sometimes they forget they may -- about a prior accident, prior treatment, things like that; does that happen from time to time?

A It does happen. And sometimes when we know that there was something five years ago we don't even dive too much into the details anymore.

Q Why?

A Because that's been a long time past.

Q Right. And forming your causation opinions, are you looking like how she was doing at the time just immediately before the collision, is that -- was that the relevant time period for you?

A Right. The causation opinion is the onset of -- the

temporal onset following --

Q Right.

A -- an inciting event, and the most plausible biological explanation for the patient's opinion and the lack of any other plausible explanations.

Q Right. For example, Mr. Winner was talk -- Guadalupe, she has a -- she had a large disc herniation in her lumbar spine, right?

A Yes.

Q But she didn't have any symptoms associated with it, right?

A Correct.

Q So you can't just look at an MRI. That doesn't tell you the whole story, does it?

A That is correct.

Q You have to use clinical correlation and look at all the various pieces and put all that together. It's a whole comprehensive analysis, right?

A Yes.

Q Right. And in this case, putting that comprehensive analysis together using clinical correlation, the onset of the symptoms, the MRI, the consistency of neck pain, pain into the arms, with the -- with doctor -- chiropractor, yourself, Dr. Khavkin, Dr. Garber who's present, were those all consistent with the traumatic disc injury caused by this collision?

A That is correct.
Q Do you believe the protrusion in this case at C5-6, do you think that was symptomatic, once again, requiring medical treatment including surgery?
A Yes.
MR. WINNER: Outside the scope, Your Honor.
MR. PRINCE: No, we talked about the protrusion being symptomatic or not symptomatic. I mean, he brought it up on cross-examination.
THE COURT: Overruled.
BY MR. PRINCE:
Q Go ahead.
A We have diagnosed this as a discogenic pain, hence, it is symptomatic.
Q Right. Through your injections, right?
A Correct.
Q And also in response to the surgery at C6-7, that Dr. Garber performed?
A Correct.
Q With regard to the July 2016 accident, was she already determined to be surgical at C6-7 before that day by Dr. Khavkin?
A That is correct.
Q Did she have any significant change in her clinical symptoms, her presentation or exam finding when she came to

see you after her July 10, 2016 accident?
A Not as it pertains to the neck.
Q Right. Do you think it was reasonable in this case for the chiropractor to refer her for an MRI?
A Yes.
Q Okay. Dr. Lewis, I don't know if we're going to hear from Dr. Lewis or not so right now all we have is Mr. Winner's statements; he didn't show you a deposition of Dr. Lewis, right?
A I did not see that.
Q Right. Now, Dr. Lewis, just so we're all clear on this --
THE COURT: Brendon, 155.
A/V TECH: It's coming.
MR. PRINCE: Oh. If we can have control of our settings. Just for the C6, just the [inaudible].
BY MR. PRINCE:
Q Remember Mr. Winner's asking you questions, well, some radiologists might -- or physicians might interpret it as being a protrusion, 2 to 3 millimeters, other people may say, I don't see that; do you remember that line of questioning?
A Yes.
Q There could be some variation?
A Yes.
Q Well, first off, I want to ask you, you read the

film yourself, right?

A Yes.

Q Do you read MRIs every day of the lumbar and cervical spine?

A If they are available to me, I do. But I rely on the report more so.

Q Right. Do you also review films in your practice?

A Correct.

Q Every day?

A Correct.

Q You have to know -- you -- do you look at films before you do injection procedures so you understand where the pathology is?

A We correlate it, the films with the MRI scans -- excuse me -- the films with the reports and then we come up with the --

Q Right.

A -- injection recommendation.

Q In this case, when you did your own review of the films, did you agree with that there was a significant protrusion at C6-7?

A I saw a disc protrusion significant at C6-7, yes.

Q Okay. I want to show you Dr. Khavkin's note.

MR. PRINCE: 275, Brendon. Exhibit No. 49, 275. No, go to the results. Okay, there. Perfect.

BY MR. PRINCE:

Q This is Dr. Khavkin who you refer to as a neurosurgeon, right?

A Correct.

Q He trained at Johns Hopkins, right?

A Correct.

Q And that's one of the finest University the training is -- I mean, medical institution in the world; right?

A Correct.

Q And it says, direct visualization, means he read it himself; right?

A Correct.

Q An independent interpretation of the MRI obtained from Align --

MR. WINNER: This is outside the scope, Your Honor.

MR. PRINCE: I'm asking -- you asked about how people can have variation, I'm asking to confirm what happened in this case.

MR. WINNER: He's asking him to confirm another witness's findings now.

MR. PRINCE: No, I'm talking about consistency with his own findings and that of the radiologist.

MR. WINNER: Objection.

MR. PRINCE: Because that's [indiscernible].

THE COURT: Could you repeat -- repeat the --

MR. WINNER: Objection stands.
THE COURT: -- question.
MR. PRINCE: Right. I haven't asked it yet. I'm just asking to --
THE COURT: Approach.
MR. PRINCE: -- to read it.
THE COURT: Please, approach.
(Bench conference)
THE COURT: What are you asking?
MR. PRINCE: I'm asking him --
THE COURT: Who are we talking about the fine institution graduate of --
MR. PRINCE: No, this is Dr. Khavkin.
THE COURT: Okay.
MR. PRINCE: The neurosurgeon.
THE COURT: Uh-huh.
MR. WINNER: Outside --
MR. PRINCE: No.
MR. WINNER: -- the scope.
MR. PRINCE: Now --
MR. WINNER: That's my objection.
MR. PRINCE: -- I mean --
THE COURT: Okay.
MR. PRINCE: Okay, well, I'm not finished with what I'm stating. Your objection is simple.

Mr. Winner said, oh, in MRIs, there's a 2 to 3 millimeter variance, you know, one guy may read it this --

THE COURT: Right.

MR. PRINCE: -- way, one guy may read it that way.

THE COURT: Right.

MR. PRINCE: I'm like, all right, did you -- number one, calling into question the accuracy of the read. So, I'm saying, you read it, Dr. Rosler read it, I agreed with the radiologist, Dr. Khavkin saw it, and then Dr. Garber saw it. So it wasn't -- and he --

THE COURT: But aren't those other two guys going to testify --

MR. PRINCE: Yeah, but -- but --

THE COURT: -- and they can say they saw it too?

MR. PRINCE: Yeah, but I'm using him. He -- the questions were asked of him. I want to deal with it, with him. That -- it wasn't just him who saw it, too, it wasn't just the radiologist or him, it was two more people who saw it.

THE COURT: And -- and --

MR. PRINCE: As to rebut the issue raised by Mr. Winner.

MR. WINNER: I said -- my question was, can two radiologists look at the same MRI and one read as normal and one read abnormalities; he said yes, he's seen that.

MR. PRINCE: Right. Okay, I'm coming at -- that everybody here in her care --

THE COURT: I don't know, I guess the converse of that is if -- because they conceded the things that they agree on, it makes it slightly stronger, but I don't know why we don't wait for those two doctors to do their --

MR. PRINCE: Because I may not --

THE COURT: -- own thing.

MR. PRINCE: Well, they're going to.

THE COURT: And -- and --

MR. PRINCE: But I'm just -- but he asked it right here and I want to deal with it. He -- that was part of his cross-examination.

THE COURT: Well, and my other --

MR. PRINCE: Calling into question the accuracy of the read.

THE COURT: My other issue is how do -- how does that command on a personal knowledge hearsay kind of objection?

MR. PRINCE: But no, because the -- number one, the record is in evidence and he referred the patients to these doctors. So it's part of his -- part of his care is what they did. He directed the care.

THE COURT: And your objection is beyond the scope?

MR. WINNER: Yes.

THE COURT: All right. I'm going to overrule it but --

MR. PRINCE: Okay. That's -- it'll be fast.

THE COURT: -- limit it just --

MR. PRINCE: Yeah.

THE COURT: -- to one question to clear it up.

MR. PRINCE: Yeah, I do.

(End of bench conference)

BY MR. PRINCE:

Q The question is simple; Dr. Lewis saw, the radiologist saw a disc protrusion at C6-7k you saw it; correct?

A Yes, sir.

Q Did Dr. Khavkin also see it according to his records?

A Yes.

Q Okay.

MR. PRINCE: And if we can look at 770, part of Dr. Garber's note, Exhibit 50. If you can go to the top, Brendon, the -- kind of there where it says "note", yeah.

BY MR. PRINCE:

Q It says here, it says, MRI of the cervical spine reveals, do you see that?

A Yes, sir.

Q It says, MRI of the cervical spine reveals a left

paracentral disc protrusion at C6-7 with nerve root impingement; do you see that?

A Yes.

Q Did Dr. Garber who did the surgery who is also here in court, did he also see an abnormality at C6-7?

A Yes.

Q So four of you did?

A Yes.

Q All right. With regard to patients who have discogenic pain, can pain -- can discogenic pain kind of wax and wane meaning some days are good days, some days are bad days?

A Any kind of pain can wax and wane and suddenly also discogenic pain.

Q Is that something you see in your practice with a patient of discogenic pain; some days -- one day it could be high, one day it could be low?

A Exactly.

Q Before you did your injection, did you ask her to come off of any of her medication, including anti inflammatories to avoid any bleed?

A Yeah, typically we tell them to come off for a few days.

Q Okay. So when she comes to the surgery center she's -- you asked her to go off of her medication because if you're

on Ibuprofen or anti inflammatory is that going to increase the risk of a bleed, right?

A Correct.

Q Can the pain -- once you're off of your medication can the pain levels then go up?

A Yes.

Q Okay. Because that's one of the reasons why you have the pain medication is to help control pain and bring it down, right?

A Correct.

Q Doctor, thank you for your time. I appreciate your time. I know it's been out of your schedule. Thank you.

MR. PRINCE: No additional questions.

THE COURT: Okay. Is this witness excused?

MR. PRINCE: Yes, unless there's -- the jury has a question.

THE COURT: Anybody? Is that a nod or a "not"? There's a nod.

(Pause in the proceedings)

THE WITNESS: (To the Court) Do they have questions? Do they have questions?

THE COURT: Um-hum. Sit tight. You're close.

THE WITNESS: yeah, thank you.

THE COURT: Anyone else?

(Pause in the proceedings)

THE COURT: (Reading). It looks like they [inaudible].

MR. WINNER: I need better bifocals. (Reading). I guess I don't have an objection if that makes sense but.

THE COURT: They all look fine to me, quite frankly, based upon the testimony so far. I'm not sure [inaudible] not fine in terms of the question.

MR. WINNER: Not objectionable I think is what you mean [inaudible].

THE COURT: Yes. Thank you for the translation though.

MR. PRINCE: Sorry, I have no --

THE COURT: Thanks for the translation though.

MR. PRINCE: I have no objection to any of those questions.

MR. WINNER: We've said what -- we're fine [inaudible].

THE COURT: [Inaudible]. Ah oh, hurry up, because looking, they're handing off more questions.

What is this? Doesn't she get a whole notebook?

MR. WINNER: And Sweikert has got lots of questions. That's fine. They're all fine.

MR. PRINCE: Yeah, they're fine.

THE COURT: All right.

MR. PRINCE: All good.

THE COURT: Thank you.

MR. PRINCE: Yep.

(End of bench conference)

THE COURT: Okay. Doctor, wait a minute. Mr. Sweikert, I have 3, 4, 5 and 6; was there a 1 and 2?

JUROR NO. 8: I got rid of those.

THE COURT: Okay. Thank you.

Doctor, do you believe in chiropractic care?

THE WITNESS: I do believe in chiropractic care as a modality, conservative modality, as an initial conservative modality just like physical therapy. I think it's personal preference what patients or people prefer, either going to the chiropractor or to the physical therapist. But I think it's a -- it's an important, reasonable first step once you get, you know, injured for whatever reason to go to one of the first conservative treatment providers such as a chiropractor or a physical therapist.

THE COURT: Did Desire ever show that she had any reservation about anything you recommended to her?

THE WITNESS: I think most patients do have reservation. I don't recall that she had a particular reservation. But most of my patients, that is just from my experience, when you ask or recommend an injection with a needle close to the spinal cord they have reservations. And they don't take that lightly simply because of the risks that

are involved. And a lot of people, the majority of people are telling me, I'm scared of needles. So we have to be very cognizant of that.

And I also tell the patients these are not injections that have to be done. These are not urgent or emergent procedures. These are optional procedures to A, find out where the pain is coming from; B, hopefully giving you some therapeutic benefit. But it's entirely up to the patient to decide whether they want to undergo the procedure.

But the majority of my patients and over the last 15 years they do have some concerns and some anxiety about these injections, which I understand.

THE COURT: Okay. Did she accept your recommendations without consideration?

THE WITNESS: Again, the same thing. We give patients the option, as I pointed out, these procedures are optional and the patient has at any given time the -- is good right or good right to refuse or say no, I don't want to do this injection. And I have had that in my practice.

THE COURT: If Desire's pain was not as bad, if it was less than 5 out of 10, would you have suggested the route of surgery knowing that the disc injury was present?

THE WITNESS: I am not a surgeon. I wouldn't recommend surgery. I think we are -- we are dealing with two components of her symptoms. One is the neck pain and the

other component is the radicular component, the numbness and the tingling in the arm.

And we all know that if a nerve root irritation and inflammation of the nerve that manifests itself as numbness and tingling, and pain, or pain, if that that persists, if there is a irritation, a chronic irritation that can cause nerve damage, which can manifest itself as weakness, we certainly are aware of that.

So I think the recommendation to go to a surgeon is or was being made not essentially to tell the patient, you have to have surgery, because I'm not a surgeon. But it was warranted because I wanted to have a surgeon explain the situation to the patient and potentially what kind of long-term effects this discogenic pain and the radiculopathy has on the patient.

THE COURT: Does this surgery typically result in ongoing pain such that the patient would seek pain management?

THE WITNESS: Well, again, I'm not a surgeon but I see patients who are about to undergo surgery and are undergoing surgery. And I often over time we develop a good doctor/patient relationship, at least that's what I'm striving for.

So patients ask me, Doctor, can you guarantee that this surgery is going to help me? And I always say, there's no guarantee. And I give the example of Tiger Woods. He had

four back surgeries and the final back surgery has helped him to win the Masters so to speak, or the same thing with Peyton Manning, he had numerous cervical surgeries that didn't really help and then eventually he had a fusion surgery and was -- then he went to the Superbowl again.

So I tell my patients, you know, there's no guarantee but we -- and I speak for my surgical colleagues their, hopefully for them, that we wouldn't recommend or they wouldn't recommend surgery and I wouldn't recommend a consultation with a surgeon if I wouldn't be convinced that a surgical option might be feasible to get the patient's symptoms better.

However, it is never an urgency or an emergency unless we have the threat of paralysis or acute spinal instability with a fracture. The patient can always opt to live with the pain as well and I make that clear to the patient as well.

THE COURT: And if a patient had prior injury with no symptoms, could trauma bring about significant symptoms without causing additional injury or damage?

THE WITNESS: Well, if you have what we call say preexisting asymptomatic condition, and especially it's in the elderly population, that renders you more susceptible to an injury that now causes pain, and it could be an injury that doesn't necessarily show as a pathological change on the MRI

scan, but it could be an injury that is due to now the onset of an inflammatory process, signaling that there is an inflammation going on that the patient receives as pain.

THE COURT: Anybody else, anything else? Do any of those questions --

MR. PRINCE: Nothing from us, Judge.

THE COURT: -- any -- other side?

MR. WINNER: No, thank you, Judge.

MR. HENRIOD: Thank you.

THE COURT: Jurors all done? Okay.

MR. PRINCE: Thank you for your time, Doctor.

THE COURT: Now he's excused?

MR. PRINCE: Yes.

THE COURT: All right.

THE WITNESS: Thank you.

THE COURT: Thanks again for your time. Appreciate it.

We're going to go ahead and break for lunch.

MR. PRINCE: Okay.

THE COURT: I'm going to take an --

MR. PRINCE: Can we approach, Judge?

THE COURT: Yep.

(Bench conference)

MR. WINNER: I just don't know how long Dennis is going to take but I have kids and I kind of need to get out of

here by 5:00 and I don't want to bring him back tomorrow. So the shorter the lunch maybe the better would be -- that's the reason I'm approaching.

MR. PRINCE: Okay.

THE COURT: That's fine.

MR. PRINCE: Want to do 45 minutes?

THE COURT: Well, here's the problem. I want you all back 15 minutes earlier because I need to deal with --

MR. PRINCE: Fine.

THE COURT: -- this before this next witness. So that only gives us a half hour.

MR. PRINCE: Well, the 45 minutes is fine. An hour is fine. That'll be fine.

MR. WINNER: Is that okay with you?

MR. PRINCE: Whatever is fine.

THE COURT: Well, I'm not staying late as I --

MR. PRINCE: Right.

THE COURT: -- said earlier.

MR. PRINCE: No, it's --

MR. WINNER: I just don't want to bring him back tomorrow.

THE COURT: I have dinner plans.

MR. PRINCE: Understood. Okay.

THE COURT: Do you know how long you're going to be? Are you going to be as long as that other one?

MR. PRINCE: Probably not. So, we can probably cover some things but he read all the records so he's a little -- he covers a little different topic but it will be probably more focused.

MR. WINNER: Thank you, Judge.

THE COURT: Okay. I'll give them an hour, we'll take 45.

MR. WINNER: Okay.

MR. PRINCE: Okay.

(End of bench conference)

MR. PRINCE: We'll be back at --

MR. WINNER: At 2:10?

THE COURT: We're going to give them until 2:30.

MR. WINNER: That's an hour and ten minutes.

THE COURT: Is that right?

MR. WINNER: Or it's an hour and five minutes. My watch is slow.

THE COURT: It's 1:26 right now.

MR. WINNER: Okay.

THE COURT: So, ladies and gentlemen, we're going to give you an hour. Is that what I said, an hour for them and 45 for us, right?

MR. WINNER: Whatever you want to do, so.

THE COURT: Yeah.

MR. PRINCE: Yeah.

THE COURT: That's what I'm going to do.

MR. PRINCE: Okay.

THE COURT: During the recess, you're admonished not to talk to or converse among yourselves or with anyone else on any subject connected to this trial or read, watch or listen to any report of or commentary on the trial by any person connected with this trial, by any medium of information, including without limitation to newspapers, television, the Internet and radio, or form or express any opinion on any subject connected with the trial until the case is finally submitted to you.

If I could have the --

THE MARSHAL: All rise for the exiting jury.

THE COURT: If I could have the attorneys back at 2:15.

UNIDENTIFIED JUROR: 2:15?

THE COURT: Jurors 2:30.

UNIDENTIFIED JUROR: Oh.

(Court recessed at 1:27 P.M., until 2:25 P.M.)

(Outside the presence of the jury)

THE COURT: Okay. I've -- is everybody here? Mr. Prince, when is it that you claim that you became aware that you were seeking a second surgery?

MR. PRINCE: In preparation with Dr. Garber and Dr. Khavkin given the rate of adjacent segment disease, and

looking at materials with Dr. Wang, that I determined that, number one, given her age, given the statistical likelihood, I then asked Dr. Garber and Khavkin that during, you know, as part of their prognosis for her did they also envision that at some point she would be fused at C4-5. Dr. Khavkin said yes because he was going to do a two-level, so that would be a single surgery for him.

Dr. Garber told me also, yes, he goes it's a 100 percent certainty as to the C5-6 level, which is the immediately adjacent segment, and because of her young age and adjacent, that, yes, at some point during her lifetime she would need C4-5. So I guess they confirmed it in two ways since they had different surgical approaches kind of using all of the data, so that's what I did. And --

THE COURT: I was asking for a date.

MR. PRINCE: -- in the -- in the first -- what's what that?

THE COURT: I was asking for a date.

MR. PRINCE: Oh, before the first trial, actually. I said that she was at risk for having a third surgery. I didn't put in a number, but then I confirmed -- I just doubled the -- in asking Dr. Garber, I doubled the number because it is the same surgery times two. So he was asked in December of 2017 what the cost of -- number one, will she have adjacent segment disease, he said yes and he gave the cost of only one

surgery at that time. But so that -- that I knew, but then I started asking preparing for the trial is she going to need up to C4-5 done.

THE COURT: And why didn't you -- why didn't you seek that at the last trial?

MR. PRINCE: I did way that she is at risk for a three-level surgery. I did -- I did say that in my last opening. I have my opening PowerPoint to say that. I just didn't include a cost number in it.

THE COURT: Did you --

MR. PRINCE: And I didn't say it quite in the same way, but I did say that.

THE COURT: When you became aware of that, did you call Mr. Winner and say, hey, look, I just talked to my expert, it looks like there's going to be a second surgery?

MR. PRINCE: I didn't. No. Well, I said it during my last opening. And so I did say in my last opening that she was at risk of having an adjacent segment surgery at C4-5, so I did say that. The only difference now is I included a cost in this opening that I didn't include the last time.

THE COURT: Okay. I don't recall seeing that.

MR. PRINCE: And I have my Power -- it would be in my -- do we have the PowerPoint from the last time or did you save over it?

THE COURT: I don't --

MR. PRINCE: And I gave you -- I gave you --

MR. HENRIOD: It says two?

MR. PRINCE: I said three, that, yeah, she would be fused up to three levels. Oh, yeah, I did for sure. And I'll even -- I have the transcript, so I can talk -- and I know I can find it.

THE COURT: But not in terms of -- certainly not to a degree of medical certainty that she's definitely going to have it. I don't believe that was presented.

MR. PRINCE: I said she's at risk of having a three-level surgery because of her age. I did say that. Yes, I did. I didn't say it in the way -- in the same words. I try to not duplicate everything I said, but I said it in more definitive terms this time than I did the last time. That is true.

THE COURT: Okay. Anything else?

MR. HENRIOD: No. You've read the brief. You've read --

THE COURT: I read the briefs. I am going to not allow the second surgery in. It's my belief that because of the non-disclosure, I don't see a substantial justification. We went through this trial once. You were only seeking for one surgery.

MR. PRINCE: Okay.

THE COURT: I think it was a surprise as evidenced

by the fact that Mr. Winner actually came up and said did you mean to say two surgeries? I think he was truly taken by surprise. I certainly was taken by surprise based upon everything I see. The fact that you said you knew about it before the first trial, that makes me wonder why we waited. I'm not saying you don't have a strategic reason for it. I just don't think that the disclosure --

MR. PRINCE: Well, that relates to the costs, then. He can still talk about what her future care is going to be. I may not -- I may not be able to ask for the cost associated with that, but he can talk about --

THE COURT: Well --

MR. PRINCE: -- part of her prognosis is going to be that she's going to have an adjacent segment at C4-5 because that is -- that is what he formed during the course of his care.

THE COURT: Well, we'll see how that goes. I'm not sure about that because I think that that's something he has to be able to opine to a degree of medical certainty --

MR. PRINCE: He is going to.

THE COURT: -- and I think there is a lot of variables that the defense would have wanted to talk about if they knew he was going to talk about a second surgery.

In his -- his report he talks about, well, yeah, there's, you know, a lot of variables, if she lives this long,

if she follows the certain percentage increase like everybody else, depending on her health, does she have diabetes, what's her weight, what's -- there's a whole lot of things the life expectancy chart that I know you guys have been at issue and we're only getting to limited, would become much more important if you're going to start talking about a second surgery.

So I think that there's a lot of variables that wouldn't have been addressed by the defense unless they knew that this was coming on a --

MR. PRINCE: Well, I mean, we can certainly talk about --

THE COURT: -- secondary surgery.

MR. PRINCE: I mean, I understand the computation of damages is one issue, but in terms of his prognosis, Dr. Khavkin is going to come up here and say, yeah, at my recommendation, she is definitely going to have it whether you do it in two surgeries or three, you're getting the C4-5 in her lifetime. He is going to say that. Dr. Garber is going to say that because that's part of the progression of her disease process. I'm not against -- under your ruling, I can't ask for the costs associated with that. I only can ask for the cost of the one surgery, but she's going to experience that during her lifetime. He didn't -- he didn't give --

THE COURT: Maybe, if she lives long enough.

MR. PRINCE: Oh, assuming she lives --

THE COURT: That may not have anything to do with this.

MR. PRINCE: Well, I guess, then, that's up for cross. Then that's a weight issue. It goes to the weight of whether assuming she lives that long. I mean, but more about the process and how the adjacent segment disease works and once he fuses two levels what it does to the next level and how that will start -- the breakdown process will start all over again. Because that is going to happen.

He's going to give an opinion in the next 10, 15 years that she's going to have a second surgery at C5-6. Then what happens, Dr. Garber? It's not the end of the story. It's a disease process. And how it works, it's a progressive disease process. And that's an opinion he formed during the course of his care unrelated to an opinion on the cost. I understand your position on cost.

THE COURT: Okay.

MR. PRINCE: But in terms of the process, it doesn't end. It's all of the sudden, oh, one surgery, that ends her care. It doesn't end her care. It actually increases her chances, particularly with her age.

THE COURT: Defense.

MR. HENRIOD: I don't --

THE COURT: I'm more inclined to give him a little

more latitude there, just so you know.

MR. HENRIOD: I don't think you can come in and suggest that there is going to be future care that they are not actually providing a number for, which I think encourages the jury, then, just to tack on more in pain and suffering because there's probably going to be even more care than we're able to substantiate now.

I think that it is not a meaningful distinction between listing costs and just -- and price. I think -- I think what I'm hearing is a characterization of the Pizarro-Ortega case, that the only thing that -- that there is a deficiency about when it comes to the disclosure is the price of this.

MR. PRINCE: Correct.

MR. HENRIOD: I don't think that that is a significant difference. Now, it was in Pizarro-Ortega because --

THE COURT: Which was different.

MR. HENRIOD: -- there what happened, right, is it's the one thing they didn't disclose.

THE COURT: Correct.

MR. HENRIOD: But as the Court makes the notes --

THE COURT: Right.

MR. HENRIOD: -- it was never in controversy --

THE COURT: Right. That --

MR. HENRIOD: -- that substantively --
THE COURT: -- they know the surgery --
MR. HENRIOD: -- was going to be needed --
THE COURT: Correct.
MR. HENRIOD: -- and what that surgery was. And here we have in this case not just non-disclosure of anything except one future surgery. We actually have the opinion from Dr. Garber in his deposition that it would only be one and he even explained why it likely would not be the one underneath, just the one above. And we don't have from Dr. Khavkin anywhere that he thinks that there is going to be the necessity for surgery in the future.
And that this was discovered in conversations pursuant to trial preparation, I think that means that it wasn't necessarily formed during care. It was formed in that collaboration. It's the time of thing that has to be reported. And I don't think you can allude to future surgeries and think that the harm of that is eradicated because we're not giving the jury a price.
MR. PRINCE: Well --
MR. HENRIOD: I think the problem with that is the jury will just imagine the price on their own and tack it in.
THE COURT: Well, but they are --
MR. PRINCE: They only can base it on the evidence.
THE COURT: That are not going to be able to

compensate for that --

MR. PRINCE: Correct.

THE COURT: -- surgery.

MR. PRINCE: Well, no, for the cost of it. The cost. I may be asking for pain and suffering because --

THE COURT: Oh, for that surgery? Okay. Then it's all out.

MR. PRINCE: Well, Judge --

THE COURT: Second surgery is out.

MR. PRINCE: Well, Judge, how do you do that? The disease process doesn't stop. It doesn't stop. And once you -- once you fuse her two levels, she's going to break down again. That's part of her future. That's -- whether he says it, Dr. Khavkin says it, that's a part of it. The only thing that Rule 16.1 says, you have to provide a computation of damages, and that's what we're talking about. That's the cost part of it. You don't have to put in there your pain and suffering damages.

And you are allowed to offer like what is her prognosis, what does her future look like? All of that adjacent breakdown, that is going to happen. That doesn't -- just because if by 45 -- yeah, Dr. Wang is even going to say it. When you fuse -- once you fuse the next level, the next level above that, C4-5, is going to break down with time. That is going to happen.

THE COURT: Well, you can -- you can argue all that with just the first surgery and the injury. You don't need the second surgery.

MR. PRINCE: Well --

THE COURT: You can argue all the potential --

MR. PRINCE: No, but I need to talk about the -- is she going to need another surgery in her lifetime, a second surgery, because that is the evidence.

THE COURT: I don't think it's the evidence. I haven't -- show me in a report.

MR. PRINCE: Well, it's not required to be in a report. It's not required. He's a treating physician.

THE COURT: Well, I think he's going a little beyond when it's in trial prep that he comes up with his --

MR. PRINCE: No, I made it.

THE COURT: Show it to me.

MR. PRINCE: I don't have the second surgery in any report. I don't have that.

THE COURT: And I think my position is buttressed by the fact that you filed your sixth supplement early case conference list, your 16.1, based upon this whole issue in trial.

MR. WINNER: That's the report we have.

THE COURT: On 5/21, that was yesterday. And by your own admission you knew about it weeks ago.

MR. WINNER: That's 5/21 -- 17.

MR. PRINCE: But I talked about -- what are we going to be able to talk about. I talked about in the first trial that she's at risk because I did talk about that.

THE COURT: Okay. I need you to pull it up for me.

MR. PRINCE: Find -- find the --

THE COURT: If that's true --

MR. PRINCE: -- transcript from the first trial.

THE COURT: -- that's different. Let me -- let me see. Can you pull it up.

MR. PRINCE: Oh, yeah, I definitely talked about it. Absolutely.

(Pause in the proceedings)

THE COURT: I just saw this. Was there a second one for a second surgery, a letter like this? Obviously, there wasn't --

MR. WINNER: No.

THE COURT: -- or somebody would have mentioned it.

MR. WINNER: It's the only one I have.

(Pause in the proceedings)

THE COURT: I'm just going to go grab something off my desk while you're looking for that.

(Pause in the proceedings)

MR. PRINCE: Okay.

THE COURT: Got it?

MR. PRINCE: I do.

THE COURT: Do we have the -- you don't probably have it right there.

MR. PRINCE: So with respect to this issue, during my first opening statement, I was talking about her having a surgery. And so by around age -- this is on page 67 of the first transcript of the first -- so by around age 40 or so, she's going to need another surgery. So now she's going to have two levels fused. She's still a very young woman with about another 40 years of life expectancy, and that cost is $280,419 to now to deal with two levels of the spine, so that is going to be in her future.

And now -- this is on page 68 -- once we have two levels fused, because we're talking about the rest of her life, you're going to hear evidence of what she's going to endure and expect. So we're going to have to plan for these issues now, but now it's going to start all over again. By the age of 55, she may very well need surgical -- surgery again in her lifetime. That's a very real risk. And so, eventually, she's going to have a real risk of having three levels fused.

THE COURT: Okay. Here's what I'm going to let you do. I'm going to let you present evidence like that, very likely, real possibility, that kind -- well, do you guy want to say something?

MR. PRINCE: Well, more probable than not. I'm saying that; right?

THE COURT: I mean, I think that's -- that's fair. That's legitimately --

MR. PRINCE: Well, it's more probable than not. I just said that in that way that that was -- I didn't have to use those exact words. I mean, I'm telling her we're talking about fusing three levels in her lifetime. Then I go on -- so I go on here.

Remember, if she had surgery with Dr. Khavkin, she was guaranteed to have a three-level, so she's likely going to go through this whole process three times in her lifetime. That's on page 67 and 68. I said likely. So that -- that's what -- you may not get all of the costs, but for her to be stripped of her pain and suffering damages because that is what the evidence is going to be. I mean, I said that during the first trial without objection.

So I understand about the cost issue, and so that wasn't in our computation. I think they still have more than sufficient time, they've got more than sufficient notice. They knew about this the last time. They said nothing to you about it, not even an objection. The only difference was Mr. Winner heard me say I'd put a cost to it. All he had to do was times two.

THE COURT: It's a big difference, but --

MR. PRINCE: It's a -- I don't know.

THE COURT: It would be to me.

MR. PRINCE: He's got time to have his experts deal with it. They don't testify for a week. They don't have to issue a report. I'm not asking to take a deposition. Their experts have never even given opinions on future cost estimates of the need for the surgery that Dr. Garber gave. None. So I don't think there's any harm or prejudice at all. They already prepared a report. They can come into court and say whatever they want to say. I don't care. I'll cross-examine them with the evidence.

So that's why when you don't do the Rule 37 analysis, it's really no prejudice to them because I said this -- it's number one, a prognosis from a treating physician, two of them, in fact. I understand about the computation, but I see Pizarro-Ortega supports my position. If there's no harm or prejudice, then they can deal with it with the record. They've got more than sufficient time. Dr. Wang doesn't testify until next Tuesday.

THE COURT: Well, like I said, I still don't see that there's substantial justification, and I don't think that it's harmless. But in terms of this particular argument, it was in his previous PowerPoint and he argued it to the jury, so on some level you are on notice about that.

MR. PRINCE: And I also gave them the PowerPoint

before we started the opening statement.

THE COURT: I know.

MR. PRINCE: Remember that?

THE COURT: I do. I was here.

MR. PRINCE: With no objection.

MR. WINNER: Well, none of this was mentioned in the last opening statement. What I heard for the first time --

MR. PRINCE: No, that was -- no, what I just quoted you was from my prior opening statement of the mistrial. That's what I quoted from.

MR. WINNER: That's not -- I don't think that's what she was asking. The current opening statement, that was not included in the screens that I looked at. He just blurted out there's going to be $560,000 in futures.

MR. PRINCE: Well --

THE COURT: Correct. But my -- I'm talking about a notice issue and a disclosure issue. And if what he went -- read, you guys definitely were on notice that that's -- I mean, I knew that they were going to talk about this debilitating thing. I had no idea that they were going to try and recover for a second surgery --

MR. WINNER: no.

THE COURT: -- in the future, so that really surprised me and that's why I'm saying that can't come in. But I don't necessarily think that some of --

MR. PRINCE: You mean the cost. The medical expense. I did talk about --

THE COURT: Well, I don't know about the medical certainty of it because honestly --

MR. PRINCE: I didn't need to say it that way.

THE COURT: -- I don't know that it matters because, quite frankly, I think that can be handled on cross-examination because nobody on this planet is going to say 100 percent certain that she's going to get a second surgery in her lifetime I wouldn't think.

MR. PRINCE: Right. And we have to prove it more probable than not. That's all we have to prove it by. That's why it's --

THE COURT: Well, I think --

MR. PRINCE: -- the burden of proof.

THE COURT: -- there's a lot more than that going on. There's a whole lot of -- it's a medical certainty, and there's also all the assumptions that go into it by your witness's own reports. There's a million factors, so --

MR. PRINCE: Okay.

MR. HENRIOD: So on those two points, I don't think that opening statement counts as a disclosure during discovery. I think 16.1 contemplates a disclosure before trial begins. I don't think that you have to object to every statement of an attorney in opening statement that you think

they won't be able to fulfill by the end of the trial, so it's not as if you admit every assertion during an opening statement by not objecting to it. And I think it is a problem to suggest that pain and suffering can be based on care that is not being substantiated as special damages. Now --

MR. PRINCE: Oh.

MR. HENRIOD: -- will her spine -- will her spine continue to deteriorate? If that's what they want to say, well, of course, everyone's will. But to suggest that there is future care out there that will be necessary to a reasonable degree of medical probability and so they should award an amorphous general damages amount on that when they can't, it's special, I think is totally inappropriate, Judge.

MR. PRINCE: Your Honor, the fallacy of this argument is I don't have to put any medical expenses in. I can just ask for pain and suffering damages. As long as I established them, I didn't have -- I don't have to put any expense in, past or future.

That could just be talking about what you have to endure in your life to satisfy the legal standard for physical, mental, pain, anguish, suffering, loss of enjoyment of your life. If that establishes -- that's the evidence that establishes it, I don't need to have any special damages. And so a treating physician can give a prognosis. If that's part of the prognosis and it's formed during the course of their

care, then I'm entitled to put that evidence on.

I understand about the special damages part, which is part of the computation, I do understand that. We only disclosed the 280,000. So I guess I won't be allowed to ask for that, and in my closing argument I'll be limited to what the evidence is. But I can talk about what she's about to endure for the next 55 years, that's part of it. And I told them that the last time.

THE COURT: I got it. Yes. I'm not as offended by that because I think that's the natural argument that he's making. You know what, frankly, I don't need an expert. Once you tell me that you fuse a spine, and it even makes sense, wear and tear, eventually you're going to have to probably fuse another one. And so you know what, if you fuse another one, common sense is going to tell me in a few more years you may have to fuse another one.

So I don't -- I don't know that -- if you're okay with some of the degradation of the spine coming in over time, why specifically it matters which way. I don't know if that makes any sense. I kind of think your -- I mean, your whole basic premise is surgery wasn't required in the first place, if I'm not mistaken.

MR. HENRIOD: True.

THE COURT: There was an over treatment.

MR. WINNER: Well, my only response would be based

on what was presented to us during discovery and presented to us up until yesterday, what was presented to us was their claim that the plaintiff would need, over the course of her lifetime, one additional surgery in about 40 years. We were okay living with that. We have to live with that.

THE COURT: Well --

MR. PRINCE: That's not the evidence, Judge.

THE COURT: Yes and no.

MR. WINNER: Well, it's -- it's not the evidence, but it's the evidence they chose to disclose until yesterday --

THE COURT: But --

MR. WINNER: -- during the second trial. And they're acting offended because that's all they disclosed.

THE COURT: But here's what I'll say. And, again, my understanding is treating physician doesn't all have to be there. And in fairness to the other side, the treating physician does make reference to the percentages and the years and the time and stuff. And, arguably, from that you could extrapolate to a second -- potential second surgery. So while they don't throw it right out there, I think there is some basis for it in the report. So I'm done now because it's time. The computations are out. They can do -- they can talk about --

MR. WINNER: So the cost is out, but the possibility

of another surgery is allowed?

THE COURT: Yeah. I mean, it is a possibility. I mean, I think to deny it is -- doesn't really make any sense, honestly.

MR. PRINCE: Yeah. We're good. All right.

MR. HENRIOD: Okay. Well, Your Honor has read Williams versus District Court, Morris Tecata (phonetic) versus Save On. I know you're familiar --

THE COURT: I don't remember.

MR. HENRIOD: -- with the standard. So we disagree.

THE COURT: OH, with that part of it?

MR. HENRIOD: So I don't think you can intuit the need for future surgery. I think an expert needs to establish --

MR. PRINCE: Oh, he's doing --

MR. HENRIOD: -- that its going to be necessary and that it is causally related. As long as I understand Your Honor understands that --

MR. PRINCE: I'm going to do that through this witness.

THE COURT: Well, I do, because as I said already, I question whether they're going to be able to get there.

MR. HENRIOD: Well, it sounds like you're going to allow them to be able to get there.

THE COURT: Do their -- I know.

MR. PRINCE: We'll lay the foundation for that.

MR. HENRIOD: Which is the --

MR. PRINCE: We'll lay the foundation for a second surgery and a third surgery in the future. I am -- that's what I plan on doing.

MR. HENRIOD: He's going to be telling us all for the first time from the stand.

MR. PRINCE: See, they -- they want to try to convert a treating physician all the way as to, hey, it's not documented in your records, therefore, it's not there.

THE COURT: Here's what -- here's what I'm thinking about it and I don't know if I can do this. Can we do a -- not a deposition, per se, but can we do a testimony outside the presence on this particular area with the witness to see what he's going to say and then we can -- rather than doing it in front of -- I mean, do you guys do outside the presence of the jury --

MR. WINNER: Sure.

THE COURT: -- things?

MR. PRINCE: We can, if you're worried about the evidentiary basis of it. If there's a foundational question.

THE COURT: Isn't that the objection?

MR. PRINCE: No. They're just saying, no, you can't disclose it, we didn't know. It's a Rule 16.1 objection they're making.

THE COURT: No, I think he's taking a new --

MR. HENRIOD: No, I don't -- I actually don't doubt that if he comes on the stand, I don't doubt the representation that he may say this. The problem is that we'll all be hearing it for the first time.

MR. PRINCE: Not for the first time. They have his report --

MR. HENRIOD: Yes.

MR. PRINCE: -- and he talked about breakdowns per year.

MR. HENRIOD: No, I'm sorry. Which doctor are we talking about right now?

MR. PRINCE: Garber.

MR. HENRIOD: Okay. Well, that was -- yeah, we had disclosure of one fusion from him.

THE COURT: Okay.

MR. HENRIOD: We did not have disclosure of two. As a matter of fact, we asked about the other one --

MR. PRINCE: I guess you can --

MR. HENRIOD: -- and he said that he did not think that that one was more likely because there's not as much movement at the level anyway.

THE COURT: I saw that. To me, that -- that's great cross-examination.

MR. PRINCE: But he's talking --

THE COURT: I don't know that --
MR. PRINCE: -- about the --
THE COURT: -- I would put it on, but that's --
MR. PRINCE: -- C7-T1 level. That's what they were asking about, and that's not what he's talking about.
MR. HENRIOD: So then now we're talking about a level that's nowhere in the reports.
MR. PRINCE: Well, because he's not required to have one in his report. That's part of his --
MR. HENRIOD: Well, or the medical records --
MR. PRINCE: Hang on.
MR. HENRIOD: -- or the deposition testimony.
MR. PRINCE: He doesn't even have to -- if he didn't have an extra report on the cost, he doesn't talk about adjacent segment disease in any of his charting. So no doctors do that. Then you're converting him to a retained expert and they're not required to have that standard.
THE COURT: But haven't you kind of, when you were preparing for trial, you started talking to him about a second surgery? Aren't you now --
MR. PRINCE: I already was saying --
THE COURT: -- transitioning him over to an expert?
MR. PRINCE: I said that before. He is an expert. By definition he's an expert.
THE COURT: Well, I know, but --

MR. PRINCE: He's a non-retained expert. We did give him material so he became a retained. He commented and rebutted some of the defense stuff, but as it relates to this issue, he does --

THE COURT: And just for the record. The doctor is sitting in the courtroom. I don't know if that matters to anyone.

MR. HENRIOD: One of the two doctors --

MR. WINNER: Dr. Garber is.

MR. HENRIOD: -- that we're talking about --

MR. WINNER: Yes.

MR. HENRIOD: -- yes.

THE COURT: So -- and he's raising his hand, as well. But I just want the record to reflect that he's been here for this whole conversation.

MR. PRINCE: Well, let's -- let's -- let me see if I can lay the foundation here to satisfy to a reasonable degree of medical probability. Because once she has the second surgery at C5-6, the breakdown process starts all over again. It's not like it ends. It keeps going. It's a disease. So he's going to talk about disease and why it's a disease and why it's 3 percent per year and how -- where the statistical analysis comes from. Their own experts --

THE COURT: He can talk about -- talk about all that.

MR. WINNER: He didn't say 3 percent a year. He said 1 to 4 percent a year. 3 percent a year is what Mr. Prince made up this morning. His report says 1 to 4 percent a year.

THE COURT: Somewhere somebody said 2, as well, when they --

MR. WINNER: And he said assuming 2 percent a year, she needs one surgery in her lifetime. That's what they disclose.

THE COURT: And so estimating 4 percent per year, she's going to need three surgeries.

MR. PRINCE: Correct.

THE COURT: And assuming 1 percent, she may never need another one.

MR. WINNER: Assuming 2 percent a year, she needs one more surgery.

MR. PRINCE: Well, Dr. Wang has testified, and he just used a conservative 2 percent. Dr. Wang talks about 3 percent a year they will have a chance of adjacent segment disease at 3 percent per year. That goes back to 2006. The defense expert. So these are statistics. He just used 2 to say even using 2 percent, it's 100 percent likely she's going to have one. He didn't ask to how many, if she was going to -- is she going to have adjacent segment disease and what's the cost of a surgery.

He wasn’t asked to give an opinion on how many, but I did say in my first opening that she’s going to have that. And that’s what the evidence is going to be. She’s going to go through this process three times.

THE COURT: But --

MR. WINNER: Yeah, then --

THE COURT: -- the fact that there’s no --

MR. WINNER: -- then maybe that --

THE COURT: -- for sure and --

MR. WINNER: -- should have been disclosed.

THE COURT: -- what is conservative --

MR. WINNER: He assumed --

THE COURT: -- doesn’t this all --

MR. WINNER: -- 2 percent a year.

THE COURT: -- highlight the fact that there is no medical certainty?

MR. PRINCE: What do you -- well, I'm going to ask --

THE COURT: You're saying 1 percent, 4 percent, 3 percent, 2 percent, he’s going conservative.

MR. PRINCE: Well, it doesn’t require certainty -- the law doesn’t require certainty from us on any level.

MR. WINNER: No, but it --

MR. PRINCE: On any level.

MR. WINNER: -- requires disclosure.

THE COURT: We feel that we've disclosed the issue, they know about the issue, I've talked about it, it's part of their adjacent segment disease. If you fuse two, what happens? Is she going to be perfect after 2? No, she's not. There's something that's going to continue to take place. You know, she'll be in her mid-40s.

MR. HENRIOD: The point of that list, one of them under 16.1 is to tell you what items of future care are going to be --

MR. PRINCE: No, it doesn't.

MR. HENRIOD: -- [inaudible] at trial.

MR. PRINCE: It requires a computation. That means a numeric computation, not anything descriptive. It's simply a numeric computation. A computation means mathematical.

MR. HENRIOD: If it had said fusion surgery, section fusion surgery with the amount, that would have been enough for us to know where he was going. Certainly more meaningful than nothing, and that that was disclosed until last night, I think does not count as fair notice. And as we go back through the reports, the depositions, the treating notes, we don't see reference at all to -- to another fusion surgery in the future. I think that's a big difference between this and the Pizarro case where in Pizarro they said the late disclosure of the amount in that case didn't require a new trial.

THE COURT: Right.

MR. HENRIOD: A new trial, only because the fact of the surgery itself was clear before trial. And as a matter of fact, it was clear when they argued about it in a motion in limine. So --

THE COURT: Well, the difference is here I'm not letting in the cost, so --

MR. WINNER: Okay.

MR. HENRIOD: But as long as they can award for pain and suffering --

MR. PRINCE: Right.

MR. HENRIOD: -- for care. She's going to be in the hospital, it's going to require these other things, it may be another surgery. If it is pain and suffering related to care that is not substantiated, that's a problem.

MR. PRINCE: Well, it is substantiated. I'm laying the foundation for it.

MR. HENRIOD: If she's going to -- well, the problem is that the foundation you want to -- the foundation the plaintiffs want to lay has not been disclosed. No, I understand we can put somebody up on the stand and they can lay all kinds of foundations about things that have never been disclosed. Then discovery ceases to have its purpose.

MR. PRINCE: No, that's not what their objection is. They're objection was the -- to the cost. That was the

objection yesterday. I told the first jury what I was planning on doing, talked about the adjacent segment to now the second level, which is C4-5, and how that's going to affect Desire and will she eventually become surgical for that. And that's what -- that's what I plan to discuss.

MR. HENRIOD: I don't think this --

MR. PRINCE: Not the cost.

MR. HENRIOD: -- is a matter of mere sticker price.

(Pause in the proceedings)

THE COURT: I guess I'm still not clear how we went from a possibility in your opening, possibility of future surgeries, to now this doctor is coming in here and going to say 100 percent.

MR. PRINCE: Well, I wasn't saying. I said she's at real risk of -- more than likely, I said, she's going to go through this three times in her lifetime and she's at a very real risk of having three surgeries. So I know with the most certainty it's 100 percent she's having a C5-6. I'm saying there's a severe risk.

THE COURT: Well, I don't --

MR. PRINCE: I mean, I'm going to put on the evidence it's more like --

THE COURT: -- know that anybody can say anybody is going to have something for 100 percent certainty.

MR. PRINCE: Right. I don't --

THE COURT: She could choose not to, so --

MR. PRINCE: I don't have to -- I don't have to say something with certainty, Judge. I want to say here something from Dr. Garber's deposition as taken on April 14, 2018. The question was, my understanding is that in your opinion Ms. Evans has a 100 percent likelihood of suffering -- the likelihood of adjacent segment disease requiring future surgery.

Yes, I mean, we have an individual who at this point is 26 years of age. In the literature, there's literally almost a 30 percent chance that people require adjacent segments within the first 10 years, okay. The actual statistic is 25.9 percent or 26 percent. In fact, part of what I just presented in Toronto at the Society for Minimally Invasive Spinal Surgery meeting is related to the cervical spine and adjacent segment disease or breakdown.

Clearly, within the first 10 years, and if she's a young person, you can have adjacent segment breakdown can manifest up to 30 percent in the first 10 years. And that's an accepted statistic within the literature. And he assumed 2 percent, you know, even cumulatively, and she's got a 55-year life expectancy. That's actually 100 percent chance of developing adjacent segment disease. She's going to be more likely than not surgical by the time of her mid-40s. What happens after that? She's got another 40 years to live.

THE COURT: How old is your client?

MR. PRINCE: She's 28. She has another 55 years from now to live. That's her -- 54 years.

THE COURT: Right.

MR. PRINCE: So that's significant. When you're using the extrapolation numbers, I mean, the numbers are the numbers. He's saying you're only -- they're only asking about one surgery, but ultimately, when you fuse her again, now you've even increased risk because now she's have two levels fused. That risk doesn't go away. That's why I said in the first opening, she's a very real risk.

Can I say it's 100 percent certain? No. I can say it's 100 percent certain for the first one, and I'm going to say more likely than not for the second one, that's my very real risk language. I just didn't put up a cost number for it the first time. Because she is a real risk.

MR. HENRIOD: In that same deposition, 30 pages later after having made that same point, he talks about one surgery in the future.

MR. PRINCE: No.

MR. HENRIOD: In the context of that analysis we're on notice of one future surgery.

MR. WINNER: Page 50 and 51, quote, there are studies out there, and, again, that's why I have, you know, looked at different thoughts and put together, particularly

highlighted on this cost estimate, the 1 percent, 1 to 4 percent per year risk of developing adjacent segment disease. And so I used a 2 percent risk as sort of a, you know, midway point of percentage that -- and you couple that with her life expectancy, she's going to need an additional surgery in the future.

MR. PRINCE: Right. But that doesn't mean -- she's going to need that within 15 years, by her mid-40s. And so, you know, what about the other 30 years of her life or longer? Almost 40 years of her life. I mean, it doesn't end once you start this process.

So I get the cost factor, but in terms of her prognosis and what she can expect in the future medically and what she's going to go through and have to undergo the surgery and all of the -- have to go through all of the treatment and all of the workup and have the surgery and what those -- face those risks, that is part of her pain and suffering damages. I wouldn't even need to put any cost.

I don't have to -- I don't have to ask for any costs to have that. You don't have to have the medical costs in order to be able to present that evidence. And I think just by the numbers themselves and her age. It's not like you're dealing with somebody who is 60 -- 60 years old. You're talking about somebody who is in her mid-20s. And they're talking about statistical analysis that it's cumulative.

MR. HENRIOD: Well, I don't think it is that matter of fact, but if it is, then I think there is even less excuse for it not having been in the life care plan before and not disclosed as an item before now. It is not the mathematical probability of another surgery that I think plaintiffs want to paint for this jury. I think that that would be misleading. If it is his common sense, then I don't see why that was not disclosed to us as part of a plan for future costs. And it's not just, you know, price of those items and what we can surmise as being possible care in the future. We're entitled to that list of -- of items. And while you don't have to have special costs in order to pursue general damages, while I get that, I don't think you can get general damages for pain related to care, medical care, that you haven't proven is going to be necessary.

MR. PRINCE: Well, get ready to prove it. I can lay the foundation.

MR. WINNER: It wasn't disclosed.

MR. HENRIOD: Well, yeah, but to be able to prove it --

THE COURT: I missed --

MR. HENRIOD: -- you have to have disclosed it.

THE COURT: I missed what you just said.

MR. HENRIOD: Okay. So if the -- if the general damages, pain and suffering, are incident to care in the

future --

THE COURT: Right.

MR. HENRIOD: -- then you have to prove -- you have to prove that that care is going to be necessary and that it is related. And whatever that proof is going to be has to be disclosed during discovery.

MR. PRINCE: No, that's the part that's the -- as a treating physician, you don't have to make that -- you do not have to put that in a note or reporting or anything like that. We did say he's going to testify about future care needs for them. They've never objected to the manner in which he was disclosed. They were just saying, well, you didn't put it in -- you didn't go into enough detail.

Now it's like I'm not asking -- you told me I can't ask for the costs. I can still talk about what she's going to experience in her lifetime. That is part of her prognosis. That's part of prognosis and part of her future care. And physicians can testify treating physicians as to future care with no reports, none, as long as they formed the opinion during the course of their treatment.

THE COURT: Explain to me page 50 of the deposition.

MR. PRINCE: Okay.

THE COURT: Where the doctor says, the disc, when you fuse it at C6-7, the most likely disc to be then dysfunctional is at the C5-6 disc because -- blah blah blah.

This seems to say that there's just going to be one surgery.

MR. PRINCE: No.

THE COURT: Am I incorrect in --

MR. PRINCE: Yes.

THE COURT: -- reading it that way?

MR. PRINCE: Yes. He is talking about what are the factors for the adjacent segment. He's -- the adjacent segment is going to be a C5-6, not a C7-T1. You're not going to have a problem at C7-T1 because it doesn't move. He is really talking about where the -- where it's going to start first. Once you do 5-6, then 4-5 is going to become a problem. He's talking about the first surgery being at 5-6. It's not going to be at C7-T1. That's a level below. It's going to breakdown upward.

THE COURT: Where is -- where is the first surgery going to be?

MR. PRINCE: 5-6, it's going to go up, it goes up in levels, not down.

THE COURT: And where is the second surgery going to be?

MR. PRINCE: 4-5, just right above 5-6.

THE COURT: And where does it say that?

MR. PRINCE: There's no discussion about that in the deposition of 4-5. But it does, if it happens by the time you're in your mid-40s, I mean, that naturally is the

progression.

THE COURT: I don't know that it is.

MR. PRINCE: Just because they didn't ask that question doesn't mean he doesn't have that opinion.

THE COURT: Well, noted that's naturally the progression.

MR. PRINCE: Well, at her -- I guess her age, I mean, he's talking about, if you go to page 48, he's talking about somebody who is 26 years old and talking about statistical data. I mean, so you'd have that surgery in your mid-40s, you've got another 30-some years to live.

MR. HENRIOD: And this discussion is in the context of an explanation for why he thinks one is in the future. I think it is one thing to try to construe charitably treatment notes to say what's in there, but not expressed in detail, and we're going to give some latitude. That's one of the reasons why you can take depositions of doctors to try to get out more detail. Here we had an affirmative opinion that one was going to be necessary. We tried to flesh out the detail on that one by taking a deposition, and there was no discussion of it even in the deposition.

MR. PRINCE: Well, if you didn't ask.

MR. WINNER: And Khavkin saw her once and hasn't seen her since.

MR. PRINCE: Well, he's definitely going to talk

about -- he’s going to definitely talk about the need for C4-5. Absolutely.

THE COURT: When was the last time he saw her?

MR. PRINCE: Who, Dr. Garber?

THE COURT: Uh-huh.

MR. PRINCE: A couple weeks ago.

MR. WINNER: No.

MR. HENRIOD: We haven’t seen that treatment.

MR. PRINCE: He just wanted to see her before he came to court to see how she was doing. He didn’t write any treatment or any recommendations. He can't do any work because she’s pregnant.

MR. HENRIOD: Then that wouldn’t be treatment. I think that it would be incident to litigation.

MR. PRINCE: Right. She asked when the last time he saw her was.

MR. HENRIOD: Oh. Pardon me.

THE COURT: When is the last time he saw her for treatment?

MR. PRINCE: 2017.

THE COURT: Then you told me earlier that the first time you heard the second surgery might be required was the other week -- a couple weeks when you were getting ready for trial.

MR. PRINCE: No. I knew it was, and I kind of more

definitively was exploring the options and how going and using the statistical data, I used it during my first opening statement, so I guess I knew it before then.

THE COURT: Well, I specifically -- that was the first question I asked when I took the stand was -- the stand, whatever this is I'm sitting on, was when did you first become aware there was going to be a potential second surgery. You said before the first trial --

MR. PRINCE: Right.

THE COURT: -- in preparation for that trial, which was months ago here in 2019.

MR. PRINCE: Okay.

THE COURT: And my point, obviously, is I understand that treating physicians can do the future care prognosis, whatever it is without it being in a report, but my concern is that it's so far removed from the treatment that I'm not convinced that it -- it is any longer.

MR. PRINCE: Well, and --

THE COURT: And that's what I'm struggling with. Having said that, I also understand that certainly part of the argument has been that she's going to potentially have issues down the road, and I think that's all been out there. I really think it's much ado about nothing, quite frankly, but --

MR. PRINCE: I mean, she's going to experience those

issues. Whether you're talking about her risk, did she have a risk for surgery, yes, I mean, what about the risk levels.

THE COURT: But that's all -- that's all coming in with respect to the first surgery, so I'm not really sure why it's so necessary for the second surgery. And if it was, I don't know why we didn't get it out there earlier.

MR. PRINCE: It's just part of -- I feel it's just part of the natural progression of this whole disease. Once you fuse it again --

THE COURT: And I'm fine with the natural progression of the whole disease. My problem is with the second surgery that was never really given notice on, and then was kind of sprung up in the opening in this case.

MR. PRINCE: How -- I didn't -- they said nothing about it the first time, I --

THE COURT: But you didn't -- you didn't -- I mean, you didn't highlight it.

MR. PRINCE: Well, I did highlight it. I said those words; right? I mean, that's what I said. I said -- I used saying $3 million. She's going to go through this three times in her lifetime. What else could you say?

THE COURT: Weren't you only 2 million the first trial?

MR. PRINCE: I don't know.

THE COURT: I think you were 2 million. Because I

remember --

MR. PRINCE: Well, whatever it is. I mean --

THE COURT: -- going, gosh, I --

MR. PRINCE: -- I said great -- more than, I said more than. So I don't -- I wouldn't limit myself.

THE COURT: Well, yeah, more than, but I think your -- your slide was more than 2 million this one --

MR. PRINCE: I'm pretty sure I asked for 3.

THE COURT: -- and more than 3 on this.

MR. PRINCE: But what is -- I'm asking for in the millions.

THE COURT: That's a lot of money.

MR. PRINCE: Absolutely. 100 percent it's a lot of money. I'm asking for a lot of money. But I told them she's going to go through this three times in her lifetime. What more -- I felt that was clear with that, that it's likely she's going to have another surgery. I don't know how much more I can say it. I guess that's how I felt comfortable saying it.

MR. WINNER: I took it to mean she was likely to have another surgery, as had been disclosed by Dr. Garber.

MR. PRINCE: No, I talked about three times and I quoted the language.

THE COURT: All right. I'm going to take 10. I wanted to watch a JAVS. Take 10. Apologies to the jury,

please.

THE MARSHAL: You got it.

THE COURT: Thank you.

THE MARSHAL: No problem.

(Court recessed at 3:13 P.M., until 3:39 P.M.)

(Outside the presence of the jury)

THE COURT: All right. Here's my decision. The doctor will not be able to opine that there's going to be a third surgery necessary. He can opine generally speaking, fusion leads to fusion. I mean, that's kind of out there. But in terms of I don't see this as treating physician stuff, I think it is disclosure.

I've already said that I don't think the computation comes in, I think, to let the third surgery in. I don't see how the defense can undue the fact that there was a price tag for the third surgery. I don't think it's as definitive as everyone else. I think the doctors really would be testifying if he were to do that more as an expert than a treating physician based upon all of the information and, therefore, it should have been disclosed and it was not disclosed.

So you can get in generally speaking years down the road, this whole process could start over again, fusion leads to fusion, but not beyond a medical degree of certainty or whatever she's going to get a third surgery.

MR. PRINCE: Right. Just so I'm clear, we can talk

about after she has the first adjacent segment surgery, that that will lead to a breakdown and the process will generally start over again and what the process --

THE COURT: Not for her, but potentially when you have a fusion it could lead to a fusion and things could happen and start over again, yes.

MR. PRINCE: Well, what --

THE COURT: But not specifically to her. Like I said, I don't think you need it. I don't think either side of you needs it. I think you got what you need, but that's my ruling. So fusion leads to fusion on a general basis, not opining that she's going to need a third surgery. And then you guys go wherever you need to.

MR. WINNER: And for Mr. Prince's benefit, stated in consistent with Dr. Garber's letter, I might have other objection to it, but I don't object to --

MR. PRINCE: Well, he's going to say with 100 percent certainty she's having one. And I'm going to say after that surgery --

THE COURT: That's between you two. And then if you open the door further, we'll deal with that later --

MR. PRINCE: And then I'm going to ask --

THE COURT: -- but that's where we are now.

MR. PRINCE: -- about the disease process starting over again.

THE COURT: You can say that.
MR. PRINCE: Okay. And then what the --
THE COURT: Generally speaking, it could start over again.
MR. PRINCE: Well, not -- it isn't generally speaking. It does happen in every -- it’s what it does. So, okay, I got it. Okay.
THE COURT: Bring in my poor jury if they didn’t leave. Let’s plan to break at 4:45, please.
MS. LORELLI: A break at 4:45?
THE COURT: 4:45.
MS. LORELLI: For the day; right?
THE COURT: I’d like to do the week, but 4:45.
(Inside the presence of the jury)
THE COURT: Counsel approach.
(Bench conference)
THE COURT: Obviously, if you're close to finishing at 4:45 we’ll finish, but if you're not close to finishing. Okay?
MR. PRINCE: Okay.
THE COURT: Because sometimes when I say by a certain time it ends up going a lot longer. So if I say 4:45, then we should be done by 5:00.
MR. PRINCE: I just don’t know. This is a little more critical witness. I understand. I’ll do my best.

MR. WINNER: I didn’t hear what you said, Judge.
MR. PRINCE: He may have to come back tomorrow. So I'm going to do my best to get it done.
THE COURT: I don’t expect you to finish him --
MR. PRINCE: I don’t, either.
THE COURT: -- by 5:00.
MR. PRINCE: No.
THE COURT: That’s why I want to break at 4:45 because what’s 15 minutes more to come back tomorrow?
MR. PRINCE: Oh my god. It’s going to be a big cost bill again.
THE COURT: Well, if we go to 5:00 is that going to be --
MR. PRINCE: No.
THE COURT: -- less of a cost?
MR. PRINCE: No. No, I'm saying --
MR. WINNER: You can't be done by 5:00 --
THE COURT: I mean, if you all --
MR. WINNER: -- either, you don’t think?
THE COURT: -- want to keep this a nice, straight, easy trial for me, you know --
MR. PRINCE: I understand. Okay. We’re ready.
MR. WINNER: So 5:00.
(End of bench conference)
THE COURT: Welcome back, and I'm sorry, folks. We

were working, for whatever that's worth.

MR. PRINCE: Okay.

THE COURT: Okay.

MR. PRINCE: Your Honor, we call Dr. Jason Garber.

DR. JASON GARBER, PLAINTIFFS' WITNESS, SWORN

THE CLERK: Please state your first and last name, and spell your full name for the record.

THE WITNESS: Jason Eric Garber, J-a-s-o-n E-r-i-c, Garber, G-a-r-b-e-r.

THE CLERK: You may be seated.

DIRECT EXAMINATION

BY MR. PRINCE:

Q And, Dr. Garber, good afternoon. What is your area of medical specialty?

A Neurological surgery.

Q And can you please describe for us what a neurological surgeon is and what a neurological surgeon does and the nature of your specialty?

A Yeah, so a neurological surgeon treats patients with problems of the brain and spine. And so what I usually do is take care of patients that may have problems, either whether it's brain tumors, spinal problems. On top of my training as a neurosurgeon, I did a minimally invasive and complex reconstructive spinal fellowship after my residency prior to making Las Vegas my home.

Q Okay. And where did you go to college, sir?
A Duke University.
Q And where did you go to medical school?
A University of Texas.
Q Okay. And after you completed your course work at University of Texas, you go onto a residency?
A Yes, sir.
Q In what area?
A Neurological surgery residency at Baylor College of Medicine in Houston.
Q Okay. And is your dad also on faculty there [indiscernible]?
A Yeah, a professor of endocrinology there.
Q All right. So you come from a family of doctors?
A Yes, sir.
Q And after you completed -- how many years was your residency and neurosurgery?
A The residency at the time at Baylor was six years because of how busy it was and the volume and the hospitals that you rotated through. So we rotated through Ben Taub County Hospital, M.D. Anderson Cancer Center, Texas Children's Hospital, the Veteran's Administration Hospital, Methodist Hospital and so forth. And so it was a six-year program.
Q And the focus of a neurosurgeon's residency is on what? What do you focusing on in terms of the anatomy of the

body that you were treating?

A Sure. So whether they're injuries or problems or pathologies that may afflict the brain, whether it’s brain tumors, aneurysms, trauma to the brain, at the same time problems with the spine, whether they're injuries sustained in accidents, whether it’s spinal stenosis, disc herniations, and then trauma, fracture, dislocations, and so forth.

Q Do you deal with nerve related issue associated with spine and spine structural problems?

A Yes.

Q Is that a focus of neurosurgery?

A Yes. Basically dealing with the neural anatomy with respect to the spine and the brain and the pathologic problems that may come with that.

Q Are you board -- now, you indicated you also did a fellowship after you completed your residency of six years; is that right?

A Yes.

Q And where -- what was -- where did you complete that fellowship training?

A Medical college of Wisconsin.

Q Okay. And what was the purpose of going for this additional training after you completed your six years of neurosurgical training?

A So I was fascinated with the spine. My interest is

spine. The majority of my practice at this point is spine. And one of the nice things about Medical College of Wisconsin, it's one of the few places that has a very well known spine program, certainly at the time, that has a crash test dummy site. And so I was able to do research on injuries sustained to individuals with respect to the cervical, thoracic, and lumbar spine. And so I enjoyed that. I did research in that. And I also got additional training in complex and minimally invasive spinal surgery techniques.

Q Okay. And are you board certified?

A Yes.

Q Okay. In the area of neurosurgery?

A Yes.

Q Okay. And do you have hospital privileges here in Las Vegas?

A Yes.

Q And what hospitals do you have privileges at?

A Mountain View Hospital, Centennial Hills Hospital, San Martin Hospital, Spring Valley Hospital, UMC Hospital. I think that's about it.

Q And we're going to be talking about a traumatic injury to the spine of, with regard to your care, of Desire Evans-Waiau. Doctor, since you moved to Las Vegas and been practicing in Nevada, have you taken calls and treated patients at the UMC trauma facility who have suffered spinal

injury and required neurosurgical either treatment or surgery?

A Yeah, so as part of our practice, I covered Level 1 trauma at UMC Hospital from 2002 until basically January of 2010. And so every night I would be on essentially for every fourth night call. So I would cover UMC Level 1 trauma for injuries sustained to the brain or the spine and whether they required immediate treatment, or if other individuals needed to follow up with me for after their injuries and determine as to whether or not additional treatment would be necessary thereafter.

Q In your field of expertise, Dr. Garber, have you published -- I know you're in -- you're in private practice?

A Yes.

Q Have you published articles in various journals in your area of specialty?

A Yes.

Q Okay. Have you -- do you -- do you lecture in your area of specialty?

A Yes.

Q How frequently do you lecture in your area of medical specialty?

A More frequently now than I have in the past. I mean, I -- to be quite frank with you, when I moved to Las Vegas, I met my wife, I have three boys, and so a lot of my time outside of my private neurosurgical practice is raising

my boys. I have three boys. And so now that my boys are older, I spend more time doing a little bit more clinical research. I recently presented at the International Society for the Advancement of Spinal Surgery in Anaheim in April. I had a paper just accepted to the Congress of Neurological Surgeons in Mexico for their national meeting coming up in July. I have a paper accepted at the North American Spine Society meeting coming up in Chicago in September, as well.

Q Will you be speaking at those -- those events?

A Yes.

Q Okay. And in addition to your training, do you have -- do you have ongoing training in the area of neurosurgery, do you go to meetings and lectures or other areas to kind of keep current?

A Yes. Neurosurgery is a lifelong pursuit of learning. It really is. And it never stops with techniques that you learn, because there can always be evolution of techniques in my field.

Q Okay. And have you qualified as an expert in the area of neurosurgery here in Las Vegas before?

A Yes.

Q As an expert witness in a courtroom?

A Yes.

Q What -- I mean, one of the things that Mr. Winner talked about was, you know, people doing medical legal work.

What percentage of your work is involved in medical legal work or treating people who have been involved in any kind of injury accident?

A 15 percent.

Q Okay. So it's a small percent?

A Yes. The majority of my patients that I see are referred to me from family and friends of people that I have treated and I have operated on. Following that would be referrals from primary care physicians, internal medicine, physiatry, neurology, and so forth. After that would be worker's compensation patients injured on the job. Lastly would be, again, 15 percent personal injury.

Q Okay. When you're asked to serve as an expert witness in personal injury cases, do you do work also on behalf of the defense?

A Yes.

Q How frequently do you do that? What percentage would you estimate between the plaintiff or versus the defense?

A I think the breakdown would be 60 percent plaintiff, 40 percent defense. And quite frankly, one of Mr. Winner's partners I have recently done work with as an expert in the defense field for his firm.

Q How recently was that?

A February 2019.

Q Okay. Now, have you had an opportunity, and in this case we'll be talking about Desire Evans. Have you had an opportunity to review her medical and billing records, deposition, and expert reports following the October 30, 2015, motor vehicle crash?

A Yes.

Q That's in addition to being a treating physician and performing surgery on her in September of 2016?

A Yes.

Q Okay. And did you form an opinion as to what -- what injuries Desire suffered as a result of the October 30, 2015, motor vehicle collision?

A Yes.

Q What -- what are those injuries, Doctor?

A So it was my opinion that she sustained a traumatic disc protrusion at C6-7, causing ongoing and persistent radiculopathy or pain down the left arm, which failed conservative management, ultimately requiring surgical decompression and stabilization at the level of C6-7 in her cervical spine or the neck.

Q Okay. And did she suffer any other injuries other than the structural injury to the C6-7 disc, did she suffer any other injuries?

A I believe she may have had some lumbar spine discomfort, as well. But more importantly, as I recall, she

also had an injury to her left shoulder.
Q Okay.
A And so --
Q Okay. What injury was that?
A I believe she had a bone contusion that I can recall in the left shoulder.
Q Right. We're going to be talking about that.
A Did she also suffer soft tissue injuries to the soft tissues of the neck and the -- and the back?
A Yes. And so in conjunction with the most significant thing being the traumatic disc protrusion at C6-7, cervical sprain-strain in conjunction with that with paraspinal spasms with that, as well.
Q Okay. Is it common if someone is involved in a motor vehicle collision to -- to -- having a structural injury, to also have a soft tissue component to the muscles, tendons, and ligaments?
A You can certainly have that, yes.
Q And do you, as a neurosurgeon, do you do any invasive treatment for soft tissue injuries like reconstructive spinal surgery like you did on Desire?
A Certainly not for soft tissue injuries, sprains or strains, absolutely not.
Q Okay. And when you were forming your opinions in this case on the -- what the cause of Desire's injuries were,

did you consider the clinical correlation of all of the available data and information which includes patient history, exam findings, response to treatment, diagnostic imaging, and other testing such as testing from Dr. Rosler?

A I believe I did, yes.

Q Okay. And why is history such an important function of not only neurosurgery, but medicine generally?

A Well, I think it's important to obtain, you know, an understanding of what was the reason the patient has come to see you? What is the problem they're coming to see you for, what is the location, the quality, the quantity, the timing, the setting, what exacerbates, what alleviates those types of symptoms that patients come to see me with?

Q Is that true, you're a neurosurgeon or you're a primary care doc, do you come in with a cold or a flu?

A Well, as a neurosurgeon you have to really look at everything. And more importantly, certainly with respect to what I see and with respect to Desire, it's to determine what injuries were sustained with the accident and what can I do to help her.

Q Okay. Now, Desire came to see you on October -- it's like July 12, 2016. Your records are in front of you. They're Exhibit 50. They've already been admitted into evidence. And you saw her on July 12, 2016.

MR. PRINCE: Bates No. 676, Brandon.

THE WITNESS: Yes.

BY MR. PRINCE:

Q Okay. And who referred Desire to you?

A I believe Dr. Rosler did.

Q Okay. Is Dr. Rosler someone who you refer patients to?

A Yes. Dr. Rosler refers me patients and I will send patients to him, as well.

Q Okay. And one of the other doctors in this case, the defense doctor, is Dr. Schifini. Joseph Schifini is a pain management doctor. Do you ever work with Dr. Schifini, the defense expert in this case?

A Often, yes.

Q And does he refer patients to you?

A Yes, he does, and I send patients to Dr. Schifini.

Q What types of patients?

A It could be both patients they refer to me or from either primary care or from friends and family of people that I have treated. But I've also seen a large number of patients that have been injured in worker's compensation injuries that Dr. Schifini and I both mutually treat.

Q Okay. And do you rely upon injection therapies provided by Dr. Schifini in making surgical decisions for your patients?

A Yes. I mean, Dr. Schifini is an excellent pain

management doctor who provides reliable information for me to aid me in helping treat patients. And, ultimately, if conservative management fails, render a surgical decision if necessary.

Q And in this case, Dr. Rosler, do you rely upon his data from -- you know, results from his injection therapy he may provide patients in making surgical decisions and recommendations to your patients like you do Dr. Schifini?

A Yeah. Dr. Rosler is an equally excellent interventional pain management doctor that I have quite reliable results that he provides me, as well as Dr. Schifini, in taking care of patients that have sustained injuries, as in the case of Desire, as a result of accidents.

Q All right. Now, let’s look at your -- the history that -- I mean, how -- when Desire presented to you. Let’s go to July 12, 2016.

A Yes.

Q And what -- what -- when did she tell you that her symptoms started?

A Well, her symptoms began after a motor vehicle accident 10/30/2015.

Q Okay. And what did she tell you what happened in that motor vehicle collision?

A So she was a restrained driver of an automobile that was attempting to make a turn. She stopped for a pedestrian

that was crossing and she was rear-ended by another vehicle.

Q Okay. Have you looked at the photographs in this case?

A Yes.

Q Okay. And as the description that Desire is describing, being struck in the rear, is that consistent, that mechanism consistent with her onset of symptoms and her complaints?

A Yes, the 1998 Silver Honda Accord that she was driving had impact to the rear bumper. The hood was -- the trunk was dislodged, and the rear driver quarter panel was indented and crumpled in, as well. What hit her, I believe, was a 2014 Acura MDX in burgundy, which had, I would say, moderate to significant front-end damage, as well, which would be consistent with a rear-end collision to the rear of Desire's automobile.

Q Is a neck -- is the cervical spine, is it vulnerable to injury in a rear-end collision?

A Yes.

Q Tell us why.

A What can happen is, and if an individual is turning, the neck can be susceptible to hyperextension, hyperflexion type injuries. Now, in conjunction if someone is somewhat turned, or if they're making a turn, you can also have axial rotation with hyperflexion extension that can also cause

injuries to the cervical spine, as well. So there's multi-factorial things based upon accidents that can occur, and certainly in the case of Desire she had an injury to her cervical spine in my expert opinion, particularly at C6-7.

Q Okay. Now, what were her complaints when she came to see you on July 12, 2016?

A She had neck pain, intermittent lower back pain, the neck pain was worse, with radiation into her left upper and some lower extremity pain, as well. But she specifically stated that her cervical spine, to my understanding, was worse than her lumbar complaints.

Q The focus of your treatment was on her low back or her neck?

A Cervical spine. Neck.

Q Yeah. And in addition to the neck pain, was it concerning to you that she had ongoing pain and numbness radiating into her left arm and to her hand?

A Yes. Frank radiation of pain, which is important, that goes down the arm, into the hand, is consistent with a radiculopathy. Now, generalized paraspinal pain --

Q What is that? What's paraspinal pain?

A Pain localized to the neck without radiation beyond, say, the shoulders or between the shoulder blades is less concerning for radiculopathy and more so concerning for a cervical sprain or strain.

Q Okay. So to -- in this case, what is a radiculopathy? I wanted to have them learn from you as a neurosurgeon. What is a radiculopathy and what are the things your -- and how do you diagnose that?

A Sure. So a radiculopathy is nerve root irritation caused by some pathologic problem. So as the nerve root exists the spinal sack and from the spinal cord --

Q If you need the spinal model, I have it here. I'm going to put it by you in case you want to use it for any demonstration.

A May I stand up and come down?

Q You can. Please do.

THE COURT: Can you hear him over there?

MR. PRINCE: I'll have the -- I'll hold the microphone.

THE COURT: Okay. Thanks.

THE WITNESS: I've never had a problem talking -- talking quietly. I'll do my best. If you have any problems, please let me know.

MR. PRINCE: I'll hold the microphone.

THE WITNESS: So what we have is we have the spine. And within the cervical spine, the spinal cord itself would be the yellow tubular structure in the center. And what comes out of that are the nerve roots. So, for example, this is C2, C3, C4, C5, C6, and 7. So we can see nerve roots come out.

Now, in between the vertebral bodies, these little jelly looking things are discs.

Now, what can happen in an accident is the disc can be injured. Now, how is that? The outside of a disc has the consistency of corn husk material. The inside nuclear material has the consistency of wet crab meat, if you will. And so if a disc is injured and torn, a portion of that material can herniate out, producing pinching of the nerve as it exits the foramen where the holes where the nerves come out. Does that make sense?

BY MR. PRINCE:

Q Okay.

A Did I explain that [inaudible]?

Q Yeah. And so as you're talking about radiculopathy, does that mean that the nerve root is irritated, emanating somewhere from the disc?

A It is my opinion based upon, you know, obviously my discussions with Desire, my review of the records, and reviewing the injections that were subsequently done after her initial injury that she had nerve root irritation as a result of a disc at C6-7.

Q Okay. And did she talk to you about the treatment that she received before coming to see you on July 12?

A Yes.

Q Okay. Did you also have the benefit of those

medical records in your chart of the prior treatment with Dr. Rosler, the chiropractor, as well as Dr. Khavkin, who is another neurosurgeon?

A Yeah, I would have had whatever records were provided to me with the referral.

Q Okay.

A And I would have reviewed them accordingly.

Q All right. And do you believe that it was reasonable for Desire to receive the chiropractic care that she received?

A I think that's reasonable.

Q Have you reviewed the defense expert reports in this case, Dr. Wang and Schifini?

A Yes.

Q Are they critical at all of the chiropractic care and the care she underwent from the chiropractor?

A I think they thought it was reasonable for conservative treatment.

Q Okay. So even though if a lawyer sent her there, the chiropractic care was reasonable and appropriate?

A I don't think that was inappropriate at all.

Q Okay. Now, what sort of treatment did she have with Dr. Rosler that was significant to you clinically?

A So Dr. Rosler performed C7 selected nerve blocks two separate times. The first in January of 2016, and the second

in April of 2016, from my recollection. And so a C7 nerve block on the left side was performed two separate times. Both times her pain reduced from an 8 to a zero, effectively. So it's both diagnostic and therapeutic for the patient. We know, based on those results, that there is a disc protrusion. We have certainly identified that on MRI.

But in conjunction with that, a selective nerve root block serves both diagnostic and therapeutic purposes here on the left. Because it temporarily alleviated the pain, but it also solidified in my mind the identification of the pathologic level for which Desire was symptomatic necessitating treatment. And if, indeed, she failed continued conservative treatment, surgical intervention, in my expert opinion, was indeed warranted.

Q Right. Before she came to see you, she saw -- are you aware that she saw also Dr. Khavkin?

A I believe so, yes.

Q In May of 2016. He recommended a two-level cervical spine fusion to her.

A Yes. So for the sake of being complete, aside from a disc protrusion or herniation, so I use protrusion or herniation synonymously or they're the same, interchangeable. She had a disc bulge, in my opinion, at C5-6. Now, at 25 years of age when I saw her, I'm very conservative to begin with. I've had back surgery myself. I don't want people to

have any more than they need. And so surely what I felt is that she was symptomatic at the C6-7 disc, which clearly was alleviated with the injections on a temporary basis. And that's the level that I wish to fix. Now, I don't certainly fault Dr. Khavkin for recommending an ACDF C5-6 and C6-7. It's just a difference of opinion respectfully.

Q Right. So before -- so you're functioning, when you see her in July of 2016, you're really in a second opinion sort of consultation initially?

A Would you repeat that, please?

Q You're -- you're -- she seeking a second opinion from you --

A Yes.

Q -- for a neurosurgical consultation?

A Yes. And, again, I encourage people, if they wish, to seek a second opinion.

Q Right.

A And certainly at her young age, you know, that's -- that's perfectly indicated.

Q And you indicated that you believe that she suffered a traumatic disc herniation at C6-7 as a result of this crash for which she needed treatment and ultimately surgical intervention. Have you been able to rule out that before October of 2015 that she had any prior medical history that would cause or contribute to the need for that surgery?