Case No. 79424

~~~~~~~~

IN THE SUPREME COURT OF THE STATE OF NEVADA

Electronically Filed
Apr 23 2020 02:28 p.m.
Elizabeth A. Brown
Clerk of Supreme Court

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
VOLUME 5
PAGES 1001 – 1250

DENNIS M. PRINCE
Nevada Bar No. 5092
KEVIN T. STRONG
Nevada Bar No. 12107
PRINCE LAW GROUP
10801 W. Charleston Boulevard, Suite 560
Las Vegas, Nevada 89135
Attorneys for Appellants
~~~~~~~~

CHRONOLOGICAL TABLE OF CONTENTS TO APPENDIX

15	Recorder's Transcript of Proceedings Jury Trial – Day 9	05/28/2019	6 7	1278-1500 1501-1583
16	Recorder's Transcript of Jury Trial – Day 10	05/29/2019	7	1584-1750
17	Recorder's Transcript of Jury Trial – Day 11	05/30/2019	8	1751-1975
18	Trial Brief to Strike Defense Medical Expert Witness, Joseph Schifini, M.D.'s Testimony	05/30/2019	8	1976-1984
19	Recorder's Transcript of Jury Trial – Day 12	05/31/2019	8 9	1985-2000 2001-2195
20	Jury Instructions	06/03/2019	9	2196-2248
21	Recorder's Transcript of Jury Trial – Day 13	06/03/2019	9 10	2249-2250 2251-2391
22	General Verdict for Defendant	06/03/2019	10	2392
23	Notice of Entry of Judgment Upon Jury Verdict	07/15/2019	10	2393-2396
24	Notice of Appeal	08/14/2019	10 11	2397-2500 2501-2546

ALPHABETICAL TABLE OF CONTENTS TO APPENDIX

08	Recorder's Transcript of Hearing: Jury Trial – Day 5	04/26/2019	1	77-238
16	Recorder's Transcript of Jury Trial – Day 10	05/29/2019	7	1584-1750
17	Recorder's Transcript of Jury Trial – Day 11	05/30/2019	8	1751-1975
19	Recorder's Transcript of Jury Trial – Day 12	05/31/2019	8 9	1985-2000 2001-2195
21	Recorder's Transcript of Jury Trial – Day 13	06/03/2019	9 10	2249-2250 2251-2391
15	Recorder's Transcript of Proceedings Jury Trial – Day 9	05/28/2019	6 7	1278-1500 1501-1583
09	Trial Brief Regarding Defense Counsel is Precluded From Stating or Implying Plaintiff Should Not Have Insisted an Officer Should Come to the Scene for a Report	05/13/2019	1	239-244
18	Trial Brief to Strike Defense Medical Expert Witness, Joseph Schifini, M.D.'s Testimony	05/30/2019	8	1976-1984

A It was my understanding there was no ongoing treatment for cervical spine symptoms or radicular symptoms prior to the accident in question that was requiring ongoing treatment. I just didn't see that.

Q Did you review the medical records from Desire's accident in 2010?

A Yes, I did.

Q Okay. And based on those medical records, have you been able to eliminate the 2010 accident as anybody contributing to the need for her surgery that you performed?

A Yeah, absolutely. We have -- if we look at the records provided from the 2010 treatment that was provided as a result of an accident, the pattern of pain distribution in her diagram with respect to her neck was isolated strictly to her neck and the back of her head. There was absolutely no radiation down her arm.

Q Okay. Well, let's -- let's show that --

MR. PRINCE: Brandon, we've got to use the split screen. Let's go to 950. We're going to use -- we're going to use part of Exhibit 81, which is Bonanza Back Center. Exhibit 950.

THE WITNESS: So 950?

BY MR. PRINCE:

Q We're going to put it on the monitor.

A Oh, okay. Sorry. Thank you.

Q And what I'm showing you now is the pain diagram from June 10 -- June 16, 2010. Do you see that?

A Yes.

Q Was that significant to you, the diagram of the pain?

A Well, that, to me, is -- is clearly consistent with a cervical sprain or strain because you can also have radiation into that suboccipital region on the back of the head. There was absolutely no radiation down the upper extremity on the pain diagram that I can see there.

Q Okay. I want to compare that to the diagram from a chiropractor facility that -- that she saw on November 2, 2015. Bates No. 150. Is that, in your opinion, a significantly different diagram and presentation?

A Yes. A little fuzzy, and I apologize, on my screen --

Q You can maybe even stand up here. If you feel like standing up, you can do that.

A Thank you. Sorry. It’s a little fuzzy on my screen. But we clearly have, as I've said, it’s my expert opinion with -- with great certainty, we have isolated cervical spine being shaded, and it’s at the back of the head. That, to me, indicates clear cervical sprain or strain. What we have, however, now after this accident is a manifestation or the origin of a cervical radiculopathy, pain radiating down

the arm as a result of this accident in question.

Q Okay. Let me show you the -- the -- I'm going to show you a pain diagram from Dr. Rosler from December 16, 2015.

MR. PRINCE: Brandon, just highlight just the top of that.

THE WITNESS: Yes. And so we have from Dr. Rosler's pain diagram --

MR. PRINCE: Go ahead, Brandon.

BY MR. PRINCE:

Q I'm going to have him just --

A Oh, I apologize.

Q He's going to make it smaller.

A Awfully fancy.

Q It is. Perfect.

A So, again, for me, there's clear differentiation between what I certainly in my expert opinion believe to be a cervical sprain here in 2010 and the manifestation of radiculopathy down that upper extremity in conjunction with what looks to be shooting pains. No shooting pains in 2010.

Q Okay.

A Numbness and tingling down to the extremities, as well, in the fingers.

Q Okay. And if you look at the scoring here on June 6, 2010, is there any pain into the arms or wrists or hands?

A No, none whatsoever. This, again, serves to reinforce this. And then not to -- to get ahead, I'm sure, of where we're going. The important thing to also understand is an MRI was performed back in 2010.

Q Right.

A And the MRI performed in 2010 was stone cold normal.

Q Okay. Let's -- I'm going to put that up there for us.

A Okay. [Indiscernible].

Q Yeah, that's fine.

MR. PRINCE: 955, Brandon. Just -- just the one screen. Okay. All the way down to impression.

BY MR. PRINCE:

Q Okay. When you say stone cold normal, what do you mean by stone cold normal?

A So that's -- that's --

MR. WINNER: May I object for a moment --

THE WITNESS: -- the technical term. No, I'm kidding.

MR. WINNER: And voir dire the witness on this, please, Your Honor.

THE WITNESS: I'm sorry, sir?

THE COURT: Approach.

MR. WINNER: I'd like to object and voir dire the witness for a moment, Your Honor.

MR. PRINCE: On what?

THE COURT: Just what voir dire?

(Bench conference)

MR. PRINCE: He’s trying to interrupt. He shouldn’t be making any speaking objections. Voir dire the witness.

THE COURT: What do you want, Mr. Winner?

MR. WINNER: He hasn’t seen the prior MRI.

MR. PRINCE: He’s talking --

THE COURT: He hasn’t?

MR. PRINCE: He’s talking about the -- he has seen this before, he has seen this record before. Oh, yes, he has.

MR. WINNER: The films?

MR. PRINCE: We don’t have the film. We don’t have the film.

MR. WINNER: That’s my point. He’s never seen the film, so now I ask him.

MR. PRINCE: Okay. Whatever. I'm going to ask him myself. The films aren’t even available. We don’t have -- there’s no films available. He needs to interpret it as normal.

MR. WINNER: There’s going to be a spoliation motion about this and --

THE COURT: There's going to be a what?

MR. WINNER: A spoliation motion about this. I do want to ask him if he’s actually seen the films.

MR. PRINCE: He can't ask that right now. He can only cross-examine him. He can do it in his cross. He’s not going to interrupt me right now to cross-examine this. I’ll ask him.

MR. WINNER: Well, in response to your question, he said the 2010 MRI was stone cold normal.

MR. PRINCE: Judge, you don’t -- you don’t get to cross -- you don’t get to like stop and ask questions during my cross-examination.

MR. WINNER: And we don’t get to mislead the jury with your questions and his answers.

THE COURT: Well, then, I feel like it’s pure cross-examination.

MR. PRINCE: Right.

THE COURT: Am I missing something?

MR. WINNER: The doctor just said the 2010 MRI --

THE COURT: Was stone cold normal.

MR. WINNER: Was stone cold normal. Correct.

MR. PRINCE: Your doctors are saying the 2013s are normal.

MR. WINNER: That’s exactly right and that’s my point.

MR. PRINCE: Oh, okay. Okay.

THE COURT: So isn't that a cross-examination? So it was stone cold normal, the truth is you never even saw it.

Isn't that how that goes? I don't -- I've never heard of --

MR. WINNER: Nobody has seen the 2010 MRI. We requested it for years. By the time they finally responded to us, they said we can't find it anymore, it's been seven years, but here's a report saying it's normal. We can't see those films. Nobody has seen those films.

MR. PRINCE: Okay.

MR. WINNER: Those films have been in the plaintiff's possession, or available to them --

MR. PRINCE: No, they're not.

MR. WINNER: -- for five years.

THE COURT: Did you file something on that?

MR. WINNER: What's that?

THE COURT: Did you file something on that?

MR. PRINCE: No, never.

MR. WINNER: Yeah, there's a spoliation brief coming on that.

MR. PRINCE: No, you never filed anything.

THE COURT: I said did you.

MR. WINNER: Yeah.

THE COURT: And you said, yes, it's coming. I'm going to overrule it. I think it's cross-examination.

MR. WINNER: Thank you.

(End of bench conference)

//

BY MR. PRINCE:

Q All right, Doctor. Those films aren't available, but looking at this report.

A Okay. So --

Q Is there any abnormality seen by this radiologist who read this film?

A The first thing I will give you is the clinical that they were presented with is a 19-year-old female, neck pain. No arm pain, no nothing else, number one. Number two, normal cervical cord, normal visualized soft tissue structures, impression, normal, unenhanced MRI of the cervical spine.

Q Okay. So is there any abnormality seen on any level of the slide in that MRI according to this radiologist?

A Nothing noted on the report.

Q Okay. How about specifically we're going to be talking about C6-7. It says normal disc hydration, morphology, normal bilateral uncovertebral facet joints, normal bilateral. Anything -- is that just -- is that normal? Is that pristine for a 19-year-old person according to that read?

A Within the report there is absolutely nothing abnormal, particularly with regard to the C6-7 disc that then, in my expert opinion, becomes injured after the accident of October 30, 2015.

Q Okay. Does at least this report support your

position and your opinion that the disc herniation or protrusion as seen in this case in C6-7 was traumatically caused as a result of the October 30, 2015, collision we're here talking about?

A Yes, it serves to reinforce the fact that despite being a remote history of an accident in 2010, no structural abnormalities were identified. The patient had whatever treatment conservatively, and it resolved.

Q Right. There was one doctor, a medical doctor who said there is possible radiculopathy in one of the treatment records. Do you remember -- do you recall seeing that?

A I believe that was used as a diagnostic took by that doctor.

Q Let's look at Bates No. 958, which is actually -- well, let's look at 957 to get the date of that. That -- that MRI was July --

A Was it June 16, 2010?

Q Yes.

A Yes.

Q That's the date.

A Yes.

Q That's before the MRI was taken; correct?

A Yes.

Q Okay. And if we go to 958, the impression, it says the patient has possible radiculopathy, and post-traumatic

headaches, which I believe was sustained as a result of the motor vehicle accident on 5/10/2010. Do you see that?

A Yes.

Q Is there any clinical evidence that more likely than not that Desire had a radiculopathy as of July -- June 16, 2010?

A No evidence of radiculopathy. If we also look just at Bates stamp No. 957, I don't have any evidence of -- of pain beyond her shoulders as in the diagram that was shown to me consistent with cervical paraspinal spasms.

Q Okay.

A There's been a differentiation after the October 30, 2015, accident where the radiation down the arm is, indeed, different than what was noted almost several years prior, 2010.

MR. PRINCE: Okay. Let's go -- Brandon, can you put up 958. I'm going to -- I'm going to do a comparison for a second here of that.

BY MR. PRINCE:

Q Do you see the impression section?

MR. PRINCE: Highlight that, Brandon.

THE WITNESS: Yes.

MR. PRINCE: All right. Okay. And then, Brandon, I want you to split screen me of the same date, June 16, 2010, I want you to show the pain diagram that we just had on. Okay.

Just pull that down, Brandon. Just pull that to the bottom, the box. There you go. Keep going. Perfect.

BY MR. PRINCE:

Q Using that diagram, comparing the statement that it was possible cervical radiculopathy to the pain diagram of the very same day, is there any clinical signs or symptoms as of June 16, 2010, of radiculopathy? Because that's the same -- the same date of the diagram.

A I respectfully disagree with the working hypothesis that this physician had regarding possible cervical radiculopathy. In my expert opinion, based upon these records that I reviewed, there is no evidence of cervical radiculopathy. Quite frankly, more a cervical sprain or strain.

Q Okay.

A And you've got, you know, what they consider to be post-traumatic headaches. You can have some occipital headaches --

Q Right.

A -- from paraspinal spasms as well, but there is nothing to support cervical radiculopathy in my opinion. And what they say more importantly is possible cervical radiculopathy. That's --

Q And then they ordered an MRI after that; right?

A Just to be sure, I would imagine.

Q Right. And that MRI was July 12, 2010, about a month after this.

A Correct. Which the report was unremarkable.

Q Normal?

A Normal.

Q All right. Let’s go to the examination of July 13th.

MR. PRINCE: Go to 939, Brandon.

BY MR. PRINCE:

Q The last visit with that chiropractor from 2010. I just want to make sure this door is shut tight. Do you see the final visit date?

A Yes.

Q That’s one day after the MRI?

A Yes.

MR. PRINCE: And, Brandon, go to 941.

BY MR. PRINCE:

Q Let’s go to using -- so go to radiology, and then through the -- all the diagnostic impression. They comment on that the MRI was normal.

A Yes.

Q And under the diagnostic impression, was radiculopathy one of the diagnoses, Doctor?

A And that, again, supports that working hypothesis may have been possibly cervical radiculopathy, but the final

diagnostic impression has absolutely nothing with respect to cervical radiculopathy, cervical disc herniation, anything of that nature.

Q Okay. Were you able to -- as a -- do you have an opinion whether you're able to rule out that there was any pre-existing issues, any prior injuries or symptoms that Desire was experiencing before October 30, 2015, that would in any way cause or contribute to your -- the surgery you performed on her on September 1, 2016?

A I make absolutely no note of any ongoing symptomatology prior to the accident in question receiving ongoing treatment.

Q Okay. Have you been able to effectively rule out to a reasonable degree of medical probability that this prior accident was caused or contributed to any need for surgery in this case?

A This is my expert opinion. It has no relation to the need for surgery following the 10/30/2015 accident in my opinion.

Q Very good. Now, when you saw her, did she tell you that she was also involved in a motor vehicle collision on July 10, 2015?

A Yes.

Q Okay. And you also reviewed the records before that day?

A Yes.

Q In your opinion, based on your review of the records, was there any significant clinical change in her complaints or her presentation before the July 2010, 2016 accident and after?

A It remained my opinion that she had persistent and ongoing symptomatology, which if they were any different after one versus the other accident, I certainly would have noted of that.

Q Okay.

A But absolutely nothing to support the fact that there was a change in symptomatology after the second accident necessitating additional workup.

Q Okay. Now, did you even order an additional MRI, a new MRI for the neck?

A I did not.

Q Why didn’t you?

A I did not feel that what she described to me, the symptoms she had, the treatment that she received, and what her pain diagrams were in conjunction with my obtaining the history deviated from the ongoing symptomatology after the first accident in question.

Q Okay. She was already determined to be surgical by Dr. Khavkin even before the July of 2016 event --

A Yes.

Q -- right? And did that change in your opinion any need for surgery or the levels for surgery whatsoever?

A It remained my expert opinion, and to this day, that no change in symptomatology after that second accident necessitated additional workup beyond what was previously done with the identification of that traumatic disc protrusion at 6-7 as a result of the 10/30/15 accident.

Q Okay. Now, after you saw her, what was your initial impression after you saw Desire in your initial evaluation?

A That, indeed, as the result of the 10/30/15 accident she had a traumatic disc protrusion at C6-7 causing ongoing cervical radiculopathy, failing conservative management, ultimately seeing two surgeons for which a surgical recommendation was also offered by me.

Q Okay. And I'm going to look at your note because I think I like the way you say it. Your July 19, 2016, note.

MR. PRINCE: 770, Brandon.

THE WITNESS: Yes.

MR. PRINCE: And go to the -- bring up the history of present illness.

BY MR. PRINCE:

Q Brandon is going to pull that up so we can have it. Okay. There’s some things you say that I want to cover. It says the patient continues to have ongoing axial mechanical neck pain, with left intermittent medial scapular radiation

with extension down her left upper extremity in a C7 distribution. What are you talking about there?

A The C7 nerve root continue to be and persistently irritated following the accident of 10/30/15 which has, indeed, failed conservative management.

Q What's a C7 distribution?

A So in the neck, between the shoulder blades, and down the arm into her hands.

Q Is that consistent with a nerve injury or nerve root irritation of the C7 nerve root exiting the C6-7 disc space?

A Yes.

Q Okay. You also say that clinically the patient has C7 radiculopathy. What does it mean to clinically have a C7 radiculopathy on the left?

A So on my examination, and, again, to some degree the limitations of electronic medical records is such that everything may not always get included, but there's a clear clinical C7 radiculopathy with her demonstration of the pain distribution.

Q Okay.

A Consistent with what she had said before to me and consistent on that day, as well.

Q Okay. 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 All right. we're going to have you -- we're going to show the jury the actual MRI image. Did you directly review the MRI of the cervical spine?
A Yes.
Q Was it reasonable for the chiropractor to order an MRI of her cervical spine?
A Yes.
Q Okay. And as part of your training, Dr. Garber, do you have specific training as a neurosurgeon reading MRIs of the brain and cervical spine, the lumbar spine, or any area of the spine for that matter?
A Yes, that would be throughout my residency, and even with different rotations. We read our own films. And, quite frankly, if I don't read my own films, I should not be doing surgery.
Q Okay.
A That's just how I feel.
Q Do you always independently review the films and not rely upon what the radiologist tells you?
A Yes.
Q Okay. And is that -- is that true for probably most spine surgeons that you're aware of, they read their own films?
A Yes.

Q All right. And I'd like to show the jury what the abnormality is that you found at C6-7.

MR. PRINCE: Brandon, can you pull that slice up. Okay. Maybe can you zoom in.

BY MR. PRINCE:

Q Maybe you can zoom down, Dr. Garber, and we're going to -- maybe identify the levels of what we're seeing, and then you can show us what we're talking about.

A So what we have here, this is an MRI of the cervical spine. Now, this is basically --

Q Well, tell us what an MRI is.

A So an MRI is a magnetic resonance imaging. So it's a magnetic image of the soft tissue and bony anatomy of a particular area of your body that gets imaged, so --

Q How is that different than an x-ray or a plain x-ray?

A So an x-ray mere looks at the bony anatomy to less a detail than, say, a CAT scan. A CAT scan also looks at bony anatomy, but with more detail and three-dimensional viewing. An x-ray is sort of a strict view of the bones, if you will. So, for example, what we have here is an MRI. It's a magnetic resonance imaging. It's an image of the cervical spine. Now, there are different slices of imaging. This happens to be a sagittal, an image if you sort of slice someone in this direction, up and down.

MR. WINNER: May I ask the witness to identify which sagittal image is being reviewed because there are many, many.

THE WITNESS: So this is a T2 sagittal image. So there are different sequences of MRIs. There's T1 imaging, there's T2 imaging, there's flare imaging. That would be a whole discussion for one day that I think is not clinically relevant here.

BY MR. PRINCE:

Q Okay.

A But what we have --

MR. WINNER: I'm just wondering which -- with which image from the radiology facility?

MR. PRINCE: 11 of 15.

THE WITNESS: I apologize. So this is Image No. 11 of 15.

MR. WINNER: Okay. Thank you.

THE WITNESS: And so what we have is we have a disc protrusion.

BY MR. PRINCE:

Q What level is that?

A At C6-7.

Q Okay.

A Which produced nerve root impingement as the nerve exist the foramen. But you can't really see the nerve because it comes out this way.

Q Okay.

A Produced nerve root impingement, giving the patient ongoing radiculopathy.

Q Is that in your -- is that, in your opinion, is -- can you clearly see that up there?

A It's my opinion, based upon the radiographic review of my -- from myself, based upon what I see, based upon the patient's clinical history and symptomatology, based upon the fact that the C7 selective never block completely alleviated her pain from an 8 to a zero twice, two different situations, that's the pain generator that she was experiencing.

Q All right. Now is C5-6 normal?

A No. There's a slight disc bulge, in my opinion, at C5-6. In my opinion, there is some degree of abnormality at C5-6 as a result of the accident, but I did not feel it warranted surgery at her age, not producing symptomatology at this time.

Q Okay. We're going to talk about that, but I want to -- we -- in your opinion, that disc protrusion at C6-7, was that caused by the trauma of the October 30, 2015, motor vehicle collision we're here talking about?

A It's my expert opinion that that disc protrusion was traumatically induced as a result of the accident and causing nerve root irritation, failing conservative management, including injections, necessitating the surgery that I

performed.

Q Okay. Now, I want to -- while -- while you're standing, I want to -- Mr. Winner said something during opening statement. He -- he talked about the radiology report from a plain x-ray, taken right after Desire personally went to the chiropractor, and I want to put that up there for a second. It's page No. 153. Because you're talking about an abnormality there, and I want to talk about how we reconcile these issues with the x-ray.

A From an x-ray?

Q Yes.

A Okay.

MR. PRINCE: 153, Brandon. If you can just -- yeah, just zoom in that, the -- the impression point there.

BY MR. PRINCE:

Q Mr. Winner told the jury in opening statement the x-ray was taken, it's absolutely normal, there's normal alignment, the soft tissues are normal, maintain neutral alignment on flexion and extension, absolutely normal, he said normal probably 20 times. Does that end the story? I mean, if you just looked at x-rays, does that tell you anything about the disc?

A X-rays have no clinical relevance when it comes to disc anatomy. The disc itself --

Q Tell us why.

A The disc itself, as we talked about earlier, has the consistency on the outside of corn husk material. The inside is like wet crab meat nuclear material. There's nothing radiographic that can be seen of the disc itself. You can see bones on plain x-ray, you can see if there's a fracture or a dislocation of the spinal bodies, but it shows absolutely no neural anatomy compression, it shows no discal anatomy. It may show in the setting of someone who is much older, in their 60s or 70s, degenerative changes, but no evidence of neural compression or disc herniations can be seen with plain film x-rays.

Q Okay. Even using that -- I want to just go step further with this. Is there any evidence that she had significant degeneration on any level of her spine, according to the plain film x-ray?

A Absolutely not.

Q Okay. That would -- that part of it would be normal; right?

A Well, I would not expect in a 20-something year old lady degeneration to be even seen on radiographic x-ray.

Q Okay. So then -- so as a neurosurgeon specializing in the diseases of the spine and doing spinal surgery, you don't just look at an x-ray and call it quits, you actually -- the MRI is the more -- is more of the gold standard, wouldn't you agree with that?

A In the setting --

Q For imaging.

A Yes. In the setting of an individual having ongoing radiculopathy down the arm, in what appears to be a C7 distribution, and what is confirmed by me in a C7 distribution, an MRI is in fact warranted.

Q Now, I want to talk about your exam on July 19, 2016. It's Bates No. 771. Did -- under -- and it says paresthesia, sensory paresthesia.

A Yes. So there were paresthesias noted on my physical examination, left C7 distribution.

Q Okay.

A So that means, basically, that there were pain, numbness, tingling, in a distribution down the left arm, more likely than not into the last two fingers, and potentially one half of the middle finger based on my clinical examination.

Q Is that the way you correlate the presenting complaints, that she had a pain in the neck, and the symptoms into the arm, as well as the MRI image? Is that one of the ways you correlated those symptoms, just through your exam findings?

A My history, physical, and the imaging studies correlate to pathology, meaning the disc herniation at C6-7, which, in my opinion, is the result of the accident in question.

Q Okay. Now, as -- let's talk about the recommendations you made to Desire as of July 19, 2016.

A Yes.

Q And did you discuss with her surgical options at that time? Let's go to Bates No. 772.

A Yeah. So given the fact that she had continuing and ongoing symptomatology, paresthesias in a C7 distribution, the identification of a herniated disc on MRI, the failure of an injection to persistently alleviate her symptoms, and at the same time appropriately diagnose that level. In that setting of a failed conservative management, I recommended the anterior cervical discectomy and fusion.

Q What does anterior mean?

A So as a surgeon, you make an incision on the anterior portion of the spine -- of the neck, you dissect down to the front of the spine, you take the anterior longitudinal ligament out, which is on the front of the spine, you take the disc out at C6-7, you remove what's called the posterior longitudinal ligament to completely decompress the spine, make sure there's not this material as well, that's kind of lodged in there in conjunction with the neural compression, and then you put a spacer with built in screws in, or a spacer with a plate and screws in.

Q Okay. And what -- I mean, Desire, as of July 2016, I think she's barely 25 years old. And what's the

significance to you, as a neurosurgeon, making a recommendation for a fusion to someone who's 25 years old?

A Well, I'll -- I'll certainly go through the risks and benefits of surgery. And after the risks and benefits of surgery --

Q And what are those risks and benefits -- risks of surgery?

A So everything that I go through with patients includes the risks and benefits of surgery. The risks including weakness, paralysis, bleeding, infection, CSF leak, or cerebral spinal fluid leak, chronic pain, hoarseness, esophageal injury, tracheal injury, injury to the recurrent laryngeal nerves, resulting in permanent hoarseness, hardware failure, need for hardware revision, need for adjacent segment surgery, stroke, blindness, and death. Those are -- everything I go over very thoroughly with patients, because I think it's important for everyone to know the potential risks and benefits of surgery.

Q Did you take lightly, making a recommendation for a surgery? I guess probably to any patient, but someone who is only 25 years old for a fusion surgery?

A Certainly not. And, again, I tried to be as conservative as I can. I recognized that there was some degree of -- of discopathy or damage to the C5-6 disc, but clinically was not needing surgery at the time that I

recommended the C6-7 surgery, which I felt was most clinically relevant.

Q You thought -- did you think C6-7 was the primary --

A Pain generator.

Q -- source of the pain -- pain generator?

A Yes.

Q Okay. And you have in your -- part of your surgical risks and benefits, a need for additional surgery. I think you mentioned a minute ago adjacent segment disease. And can you tell -- tell us, Doctor, what is adjacent segment disease?

A So when you perform an anterior cervical discectomy fusion, you remove a disc, you put in a spacer with built in screws, or a spacer with a plate, so you create a bridging fusion between two vertebral body segments. And so what happens is, depending upon time, the disc above and below can take the strain of the one that you have removed, does that make sense? So that each disc has a certain function in your spine. Once they're injured, and you ultimately have it fixed, the discs above and below take the strain. Now, we certainly know that being fused at C6-7, the disc at C5-6 and C7-T1 then take the strain. Now there's certainly, biomechanically, less motion at the C7-T1 disc, so the C5-6 disc is going to take some more strain.

Q Why is that?

A Just because of the -- of the biomechanical motion

and properties of that disc itself, versus C7-T1. The C7-T1 disc, the T1 vertebral body has ribs coming out of it, so that provides additional stability and structure and reduction of motion, flexion, and rotation.

Q Where's -- at what levels in the cervical spine is the greatest degree of motion?

A Mid cervical spine.

Q Which are what levels?

A C5-6 and C6-7.

Q Okay. And if you fused one, is there any more motion left in that segment?

A Once that segment is fused, so in the case of Desire, with her segment C6-7 fused, there is no motion there. The key is to decompress the disc that's broken, put in a spacer, and allow fusion to heal, so there is no motion, because that disc was broken as the result of the accident. But the disc above, and to a lesser degree below, have to take the strain.

Q Right.

A And more likely than not, the C5-6 disc takes more of that strain of motion.

Q Okay. And are you -- based upon your education, training, and experience, as well as the -- the work you continue to do and your ongoing education, are you familiar with the literature as to the degree of adjacent an segment

disease -- help me, is there statistical data that's available to you as a neurosurgeon as to how this occurs and -- and at what rate it occurs?

A Yeah. So in the literature, the risk of developing adjacent segment disease is 1 to 4 percent per year. I usually quote people 2 percent per year. Now, one thing we have to keep in mind, and other literature also quotes, that 30 percent or so of individuals can develop adjacent segment disease within 10 years.

Q I want you to explain for us what is -- exactly what is adjacent segment disease, and how it -- how it works.

A Okay. Because the disc, at a certain level, takes the strain of the one that has been fused, it has to work harder. And when it has to work harder, it can break down at a faster rate than it would normally over the life of that disc, over the life of the person. And what we see, then, we know that there is some degree of derangement or slight abnormality -- slight abnormality at C5-6.

Q In Desire's case?

A In Desire's case. So that we know, unfortunately, that disc may have work a little harder, and may break down quite sooner because of the inherent initial damage from the accident, but my unwillingness to proceed with surgery there because there was no symptoms coming from there.

Q Okay. So you wanted to offer the least invasive

surgery as possible --

A I'm very conservative.

Q -- for her?

A Like I said, I've had back surgery myself. I try the least amount of surgery with the maximum benefit.

Q Now when you're talking about the 3 percent per year, or 1 --

A 2 percent.

Q -- or 2 percent --

A Sure.

Q -- 1 to 4 percent. Have you see the testimony of Dr. Wang, where he's talked about it's -- you know, in the literature, 3 percent per year?

A I believe he quotes 3 percent.

Q Right. And you've also testified in your deposition to Mr. Winner's firm that the literature out there supports it, there's a 30 percent chance that adjacent segment disease requiring surgery after 10 years of the fusion.

A That's correct.

Q Okay. So it's 3 percent per year of the need for another surgery at the -- an adjacent level; right?

A Yes.

Q Okay. And it goes 3, 6, or 2, 4, 6, or 3, 6, 9, and it's additive each year?

A It's a cumulative process.

Q Okay.
A And once you've had that surgery, you have to be cognizant of that.
Q Is it a disease? Does it cause a disease?
A A -- a cervical spine fusion sets for a cascading of events that does indeed, in my expert opinion, constitute a disease process, which has to be monitored and treated accordingly.
Q And -- now you said earlier that Desire, when you were having this conversation with Desire, you only recommended one level, but at that time, did you educate her that she's going to need future surgery at the levels above C6-7?
A I was certainly very concerned about what's called adjacent segment breakdown, or disease, and I would have, again, in conjunction with all of my risks and benefits and -- and informed consent, tell someone regarding the need for possible -- more likely than not, in her case, surgery at the level above.
Q Okay. And giving her -- I mean, you did the surgery on September 1st. We're going to talk about that in a moment, but how soon, given she has a C5-6 problem we could --
MR. PRINCE: Maybe put that image back up, Brandon. The image. The MRI.
BY MR. PRINCE:

Q Okay. Now in circle, we're talking here -- I'm going to -- I'll just stand back. That's the C5-6 level, if you could stand -- maybe stand up here, doctor.

A Yeah. I see the C5-6.

Q C5-6 level. Because there is already some compromise at C5-6, does Desire have a risk of accelerated adjacent segment disease because of the trauma?

A Yes.

Q And in the future?

A Yes, in my opinion.

Q Why?

A Again, as we discussed earlier, the disk has some degree of compromise in the components of it. We have the outer annulus and we have nuclear material. So the annulus of this disk at C5-6 has been compromised. It's not -- it's not normal. Everything else is normal. But we have this bulge here, we have a herniation here. This was most clinically relevant to treat her ongoing symptoms, which failed conservative management after the accident of October 30th of '15. But I am concerned about that down the road. But at 25 years of age, to commit her to a two-level fusion with this level not causing symptoms, I did not want to do that.

Q Right.

A And -- and the other thing --

Q But --

A Hold on, sir.
Q But once you fuse C6-7 and you now have a compromised disc already at C5-6, is she at risk for accelerated adjacent segment disease at that level?
A Yes.
Q Okay. Because it's compromised?
A Unfortunately, yes.
Q Using the statistics, the 1 to 4 percent, are they typically talking about a compromised disc, or a normal disc?
A Well, those statistics provided in the literature are in reference to discs that are normal in most cases above a fusion, or an asymptomatic disc, as well.
Q Okay.
A And so we have to keep in mind that in the setting of some degree of abnormality, that that adjacent segment breakdown can be in fact accelerated as you had mentioned.
Q Okay. Do you think that's going to occur in Desire's case?
A More likely than not, yes.
Q That's your opinion to a reasonable degree of medical probability?
A Absolutely.
Q All right. And now let's talk -- talk about the surgery. You did the surgery on September 1, 2016, at Valley Hospital.

A Yes.

Q And there is some discussion --

MR. PRINCE: Let’s -- let’s go to Bate No. -- what’s the -- what's the [indiscernible], Brandon? I think it’s demonstrative. I can't find your note in here. Oh, here we go. Got it.

BY MR. PRINCE:

Q Look at 778.

A Yes.

Q Okay. And can you just briefly tell us what you did, doctor?

A Yes. So what I did was, as we discussed briefly earlier, make a small incision on the anterior portion of her neck, dissected and went down to the front of her spine, took the disc out at C6-7, decompressed the spine, put in a little spacer with built in screws, and put a drain in overnight, and then closed her up.

Q Okay.

A Now, one thing I just would like to point out to you, just because I see this in the body of the dictation, is that the anterior cervical discectomy was performed at 6-7, sub ligamentous disc protrusion material was removed in two distinct fragments. So I did find herniated nuclear material under that posterior longitudinal ligament.

Q Oh. So let’s -- yeah, let’s go to 778, then. Just

go to the bottom, so we can --

A Sorry.

Q -- identify what you're talking about.

A And I just think it’s important to know that because that -- yet another final confirmatory piece of information, intraoperatively identifying two fragments of disc material causing neural compression that were decompressed.

Q Okay. Let’s kind of break that down.

A Yes.

Q It says --

A So may I -- may I come up here and show you?

Q Yeah. Yeah. I think -- I think I see it right here.

MR. PRINCE: Brandon, start -- start with the highlighting.

THE WITNESS: So right here. So the anterior cervical discectomy was performed at 6 -- C6-C7. Some ligamentous disc protrusion was removed in two distinct fragments. So intraoperatively, I was able to identify two small disc fragments that squirted out from that disc, causing neural compression that I decompressed. And then what I did was the post -- the remainder of the posterior longitudinal ligament was removed to make sure that the fecal sac and nerve routes were adequately decompressed.

Q What does decompression mean?

A Make sure that the nerves and the spinal sac itself and the spinal cord do not have any compression --

Q Or pressure?

A -- or pressure on it, if you will, causing --

Q Right.

A -- the pain that she was experiencing.

Q So are you saying to us that you saw a disc herniation, or disc material, that wasn't seen on the MRI intraoperatively?

A Well, the MRI, in my expert opinion, shows a disc herniation.

Q Right.

A The operative note is the final confirmatory test to demonstrate, and I specifically dictated it. Two disc protrusion materials, sub ligamentous nature at C6-7.

Q Well, the only surgeon that was in there was you; right?

A Yes.

Q And so when you dictated that, you found two disc fragments; right?

A Yes.

Q So if the doctors for the defense get in here and say, oh, that MRI was completely normal, forget the MRI for a minute, you've -- you looked with your own eyes and saw the disc material coming out; didn't you?

A The operation served to reaffirm and confirm the presence of a disc herniation causing her left C7 symptomatology, in my expert opinion, as a result of the accident of 10/30/15.

Q Okay. Any complications --

A None.

Q -- after the -- after the surgery?

A None.

Q How did she do, clinically, after the surgery?

A Quite frankly, I think she did very well.

Q Okay. Did it reduce her symptoms?

A Significantly.

Q Did it -- did it take away not any neck pain, but arm pain?

A Yes.

Q And arm numbness?

A The radiculopathy, as I can recall, resolved.

Q Okay. Now, we're -- in this case in your review, was it significant to you that Desire had a bone contusion of the left shoulder?

A We had discussed that earlier. And so --

Q Yeah, I want you to kind of --

A -- my opinion about that is, you know, if you're rear-ended, and for whatever reason you end up hitting your shoulder on the side of the car, and in a Honda Accord, if you

have on the door a bolster, if you will, and you hit that, there's an impact to the shoulder, but we can't forget about the impact to the cervical spine, the translation of forces, if you will. There is definitive documentation of a contusion of that bone in the shoulder. And in my opinion, in conjunction with that bone contusion, translation of forces causing the traumatic disc protrusion at 6-7, in my expert opinion.

Q Okay. Now, a couple more -- few more points. The mere fact that Desire didn't report any symptoms or injuries at the scene, does that in any way mean that she wasn't hurt in the way you described here today?

A None whatsoever.

Q Tell us why.

A Just because you don't instantaneously complain of anything at the scene of an accident doesn't mean you've not been injured. Individuals involved in accidents are going to have a surge of corticosteroids and things like that, you're sort of juiced up, if you will, you're excited, there's a lot of things going on. The accident, with the photos of the injuries, photos of the automobiles, it was not inconsequential. So it doesn't mean you have to have instantaneous pain. And in addition to that, the manifestation of a disc herniation producing symptoms doesn't have to be right then and there, right at the time of the

accident. It could be a day or two or three or so after the incident in question.

Q Does it take hours, and sometimes days or weeks to have the full constellation of symptoms and problems?

A You can. And don't forget also is that a disc itself, when it's damaged, when it herniates, not only is there nuclear material that can pinch the nerves, but there's also a chemical process that that occurs after that, a chemical irritation, if you will, that can then occur a day or two or three afterwards.

Q Yeah. And what -- what causes the -- the body to become -- become painful? Is it an inflammatory response?

A The disc, when it's damaged, can incite an inflammatory response, where inflammatory or inflammation mediators in the blood come to that area. Now, the discs themselves are avascular, there is no blood vessels in the disc. There's not like a big blood clot from the disc. But the inflammatory mediators then migrate to where that disc has been damaged, and can, over the next several days, cause an inflammatory response, if you will.

Q Right. Do you think it was reasonable for Desire to wait to go receive, to seek care at the chiropractor on Monday? This happened on a Friday night, wait until Monday?

A I certainly think it's very reasonable to see if your symptoms improve over a period of time as opposed to

rushing off right away. Unless there's, you know, a frank paralysis or something going on that's above and beyond what you're hoping is nothing more than a sprain or strain. But certainly in her case, it was not because of the radiculopathy.

Q Right. And one of the -- in his PowerPoint, Mr. Winner said that you did your treatment and surgery on a litigation lien. Did you do -- did you do this surgery on Desire on a litigation lien, Dr. Ross -- or Dr. Garber?

A No.

Q Okay. So that would be false?

A I did not do her surgery on a lien.

Q Okay. Were you in any way influenced by the chiropractor in performing your surgery?

A None whatsoever.

Q All right. Do you think that the chiropractic treatment that Desire received was reasonable and appropriate to treat the injuries she received?

A Yes.

Q Was the treatment from NLV, which is the medical Dr. Ross, from -- who provided some medical management, prescription medication, was that reasonable and appropriate?

A Yes.

Q Was the treatment by Dr. Rosler reasonable and appropriate, including his injections?

A Absolutely.
Q What about Dr. Khavkin, his -- his consultation, was that reasonable --
A Very reasonable.
Q -- and appropriate? Do you have an -- what about your own treatment and surgery that you performed on September 1, 2016, was that reasonable and appropriate?
A Quite frankly --
Q Also related to this accident?
A I think, quite frankly, both reasonable and successful.
Q Okay. What was it -- is the response to treatment supportive of your opinions in this case that she was -- how she was injured in this collision, that she responded so favorably to your surgical treatment?
A Yes.
Q And with regard to all of the billing, have you read all of the medical billing in this case?
A Yes.
Q And for -- for Desire --
MR. PRINCE: And that's Exhibit No. 54, Bates No. 328, Brandon. We're going to put it on the monitor. Yeah. Maybe just highlight it, maybe the 1 through 10, then. The whole thing. There you go.
BY MR. PRINCE:

Q Did you review those charges for all of the medical care and treatment for Desire in this case, all of the charges?

A Yes.

Q Do you have an opinion whether those charges are usual and customary for the service that were provided by all of the care providers, including yourself?

A Reasonable, usual, and customary.

Q All right. Do you have an opinion whether those medical expenses were reasonably incurred as a result of the injuries caused by the October 30, 2015, motor vehicle collision?

A Yes.

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

A Absolutely.

Q All right. I want to talk to you now before we kind of wrap up here before we go, I want to talk about -- I'm going to show you the x-ray of Desire's neck, okay. I'm going to talk about adjacent segment and the duration, and when you expect her to need another surgery, and how this process will start over.

MR. PRINCE: So I want to show, Brandon, it's No. 4.

BY MR. PRINCE:

Q What are -- what are we showing to the jury here,

Dr. Garber?

A So this is an AP. So this is a front back view of her spine, x-ray only, this is a side view of her spine, x-ray only. So the spacer is in here, with built in screws, and that -- that's basically the procedure that I performed, anterior cervical discectomy infusion. And so the concern regarding adjacent segment breakdown, in my expert opinion, will come at C5-6, above her prior fusion over time.

Q Okay. And --

A And more likely than not.

Q Okay. And do you have -- using the statistical data that you provided, and given the fact that she's got the -- already a compromise at C5-6, what is your estimation as to when that disc will become symptomatic and require surgery?

MR. WINNER: That's beyond the scope of the report, Your Honor.

MR. PRINCE: No, it's in his report.

MR. WINNER: No, it's not.

THE COURT: Approach.

(Bench conference)

THE COURT: Give me the question.

MR. PRINCE: What?

THE COURT: Give me the question. And then do you know where it is? Where's Mr. Winner? Is he looking for it in the report?

MR. PRINCE: He says it’s a 100 percent chance of happening. I'm asking when it’s going to happen. He’s saying it’s going to happen, I'm asking him to give me a time -- a time range.

MR. WINNER: It’s the when that’s not in here.

MR. PRINCE: Oh, he’s a treating physician, Judge. He -- he’s already testified that he gives -- he educates patients on -- not everything he has to say has to be word for word in this report. I'm asking him to give a time estimate. That’s not --

MR. WINNER: And --

MR. PRINCE: That’s gotten ridiculous now.

MR. WINNER: Okay. Now, he’s just making it up and saying it’s in his report. When it’s pointed out it isn’t, just say it doesn’t need to be in his report and you get mad.

MR. PRINCE: It doesn’t.

MR. WINNER: It’s not in his report. He’s giving new information about futures in his report. I object.

MR. PRINCE: Judge --

MR. WINNER: I'm hearing this for the first time today that he’s been deposed. No.

MR. PRINCE: You're a joke.

MR. WINNER: I'm a joke.

MR. PRINCE: Yeah.

MR. WINNER: Good. Making shit up does not make you

clever.

MR. PRINCE: Yeah. It says it's going to have 100 percent of developing in her lifetime. I'm asking when it's going to happen in C5-6.

THE COURT: C5-6?

MR. PRINCE: Yeah, that's the level they're talking about.

THE COURT: I know. In her lifetime is where we are; right?

MR. PRINCE: Yeah. But I want to know when he's -- right, I'm going to ask --

THE COURT: He doesn't know.

MR. PRINCE: Yes, he does. He's going to say that.

MR. WINNER: Why didn't he say so?

THE COURT: Well, then -- then I want to know who's going to win the derby next year. I mean, how do you know that?

MR. PRINCE: He's going to give a time estimate. He can give a time estimate.

MR. WINNER: Then he should have given it before. When --

MR. PRINCE: I'm going to ask it a different -- I'm going to ask him it by the time she's 45, does she have a greater than 50 percent chance of requiring that 50 by requiring an adjacent segment surgery --

MR. WINNER: It doesn't --
MR. PRINCE: -- at C5-6.
MR. WINNER: -- say that either. If 2 percent a year --
MR. PRINCE: Yeah. 25 -- 25 -- just do the math. He said that's conservative.
THE COURT: Why --
MR. WINNER: That means over the age of 50 --
THE COURT: Does 2 percent per year mean in 50 years is when she gets her first --
MR. PRINCE: No.
THE COURT: -- surgery, she'll be 78? So that -- I mean, that's when you get to 100 percent.
MR. PRINCE: Yeah, but that's not more probable than not.
THE COURT: So you only need 100 percent when you get to --
MR. WINNER: 2 -- 2 percent a year would be more probably than not, according to that math, in 25 or 20 -- 25 years, meaning over the age of --
THE COURT: 58.
MR. WINNER: What is she? What is she now --
MR. PRINCE: Yeah. But he's not --
MR. WINNER: -- 29, 28?
MR. PRINCE: But he's also saying that she's got

disc compromise. He's not married to that report on everything that he -- you don't have to marry that report. He's also a treating physician, Judge, and he's talked about how it's going to be accelerated at C5-6 because she's already has a preexisting issue there.

MR. WINNER: Yeah. It would have been --

MR. PRINCE: It's not a normal level.

MR. WINNER: -- nice if you'd have asked him those questions before you asked him to write the report.

MR. PRINCE: No, judge.

MR. WINNER: No, we object.

THE COURT: All right. Sustained. You can try and ask him a different way, but I'm going to sustain it the way it is.

MR. WINNER: Thank you.

MR. PRINCE: Unbelievable. Okay.

(End of bench conference)

MR. WINNER: Sustained?

THE COURT: Sustained.

BY MR. PRINCE:

Q Dr. Garber, do you -- do you have an estimate as to when Desire will require an adjacent second surgery at C5-6?

MR. WINNER: Same objection --

THE COURT: Sustained.

MR. WINNER: -- for the same reason.

THE COURT: Sustained.

MR. PRINCE: All right.

BY MR. PRINCE:

Q Do you have an opinion whether she will require an adjacent segment surgery during her lifetime?

A Yes.

Q Okay. And --

A There's a 100 percent chance of requiring surgery --

Q All right.

A -- at that adjacent segment.

Q Okay. And --

THE COURT: All right. Mr. Prince, we're going to -- we need to wrap up. We had some commitments by 5:00, so --

MR. PRINCE: Okay. Okay.

THE COURT: Is this an okay stopping point?

MR. PRINCE: No. But -- I mean, we're -- I'm almost done, but it -- it's fine. He's got to come back, and we've got to figure this out for tomorrow.

THE COURT: Okay.

MR. WINNER: I don't have -- I don't mind staying if you're close to finishing, but --

MR. PRINCE: I think we have to leave by 5:00, so --

THE COURT: We do.

MR. WINNER: Okay.

MR. PRINCE: [Inaudible].

THE COURT: So 1:00 tomorrow, doctor?

THE WITNESS: Yes. I have an arbitration, but let me see what I can do.

(Bench conference)

MR. PRINCE: We need to have a verbal discussion on these issues.

MR. WINNER: I just want to know if he -- if he's coming back tomorrow.

THE COURT: He's coming back tomorrow --

MR. PRINCE: He is.

THE COURT: -- at 1:00.

MR. WINNER: Okay.

MR. PRINCE: He's coming back.

MR. WINNER: All right. I thought I heard --

THE COURT: He's going to figure it out.

MR. WINNER: I thought I heard him say no.

THE COURT: He -- he did say he has an arbitration, but he's going to work it out.

MR. PRINCE: Yeah.

MR. WINNER: All right. Appreciate it.

MR. PRINCE: Thank you.

(End of bench conference)

THE COURT: Okay. Ladies and gentlemen, we're going to take our evening recess. We'll be back tomorrow at 1:00, okay.

And during the recess you're admonished not to talk or converse among yourselves or with anyone else on any subject connected with to this trial or read, watch, or listen to any report of or commentary on the trial or 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 with the trial until the trial -- the case is finally submitted to you.

Have a safe trip home. See you tomorrow.

(Jury recessed at 4:58 P.M.)

THE COURT: Anything outside the presence?

MR. PRINCE: I do. I want to clarify, Judge, just the -- the issue on adjacent segment. I mean, I don't understand why he can't give an opinion on what he estimates the time period is to be more -- on a more likely than not basis. It -- not -- it doesn't have to be stated to a 100 percent certainty. He went there on his report saying she's definitely having one.

THE COURT: Well, I think -- I think he said in her lifetime, and I think that's what the report --

MR. WINNER: That's --

THE COURT: -- says and that's --

MR. WINNER: That's fine.

THE COURT: -- what he's --

MR. PRINCE: No. No.

THE COURT: -- testified to.

MR. PRINCE: But, no. But -- but Judge, he's going to give an opinion, as a treating physician, as a neurosurgeon, as to a time estimate. He just gave that's a certainty, she's definitely having it, more than --

THE COURT: Okay. Let's -- well, let's -- we'll meet at 12:30 tomorrow, and -- before the jury comes in, and we'll -- we can hash this out, all right?

MR. HENRIOD: Yeah. That's fine.

THE COURT: Do the attorneys --

MR. HENRIOD: I'll just add that It'll be a new opinion --

MR. PRINCE: It is not.

MR. HENRIOD: -- and that's the problem.

MR. PRINCE: That can never be a new opinion, Judge. It's just not an opinion.

THE COURT: Well --

MR. PRINCE: Okay.

THE COURT: Tomorrow. And -- we -- and we -- figure it out tomorrow. We are absolutely not going late. I would like to get out a little early tomorrow. I need to get --

MR. WINNER: Okay.

THE COURT: -- across town and then cross town --

MR. PRINCE: Understood.

THE COURT: -- and they're standing room only. How many witnesses do you have for tomorrow?

MR. PRINCE: I have him and Dr. Khavkin. I'm only -- I've got about 15 minutes left with Dr. -- 15 -- about 15, 20 minutes left with Dr. Garber.

MR. WINNER: Khavkin's got to be short, I assume?

MR. PRINCE: Yeah.

MR. WINNER: One visit? Yeah.

MR. PRINCE: Yeah.

THE COURT: Okay.

MR. PRINCE: But he's going to talk about that he believes that she was ultimately going to get to C4-5 because that was his opinion during -- formed during the course of his care.

THE COURT: Okay. Just getting a rough idea. See you tomorrow, then, at 12:30, okay.

MR. WINNER: Okay.

MR. PRINCE: Very good. Thank you, Your Honor.

THE COURT: Thank you.

(Court recessed at 5:00 P.M., until Thursday, May 23, 2019, at 12:30 P.M.)

* * * * *

INDEX OF WITNESSES

PLAINTIFFS' WITNESSES:

DR. HANS JORG ROSLER

DR. JASON ERIC GARBER

* * * * *

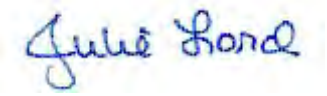
INDEX OF EXHIBITS

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.



VERBATIM DIGITAL REPORTING, LLC

14

RTRAN

DISTRICT COURT
CLARK COUNTY, NEVADA
* * * * *

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

BEFORE THE HONORABLE MARY KAY HOLTHUS, DISTRICT COURT JUDGE

THURSDAY, MAY 23, 2019

RECORDER'S ROUGH DRAFT TRANSCRIPT OF:
JURY TRIAL - DAY 8

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, FRIDAY, MAY 24, 2019

(Case called at 12:57 P.M.)

(Outside the presence of the jury)

THE COURT: Okay. We're back outside the presence of the jury. Was there something --

MR. PRINCE: I think we were just going to talk about where we left it yesterday about the adjacent segment disease issue.

THE COURT: Okay.

MR. PRINCE: I understand, you know, you're only going to allow me to talk about if she's going to need one surgery.

THE COURT: Correct.

MR. PRINCE: I can't talk about a second. But where I'm going to -- I am going to talk about how the percentage of the cumulative effect of those, and what happens after [indiscernible] how those start, and the process and starts over again, because she's going to have to experience that in her lifetime.

So, I'm not going to talk about the necessity of a second surgery as it pertains specifically to this case but just in general how that works. I think that he's obviously entitled to that. He's talked about that. Number one, he formed that opinion during the course of his care. He talked about the rate of breakdown between 1 to 4 percent. He's said

that it occurs anytime you have a fusion and so we're just going to talk about time periods and the cumulative effect of the adjacent segment disease.

THE COURT: Okay.

MR. WINNER: My only objection was to the time period because that had not been in the report which you sustained. Mr. Prince, to my understanding, was going to talk about when the adjacent segment breaks down, how that is treated to which I do not object.

THE COURT: Okay.

MR. WINNER: Yeah.

THE COURT: Then we're good.

MR. PRINCE: Okay. Ready to go.

MR. WINNER: My objection was just to timing.

MR. PRINCE: Well, I can't say, I'm going to say, will she require another surgery, and he'll say "yes". And then -- so he -- we -- he can -- he has definitely given that opinion already.

MR. WINNER: And that's fine.

MR. HENRIOD: No, no.

MS. LORELLI: No.

THE COURT: Well --

MR. HENRIOD: No, he'll definitely require a third surgery.

THE COURT: No, he's talking about a second surgery.

MR. PRINCE: I said, no -- yeah.
MR. WINNER: The one additional --
MR. HENRIOD: The one.
MR. WINNER: -- during her lifetime.
MR. PRINCE: Yeah, yeah, then what happens after she has that.
THE COURT: One more surgery during her lifetime.
MR. PRINCE: Well, yeah, what happens after she has that and then, you know, how -- it's -- the disease will breakdown and will start over again. She's going to need --
THE COURT: Yeah, I think we -- I think I ruled that not necessarily where it was going to go from there but --
MR. HENRIOD: As long as there's no --
THE COURT: -- fusion is fusion.
MR. HENRIOD: -- yeah, I mean, as long as there's no inference or suggestion of what that process leads to is another surgery.
MR. PRINCE: Okay.
THE COURT: Okay. Are we good then?
MR. WINNER: Will she need another in her lifetime and what happens I don't have any objection to.
MR. PRINCE: Well, yeah --
MR. WINNER: [Inaudible].
MR. PRINCE: -- I know, but I'm going to talk -- but that's not the end of the story for her so I'm going to say

after she has another surgery or anybody has another -- if they have adjacent segment surgery what happens to them. Is all of a sudden is that better or does the whole process start over again?

So I'm going to explain the process because she'll have to endure that no matter what at whatever point.

THE COURT: As long as you keep it that generally and you don't start getting into more specifics.

MR. PRINCE: Because Dr. Khavkin's coming up here and he's going to say that she's going to -- she would require in his mind a third level. He's going to say it because he recommended a two-level whether -- however you started to get there. And he formed that during the course of his care and we'll deal with that --

THE COURT: Well, that's a different --

MR. PRINCE: Okay. Understood.

THE COURT: That's a different thing though. That's a result of what he saw in the first place --

MR. PRINCE: Correct.

THE COURT: -- not followup care.

MR. PRINCE: Understand.

MR. HENRIOD: Well, and we can object to that too, but we can table that since --

MR. PRINCE: Okay.

MR. HENRIOD: -- you can shake your head -- we

object to that, too.

THE COURT: Okay.

MR. HENRIOD: We can table the issue until after this witness.

MR. PRINCE: Okay.

THE COURT: Okay.

So do we have our jury?

THE MARSHAL: Yeah, they're here.

THE COURT: Are you all ready?

(Pause in the proceedings)

(Jury enters at 1:01 P.M.)

THE MARSHAL: Is it related to the case?

JUROR NO. 3: Related to the case? Yeah, but it's not related to the witness.

THE MARSHAL: Okay.

JUROR NO. 3: It can wait, I guess.

THE MARSHAL: We have a question. Had to write it o a piece [inaudible].

JUROR NO. 3: I may have missed the answer to it earlier but [inaudible].

MR. PRINCE: I'm okay with --

THE COURT: A question to -- to what? I'm sorry.

THE MARSHAL: What is the question to, exactly?

Don't read it out loud. We just need to know what it's --

THE COURT: Well, just give it to him then. Is it a -- well --

(Marshal hands question to Court)

(Bench conference)

THE COURT: I'm not sure --

MR. PRINCE: Oh, okay.

THE COURT: I'm not sure who that goes to or what that goes to or whatever but --

MR. PRINCE: Yeah, we really can't answer that.

MR. WINNER: I'm not sure we can answer that, can we?

MR. PRINCE: No, I don't think we can.

MR. WINNER: I don't think we can answer that.

MR. HENRIOD: I mean, unless you no concerns and if you do then --

MR. PRINCE: No, I'm not --

MR. HENRIOD: -- I don't want to push it.

MR. WINNER: I don't think we can --

THE COURT: Okay. I'm just going to mark it.

MR. PRINCE: Okay.

MR. WINNER: Thanks.

(End of bench conference)

THE COURT: We're going to mark it.

JUROR NO. 3: Okay.

THE COURT: And there you go.

JUROR NO. 3: You're going to mark it?
THE COURT: Marking it.
JUROR NO. 3: [Inaudible] be.
THE COURT: Thank you.
MR. PRINCE: Good afternoon, everyone.
All right. We're ready. Doctor -- I mean, we're ready for Dr. Garber again, Judge.
THE COURT: Okay.
Doctor, I'll remind you you're still under oath.
THE WITNESS: Yes, Your Honor.
MR. PRINCE: I was just ready, Dr. Garber. Now what did I do with my pen.

DR. JASON GARBER, PLAINTIFFS' WITNESS, PREVIOUSLY SWORN

DIRECT EXAMINATION (RESUMED)

BY MR. PRINCE:

Q All right. Dr. Garber, thank you for coming back. I kind of want to go back a second. I want to go back to your operative note just for a moment and then we're going to work our way through and have a discussion about adjacent segment disease.

MR. PRINCE: And for the reference, your operative note is part of Exhibit 51, Bate No. 307. Brendon, if you could pull up 307.

THE WITNESS: [Inaudible].

MR. PRINCE: Oh, I'm sorry. Can I have the binder

one? Well both binders, probably. Thank you, Doctor. Sorry.

THE WITNESS: Thank you.

MR. PRINCE: Bates No. 307. And pull up the [inaudible].

THE WITNESS: So, I'm sorry, what number? I apologize.

BY MR. PRINCE:

Q 307.

A Yes.

MR. PRINCE: Brendon, if you'd like to start in here, the anterior cervical discectomy, [indiscernible].

THE WITNESS: Yes.

BY MR. PRINCE:

Q I've highlighted the section that I want to focus on and it says the anterior, that means the front, right?

A Yes.

Q Cervical discectomy. What does discectomy mean?

A So once you make an incision on the skin you go down to the front of the spine. You take out the anterior longitudinal ligament. You then take the disc out, so that includes, you know, the annular portion of the disc, the nuclear material much like the crab meat, and then you have to -- you haven't done the job until you've taken off the posterior longitudinal ligament as well.

Now, what has happened in her case was the

identification of some nuclear disc material going through the posterior part of the annulus causing that nerve root impingement as we have discussed yesterday. That was then removed with little pituitaries.

The remainder of the posterior longitudinal ligament was then removed to ensure no underlying further disc material was noted. Everything was well decompressed. The spacer then went in with the three built-in screws.

Q Okay. So you removed the ligament from the front of the spine, right?

A Yes.

Q And then you removed the disc, right?

A Yes.

Q And when you removing the disc you said you removed things in two distinct fragments. Are you --

A There was --

Q -- confirming the presence of a disc herniation?

A Yes, a disc herniation was indeed noted intraoperatively with two fragments going through the posterior longitudinal ligament.

Q Is that like a --

A So the subligament is under the --

Q -- so on the back of her spine [inaudible].

A -- posterior longitudinal ligament. That posterior longitudinal ligament is in -- on -- if you will, in front of

the fecal sac --

Q Okay.

A -- on top of it, if you will. So if the patient is lying down you come to the posterior longitudinal ligament first and once you've opened that up the dura, the fecal sac containing the spinal cord and the exiting nerve roots are then visible thereafter.

Q Okay. So once you visual it were you able to see two distinct fragments of disc --

A I pulled out two little fragments.

Q -- material? Okay. Did you confirm during your surgery the presence of a disc herniation?

A Yes.

Q Okay.

A With the subsequent two fragments removed in the process.

Q Okay. And we saw that there was a protrusion or as you've characterized it as a herniation on the MRI that we discussed yesterday; correct?

A Yes.

Q Is this confirmation of what you saw on the MRI?

A Absolute confirmation. So what that told me was that there were two pieces of nuclear material that went through the ligament causing the neural compression. Those were removed and the posterior longitudinal ligament was

removed and the decompression was completed.

Q Mr. Winner said during his opening statement during some question of Dr. Rosler yesterday that sometimes surgeons, radiologists, they'll review MRIs and they may see different things. Does that happen?

A I would imagine that seeing different things is one thing, but the intraoperative of subligamentous disc protrusion material is, without question --

Q Right.

A -- confirmation of that disc herniation.

Q Okay. But I just want to ask as a general question, at times can surgeons or radiologists disagree on their interpretation of an MRI?

A Yes.

Q Just in general?

A Yes.

Q Okay. And in this case is the discussion about whether the MRI is normal, or whether there's a disc protrusion, is that even relevant anymore given what you found during your surgery of two distinct fragments?

A There really is no further question or --

Q Okay.

A -- shouldn't be any question. Again, I was able to distinctly remove two little fragments that had squeezed in between the posterior longitudinal ligament causing

neurocompression. Those were removed with a pituitary rongeur.

Q What is a pituitary rongeur?

A It's a little took that we use, like a little pincher. Take those out. And then I use what's called a kerosin [phonetic] punch, a little punch to take off the rest of the posterior longitudinal ligament to make sure no more material was behind it.

So these little -- the disc was injured in the accident of 8/30 of '15. Material went through the annulus, through it, and it was sort of under the ligament. That's why it was called subligamentous disc herniation -- under the ligament.

I pulled those little out -- there was a little hole in the ligament where the disc [indiscernible] went through, those two little pieces. Then I put my little punch in there and opened up that posterior longitudinal ligament to make sure nothing else remained for neurocompression.

Q Okay Are the operative findings, Dr. Garber, the most definitive there are on the presence of a disc herniation at C6-7 in Desire's case?

A In my expert opinion, it has to be.

Q Right.

A It has to be.

Q So if someone gets up here next week and testifies

that the C6-7 disc is normal on MRI, is that accurate given your findings during your surgery?

A That is incorrect.

Q Okay. All right. Now, the chiropractor -- did you note in your review of the records that the chiropractor told Desire that she was at maximum medical improvement from a chiropractor standpoint in February of 2016?

A I believe I recall that.

Q All right. What is maximum medical improvement?

A Well, at that point, Desire had had an injection in January with Dr. Rosler. I would imagine that the perception of that is, best improved with what the chiropractor can do to still help her with her condition.

And in the setting of having a disc herniation beyond any cervical strains, there's nothing further a chiropractor can do with the setting of that persistent symptomology.

Q Right. Does it mean that she was no longer injured or would experience symptoms in the future after the chiropractor discharged at quote/unquote maximum medical improvement?

A No. That means at the time, at least my understanding and my perception of that, is that the patient -- there was nothing further that the chiropractor could do. And whether or not the patient was stable at that point,

meaning, minimal symptoms or a lot, nothing else could be don from a chiropractic standpoint.

Q Okay. Now, in your mind, when she came to see you from a surgical standpoint when she came to see you in July of 2016 was she at maximum medical improvement or did she need further care, when she first came to see you?

A She was still having ongoing symptomology.

Q So there was just nothing further that a chiropractor could do to help her in resolving those symptoms?

A No. And she also had two prior cervical injections.

Q Okay. Now, I want to now turn our attention, doctor, to discussing the adjacent segment disease and the cumulative effect of adjacent segment disease; okay?

A Yes.

Q And yesterday, we talked about like the rate of adjacent segment disease; do you recall that discussion?

A Yes.

Q And you recall -- and you've read Dr. Wang's deposition where he said -- testified in Clark County that it's his opinion that adjacent segment disease occurs at approximately three percent risk per year that someone's going to need another surgery at an adjacent level; do you recall that?

A Yes.

Q And in your report, you indicated it occurs anywhere

from between a 1 to 4 percent likelihood per year on a cumulative basis that someone would need a -- require surgery on an adjacent level?

A Yes.

MR. WINNER: I'm going to object, Your Honor. I don't believe that is in Dr. Wang's report.

MR. PRINCE: No, I said in his report, Dr. Garber's report, his own.

MR. WINNER: No, it's not.

BY MR. PRINCE:

Q Dr. Garber, did you put in your report -- I have it here -- did you put in your report --

A It certainly was in my deposition and I would imagine in my report in conjunction with the preparation of the adjacent segment disease report that I did.

MR. WINNER: Dr. Garber's report says 1 to 4 percent.

MR. PRINCE: That's what I said.

THE COURT: That's what he said.

MR. WINNER: The speech about Doctor --

MR. PRINCE: That's what I said.

MR. WINNER: And you made a speech about Dr. Wang that is not in the evidence.

BY MR. PRINCE:

Q Well, did you review Dr. Wang's testimony

[inaudible]?

MR. WINNER: I move to strike counsel's speech about Dr. Wang that is not in the report and not in the evidence.

MR. PRINCE: I'm asking if he read it.

THE WITNESS: Yes.

MR. PRINCE: Okay.

BY MR. PRINCE:

Q And in your deposition --

THE COURT: Overruled. Dr. Wang's testifying, correct?

MR. WINNER: No.

MR. PRINCE: He's not going to testify?

THE COURT: Approach.

MR. HENRIOD: Yeah, he is.

MR. WINNER: He will testify that plaintiff didn't oppose it.

MR. PRINCE: Well, I don't need to. I have a lot of testimony [inaudible].

BY MR. PRINCE:

Q Okay.

MR. HENRIOD: Still want the approach, Judge?

THE COURT: Will you approach?

MR. WINNER: Yes.

(Bench conference)

THE COURT: What are you -- tell me what your

objection.

MR. WINNER: He made a speech about something Dr. Wang said in the deposition in 2006, and asked him if he agrees with it. That's not in his report what he said is I don't think he's reviewed any depositions from Wang from 2006. If he did it's not in his report. What he did do is look at Wang's report in this case and Mr. Prince is making speeches about what Dr. Wang might have said in a deposition 13 years ago.

MR. PRINCE: Right.

MR. WINNER: And --

THE COURT: How do we get that -- how is that coming in?

MR. PRINCE: Right. Because I'm going to ask Dr. Wang. He's testifying. I'm like --

THE COURT: Okay but he hasn't testified yet so --

MR. PRINCE: Yeah, I know.

MR. WINNER: No --

THE COURT: -- it's not --

MR. PRINCE: I'm asking him. He's an -- he's an expert and there's this dispute about this and I asked him, does he agree with that; if Dr. Wang testifies to that do you agree with it? Maybe --

THE COURT: You can say that but --

MR. PRINCE: Okay, that's fine.

THE COURT: -- don't be reading his deposition to him --

MR. PRINCE: That's what I'll do.

THE COURT: -- from 2006.

MR. PRINCE: I didn't read his deposition to him.

THE COURT: Well, whatever.

MR. PRINCE: I just said he testified to it, do you agree to it.

THE COURT: Go ahead.

(End of bench conference)

THE COURT: Sustained.

MR. PRINCE: Okay.

BY MR. PRINCE:

Q Dr. Garber, if Dr. Wang testifies that it's his opinion based on his years of experience and training that adjacent segment disease occurs at approximately 3 percent per year, do you agree with that?

A Yes.

Q Okay. In your deposition, do you recall Mr. Winner and his law firm, they were asking you questions about adjacent segment disease and the rate, and you telling them that the literature -- at 30 -- there's a 30 percent chance of adjacent segment disease surgery within 10 -- the first 10 years --

A Yes.

Q -- do you recall that testimony?
A Yes.
Q Is that approximately a 3 percent per year adjacent breakdown?
A Yes.
Q Okay. All right. And I want to kind of walk through out how this works. And do these percentages apply to all your patients who undergo anterior cervical decompression fusion surgery like Desire did?
A Any patient that undergoes a cervical spine fusion or a lumbar spine fusion for that matter is subject to adjacent segment disease and breakdown.
Q Okay. All right. Do these percentages apply to Desire?
A Yes.
Q Okay. Did you tell her that as part of your preoperative discussion?
A Yes. As we talk about the risks and benefits of surgery and I believe that I went through a litany of those yesterday, well, that also includes the need for additional surgery.
Q Okay. Is that your custom and practice to have that discussion with any patient who's undergoing a fusion surgery?
A Any surgery at all, yes.
Q Very well. All right. So I wanted to now --

MR. PRINCE: Brendon, if we could put up our graph.
BY MR. PRINCE:
Q I want to kind of illustrate how this works. So let's assume now you did a surgery today on a patient; okay?
A Yes.
Q You did a single level fusion, whether cervical or lumbar, let's just use the same 3 percent; okay?
A Yes.
Q So in year one, there is a 3 percent likelihood that that person will now -- the disc above or below will be broken down and require a surgical procedure; correct?
A Yes.
Q Year two, it's going to be now six percent?
A Yes.
Q And so let's say by year five, it's a 15 percent likelihood --
MR. WINNER: Your Honor --
THE COURT: Yeah, approach.
MR. WINNER: You just sustained this objection --
THE COURT: I did.
MR. WINNER: -- yesterday.
MR. PRINCE: Well, no, he's got to explain how it works.
MR. HENRIOD: No. Can we take this down?
THE COURT: Yep. Remove that, please.

(Bench conference)

MR. PRINCE: Judge, how --

THE COURT: I think you're back-dooring the timing.

MR. PRINCE: No. Judge, he talks about in his report 1 to 3 percent. He talks about in his deposition 30 percent. They've got to know how it cumulatively works.

MR. WINNER: What he said in his report is 1 to 4 percent.

MR. HENRIOD: [Inaudible] is that we don't come into the time when what we're showing them is the time line.

THE COURT: I did.

MR. PRINCE: Well, no, Judge --

MR. HENRIOD: A demonstrative of the time line --

MR. PRINCE: Judge [inaudible] --

THE COURT: You can argue -- you can argue [inaudible] --

MR. PRINCE: -- you have to show it, it shows by time.

THE COURT: No you don't.

MR. PRINCE: This is -- this is about time. The whole -- that's a function --

THE COURT: In her lifetime.

MR. PRINCE: They say per year. It goes per year. And I'm showing the cumulative effect of that.

THE COURT: You said that more likely than not right

at 50 percent. I think you're trying to nail him down to a time after I say you couldn't --

MR. PRINCE: I'm not --

THE COURT: -- yesterday. And I'm not allowing that because here's what I kind of feel like. I feel like it's kind of a backdoor of the second surgery that we've already said was not coming in as well as the compensation. So because you --

MR. PRINCE: No.

THE COURT: -- in opening mentioned the second surgery that I don't think should have come in in the first place, to the extent that it's somehow or otherwise I think balance them out, I'm going to sustain it.

MR. PRINCE: Well, Judge --

MR. WINNER: Thank you.

MR. PRINCE: -- they have to know how the -- the time works, Judge.

THE COURT: You can argue -- you can argue it. You've got all the percentages --

MR. PRINCE: No, I -- no, I -- no, I don't.

THE COURT: -- in you can get it [inaudible] one percent, two percent, three percent.

MR. PRINCE: I have to have him explain it.

THE COURT: You can explain it in argument. But I've said [inaudible] this witness --

MR. PRINCE: Well, I have to have it in evidence --
THE COURT: -- to not nail it down.
MR. PRINCE: -- [inaudible] works.
THE COURT: You have it in evidence. You have everything you need in evidence.
MR. HENRIOD: [Inaudible].
THE COURT: You can talk one percent, you can talk four percent, you can -- you can throw all that out [inaudible] in argument, in -- but I've already said this isn't coming in.
MR. WINNER: Thank you.
MR. PRINCE: Well, what part of this -- I'm talking about the part that's objectionable.
THE COURT: The whole diagram --
MR. PRINCE: Why?
THE COURT: -- because I believe --
MR. PRINCE: Well, that's how it works.
MR. HENRIOD: Because it's driving -- I think because it's driving --
MR. PRINCE: But that's how it works.
MR. HENRIOD: -- to what they -- it's driving to a date range --
THE COURT: That's exactly what it is.
MR. HENRIOD: -- and that's -- that's what [inaudible].

MR. WINNER: That was a sustained.
MR. HENRIOD: [Inaudible].
MR. WINNER: Thank you.
(End of bench conference)
THE COURT: Sustained.
BY MR. PRINCE:
Q Okay. Now, talking about the cumulative effect of adjacent disc disease and the need for surgery. Let's assume in say 15 years after the initial surgery, just hypothetically, you have to now -- the disc became symptomatic to the point of requiring surgery; okay --
A Yes.
Q -- hypothetically. After you do a second surgery -- so now there's two levels fused, whether it being a cervical or the lumbar spine, what happens to the level above that?
A So as we discussed earlier you create a lever arm at a one level fusion between two vertebral bodies. So you fuse vertebral body number -- your X with Y. So when you fuse that, the discs above and below take the strain. And then what happens is it starts where the patient can start to have symptoms from what's called adjacent segment breakdown at discs above and below.
Q Okay.
A And we sort of discussed yesterday --
Q Yeah.

A -- where sometimes that can happen, more likely than not, at which particular level in the cervical spine which is more susceptible to that. And if that breaks down over a period of time and your hypothetical situation of 15 years, and they fail conservative management, then you may have to offer them an additional surgery at that time.

Q Right. And let's assume the person has a surgery in 15 years so now they have two levels fused, so it's their second surgery. What happens after that? Does the process start all over again?

A What happens is the clock starts over. It's -- it is a chronic process of accelerated pathology within the spine as a result of an accident that causes a cascading of events; does that make sense?

Q Yeah. Can you explain a little bit more like more in laymen's terms or --

A So for example --

Q -- basic [inaudible]?

A -- if in 15 years a hypothetical patient requires a fusion at adjacent segment that doesn't mean for the rest of their life every other disc is going to remain normal. The other discs have to assume the responsibility of motion in that person's neck over the remainder of their life.

And once again, that hypothetical person may end up having symptomatic dysfunction of that disc above that second

surgery, second level fusion that I've discussed.

Q Okay. Now, I want to talk about Desire for a minute. You indicated yesterday --

THE COURT: Brendon, can you pull up the cut we used? And you just hone in, Brendon, on just the two -- or the 5-6 and 6-7.

BY MR. PRINCE:

Q Yesterday, we were talking about -- and this is the C6-7 disc here?

A Yes.

Q That's the one you did surgery on?

A Yes.

Q We also talked about C5-6?

A Yes.

Q Okay.

A Which has a disc bulge in my opinion.

Q Right. There is already some pathology there.

A There is already some pathology as a result of the accident that is present.

Q Right.

A And as I discussed before, the derangement of that disc, although not warranting surgery in my opinion, is going to potentially and more likely than not cause problems at a faster rate than if an individual had an isolated disc requiring surgery at that one level, with no pathology

elsewhere in the spine; does that make sense?

Q So are you saying then, because Desire has a problem at C5-6 already caused by the trauma of this accident, that that disc is just going to break down even faster than the 3 percent you're talking about and become symptomatic sooner?

A That is my concern.

Q Okay. Is that your opinion to a reasonable degree of medical probability, more likely than not in this case?

MR. WINNER: But it's not contained in the report and I renew my objection, Your Honor.

MR. PRINCE: Well, it is in his report. And that's part of his --

BY MR. PRINCE:

Q Did you form that opinion during the course of your treatment?

A Yes.

Q Was that something you considered when you --

MR. WINNER: I'd a ruling on my objection, Your Honor.

BY MR. PRINCE:

Q -- offered surgery [inaudible]?

THE COURT: Overruled.

MR. WINNER: These are new opinions being heard during trial.

THE COURT: Overruled.

THE WITNESS: I would have discussed with Desire extensively, not only the risks and benefits of surgery, but would have explained look, you have a disc bulge at C5-6. In my expert opinion it isn't causing active symptomology now warranting me doing a two level fusion on a 25-year old young lady with children. It just is not the right thing to do, in my opinion.

BY MR. PRINCE:

Q Right. Now, Dr. Khavkin, he actually recommended fusing that level.

A And there's nothing wrong with that.

Q No, I know, but he actually recommended doing surgery at that level.

A He did. And again, there's nothing wrong with that. Look, I just consider myself conservative.

Q No, right, it's a different -- your different surgical judgment.

A Just -- just a different opinion.

Q That's fine.

A And if you have the opinion of -- you know, if you ask two surgeons you may get three opinions.

Q Right. And so just on that point, given it already has concerns, were you already concerned at the time you offered Desire surgery that that disc is going to require surgery at even a sooner rate because it already has pathology

as opposed to the traditional 3 percent per year chance of -- or likelihood of having a surgery because of adjacent segment disease?

A Yes. The literature cites adjacent segment breakdown not with the assumption that there is already pathology as a result of an injury at the adjacent segment. And we have pathology at the adjacent segment which in my opinion is not symptomatic warranting a surgery at the time, but unfortunately, compromising to some degree the integrity of the disc.

Therefore, in my opinion, putting her at risk for a need for surgery sooner than later.

Q Very good. Do you believe that Desire will require a surgery at -- in her future?

A A hundred --

Q And --

A -- percent, absolutely.

Q Okay.

A In my expert opinion.

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

A Yes.

Q Was that as a result of the trauma of the October 30th, 2015 motor vehicle crash?

A Yes.

Q Is there any other more likely or more probable cause other than that?

A No.

Q Okay. And once she has that surgery does all of this process start over again, this adjacent segment disease process start over again for her?

A Yes.

Q And is that your opinion to a reasonable degree of medical probability?

A Absolutely.

Q And beyond that are you certain?

A Yes.

Q Okay. Now, I want to talk about -- kind of step back for a minute -- what a patient goes through as part of this adjacent segment disease like starting, you have the surgery, then the pain comes back and kind of the natural progression of this disease to the point of requiring a surgery. We haven't really talked about that.

I mean, do you counsel patients and have discussions with them about what they can expect, you know, once the symptoms start to return and going forward?

A Yes.

Q Do you treat patients who have adjacent segment disease, in your practice?

A Yes.

Q Do you counsel them on their options, both operative -- you know, operations, or conservative management until the point they need the surgery?

A Yes. And after an initial surgery I -- you know, if someone starts to have symptoms I don't rush to, you know, recommend surgery right away. What we try to do is, again, conservative treatment; physical therapy, interventional pain management, chiropractic care, if necessary.

But I just don't rush off to surgery. And unfortunately, again, as I had mentioned earlier about that cascading of events, it's sort of this, you know, crescendo, decrecendo, you know, going up and down of cervical spine abnormalities certainly following an accident.

And so we have a situation where someone's injured. They have onset of symptomology. They have failed conservative management, ultimately, requiring surgery. They have surgery. They have improvement. And they improve.

Over time then you can develop adjacent segment breakdown which may require medications again, physical therapy, injections up to the point where they may require adjacent segment surgery --

Q Okay.

A -- as I have discussed yesterday.

Q All right. If we can --

MR. PRINCE: Brendon, let's go to 74, Demonstrative

74.

BY MR. PRINCE:

Q So we had -- part of when we were meeting to discussing you kind of had an interesting analogy. It's kind of -- you told me about what day, what day does this process start all over again, and you have these discussions with your patients about what day does the pain start, do you have to reach for that pill, go to that doctor visit. Do you recall that discussion?

A Yes. I mean, I have that discussion with my patients. It is something that I always fear after my having back surgery. I always sit there and wonder, I have to look over my shoulder every day after I've had surgery wondering if I'm not going to overdo it, and hurt myself, following my surgery.

And so there's always something. And if I overdo it one day after having my surgery I'm like, I just want it to get better, let me take some, you know, some Ibuprofen or something and hopefully -- and it will continue to improve.

But not everybody continues to improve --

Q Right.

A -- and they can continue after a fusion to have problems for which, I believe you put up a slide regarding what may additionally be required after an initial surgery following an accident.

Q Right. I mean, at some point during this adjacent segment breakdown process will the patient develop chronic pain as a result of the adjacent segment disease and the breakdown of the disc?

A You can start to have recurrence of symptomology at a different level --

Q Right.

A -- causing pain.

Q And will that pain eventually become chronic?

A It can become chronic and ultimately require surgery.

Q Right. But before surgery, do the -- go through like what Desire went through already in this case; doctor visits, x-rays, MRIs, physical therapy, and injections before you ultimately go to surgery?

A Yes.

Q So you have to complete the whole process again?

A It's just like reinventing the wheel.

Q Okay. And so when you offer surgery to someone, Dr. Garber, I mean, I think you said yesterday, you tell them to hold on as long as possible and basically if they get to the point of their wits end before they have their surgery?

A Surgery for me is always a last resort. I do not want to operate on anybody until they have not only failed conservative management but I ask them, you have to decide; is

your pain and are your symptoms bad enough that you wish to consider surgery? And ultimately, after the failing of conservative management there's nothing else to offer if they -- if their symptoms are bad enough.

Q Right.

A And then surgery can be most beneficial for many people when properly indicated.

Q Right. In your opinion, will Desire have to go through all of this process as a result of adjacent segment disease; the return of pain, the development of chronic pain, doctor visits, MRIs, physical therapy, conservative management, injections and ultimately at some point surgery?

A Yes.

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

A Absolutely.

MR. PRINCE: Hang on one second, Your Honor.

Your Honor, thank you. I'd have no additional questions.

Dr. Garber, thank you for your time.

THE WITNESS: Thank you.

THE COURT: Mr. Winner?

MR. WINNER: May I have Defense Exhibit DD, please?

MR. PRINCE: Your Honor, can we approach, please?

THE COURT: Sure.

(Bench conference)

MR. PRINCE: None of his exhibits are in evidence and I don't agree to any -- I haven't stipulated to the admission of his exhibits, and I won't, because they're not redacted properly. All of Dr. Garber's records are in the plaintiffs' exhibit.

MR. WINNER: No, they're not.

MR. PRINCE: Which --

MR. WINNER: You had edited them out.

MR. PRINCE: No.

MR. WINNER: Yes.

MR. PRINCE: I don't feel I did. I used all of yours, whatever you gave, I put in my final file.

THE COURT: Is --

MR. PRINCE: I used your exhibits. I actually converted your [indiscernible] have a complete set. I used your records.

THE COURT: (To Clerk) Is Defense Exhibit DD in evidence?

MR. WINNER: No.

THE CLERK: These are all [inaudible].

MR. WINNER: Not yet, they're not.

THE COURT: Okay. So it's -- we're just looking to authenticate and offer; is that the plan here?

MR. PRINCE: Well, they're authenticated.

MR. HENRIOD: [Inaudible].

MR. PRINCE: But I don't agree that they're -- they can be admitted, because if he doesn't have -- if they're not redacted, and they have all kinds of insurance information, other stuff in there, so I'll not --

THE COURT: Well, they can -- they can be admitted subject to redaction, if there's required redaction. That's no biggie.

So just -- do you know whether -- does somebody want to find it so she's not --

MR. WINNER: Yeah.

Caitlyn?

MS. LORELLI: Yes.

(Pause in the proceedings)

THE COURT: I don't want it.

THE CLERK: I don't know if you need to see it.

THE COURT: I don't want to see it.

Counsel do you guys agree on what needs to be redacted?

MR. PRINCE: No. I've never -- no. We don't --

MR. HENRIOD: No. I mean, we wouldn't have an issue with if we didn't think that stuff wasn't redacted that didn't have to be.

MR. PRINCE: Well, we had a 2.67 --

THE COURT: I don't understand that necessarily but.

MR. PRINCE: We had a pretrial conference where we did a --

MR. HENRIOD: We didn't [inaudible] --

MR. PRINCE: -- a record where we had a court reporter there and they didn't -- they were not even offering their exhibits in because they're not redacted corrected.

THE COURT: Are you guys required to offer exhibits ahead of time?

MR. HENRIOD: Well, and yes, [inaudible].

THE COURT: Can't we just do it in trial? Isn't that the point?

THE COURT: You can, but I'm saying I don't --

MR. HENRIOD: [Inaudible] --

MR. PRINCE: -- I don't agree to their --

MR. HENRIOD: -- [inaudible].

MR. PRINCE: -- [inaudible].

THE COURT: Oh, no that's fine. They can leave -- [inaudible] but I need to know -- Mr. Prince, I need to know what --

(Pause in the proceedings)

MR. PRINCE: We ended up making -- the defense, their whole exhibit, proposed exhibit became ours, but we redacted it all correctly. So we have the same records they have.

MR. HENRIOD: Well, then there shouldn't be a

problem.

THE COURT: So you're saying their DD --

MR. HENRIOD: What we're disagreeing with about is the scope --

MR. PRINCE: Why can't we just use what's in --

MR. HENRIOD: -- without redaction.

MR. PRINCE: -- why can't he just use what's in evidence?

MR. HENRIOD: Because we disagree about the scope of the redaction.

MR. PRINCE: Which ones?

MR. HENRIOD: [Inaudible] Mr. Winner on the specific.

MR. PRINCE: Yeah, he's never said anything about that.

THE COURT: So Defense DD is the equivalent of Plaintiffs' what?

MR. PRINCE: 50. Exhibit 50 is the same, Tom. [inaudible].

(Pause in the proceedings)

THE COURT: Could somebody -- could somebody tell me what the redaction that's at issue is?

Okay.

MR. PRINCE: It's 50.

(Pause in the proceedings)

(End of bench conference)

THE COURT: All right. Mr. Winner, did you find what you're looking for?

MR. WINNER: Yes.

THE COURT: Okay.

CROSS-EXAMINATION

BY MR. WINNER:

Q Doctor, do you have Exhibit DD in front of you?

A Is it okay if we turn off the noise?

THE COURT: Oh, yeah, the white noise.

THE WITNESS: I couldn't hear, I apologize.

THE COURT: Okay. I didn't even notice it.

THE WITNESS: Okay. Yes.

BY MR. WINNER:

Q Exhibit DD, do you have that in front of you?

A There we go.

Q Did you tell the jury yesterday or did I hear you tell the jury yesterday that this patient was referred to you by Dr. Rosler?

A That's my recollection.

Q Okay. Would you turn to page 62, please?

A Yes.

Q Did you ask the patient on an intake form how she learned about your practice?

A So it says right here, how did you learn about our

practice? It says, Other, lawyer.
Q I'm sorry?
A It says, other, and then lawyer.
Q She was referred by her lawyer, correct?
A She may have heard about our practice from a lawyer. I don't know if she was, indeed, referred by a lawyer. More likely than not, Dr. Rosler referred the patient to me.
Q Could you tell the jury where you were this morning, please?
A I was in surgery at Valley Hospital.
Q Were you in an arbitration hearing this morning?
A I subsequently went to an arbitration hearing.
Q On who's behalf were you appearing in the arbitration hearing?
A The patient or the attorney?
Q The attorney.
A Paul Powell.
Q Paul Powell?
A Yes.
Q And was Paul Powell the attorney who was representing this particular patient at the time you saw her?
A I believe she was.
Q And she indicate the responsible financial party would be Paul Powell when asked that -- your form?
A If was seeing her, when she first came to see me,

and it being the responsible party from Paul Powell, then yes. But quite important to remark as I had said yesterday, I performed her surgery on her insurance.

Q Doctor Rosler yesterday, and I think you yesterday, were talking about the difference between a bulge and a protrusion and a herniation; correct?

A Yes.

Q Okay. Do you distinguish between a protrusion and a herniation?

A For me, as I said yesterday, a protrusion and disc herniation are essentially synonymous. A bulge is a bulge.

Q Dr. Rosler testified yesterday -- Dr. Rosler testified yesterday that a protrusion is very different from a herniation because with a protrusion there's no disc material going outside the disc space, it's contained in the disc space.

A That's Dr. Rosler's discussion of it. I would respectfully disagree.

Q Okay. Would you agree that no physician looking at that 2015 MRI found a herniation, meaning, any disc material getting outside the disc space [inaudible] --

A False.

Q -- neither a bulge or a herniation was found.

A Bulge or herniations are two different things. Let me clarify. There was a disc herniation, in my expert

opinion, based upon my review of the medical records, and the films themselves. Based upon her symptomology a C7 radiculopathy existed. The patient had a bulge which is a slight bulging of the annulus as we discussed, about the architecture of the disc yesterday.

There is frank nuclear material that is breached through the annulus or the outside of a disc that in my opinion, that way I use terminology a protrusion and a herniation are synonymous terms. They are the same for me.

Now, whether Dr. Rosler thinks differently of a protrusion or a herniation, to me it's the same. A bulge is different however.

Q Let's use the same terms there. On a herniation, as Dr. Rosler described it, would be nuclear material, disc material getting outside the disc space, outside the annulus; okay?

A That's Dr. Rosler's description of it.

Q Okay.

A Okay.

Q Did the radiologist see anything like that --

A I believe there was a --

Q -- in 2015?

A -- disc protrusion at C6-7 noted.

Q Okay. Protrusion meaning --

A Herniation, in my opinion.

Q Okay. In your opinion. Was there any -- any -- any nuclear material going outside the disc space on the radiologist's read of that film?

A May I have the report? What Bates stamp number is that, please?

Q You don't remember?

A I'm happy to tell you that my recollection is a disc herniation present at C6-7.

Q Can you identify any other physician in the case who agrees with you that there was a herniation at C6-7?

A There's nobody else that needs to agree with me, intraoperatively, subligamentous disc material was present and found in the operating room.

Q Okay. Understood.

A So --

Q On any of the films --

A -- regardless of what the radiologist said, clearly, the clinical picture, the MRI reviewed by me, the symptomology and the confirmatory surgery which demonstrated a subligamentous disc protrusion removed in two distinct fragments, as documented intraoperatively by me, was noted. I was the surgeon. I found that.

Q You saw disc material outside the disc space when you -- when you operated on -- in September of 2016?

A And there was subligamentous disc material. So let

me go over the anatomy again, if you wish; is that okay?

The annulus the disc contains the nuclear material consistent with crab meat. Behind that, in front of the spinal cord and the nerve roots is the posterior longitudinal ligament.

Now, may I have a scratch pad with some paper?

MR. PRINCE: You can.

BY MR. WINNER:

Q No, I'd like you to answer my question, please.

MR. PRINCE: Well, Your Honor, he's trying to answer the question. He asked --

THE WITNESS: I'm trying my best to answer it. You have material that breached through the annulus of the disc and, in fact, went through the fibers of the posterior longitudinal ligament, putting it subligamentous under the ligament causing nerve root compression.

And hence, the reason intraoperatively I made the notation of that.

BY MR. WINNER:

Q Intraoperatively, you did that?

A Yes.

Q Did you see that on any MRI?

A Yes. That is why I operated on her. I did not operate on her for absence of radiologic and clinical findings. Nobody would operate on somebody with absence of

radiological on MRI, and clinical findings, after failure of conservative management, after someone was involved in an accident.

Q So you know Dr. Wang, of course?

A Yes.

Q You said you respect Dr. Wang?

A Yes, I do.

Q Professor at the University of Southern California?

A Yes.

Q If Dr. Wang were to testify that if he gave those films, that 2015 MRI to his fellowship students, and they found any operable pathology he would fail them, what would you have to say about that?

A First of all, I respectfully disagree with Dr. Wang, and second of all, he was not in there, in the operating room performing the surgery on Desire, who in fact had a disc protrusion.

Q Okay. If a traumatic disc protrusion or a traumatic disc herniation happens, wouldn't you expect pain to develop immediately?

A Not necessarily, no.

Q Not necessarily? Does it --

A No.

Q -- often happen?

A More likely than not, it does not have to be that

way.

Q More likely than not it doesn't have to be that way?

A Let me restate that. You do not have to instantaneously have onset of radiculopathy, pain down the arm, as a result of a traumatic disc protrusion.

Q Do you need to have an immediate neck pain if there's a traumatic disc protrusion or disc herniation?

A Not necessarily, no.

Q Okay. What happened two days before she saw you for the first time?

A Two days before me?

Q You saw her July 12th, 2016. What happened two days before she saw you?

A She was involved in a motor vehicle collision.

Q Okay. Are you aware in that motor vehicle collision she had immediate onset of neck pain, immediate onset of arm pain, immediate onset of back pain and was taken by ambulance to the hospital?

A To Sunrise Hospital.

Q You are aware of that?

A Yes.

Q Okay. Dr. Rosler testified yesterday that he thought she needed a repeat MRI. Why wasn't one done?

A It was my opinion, based upon my discussions with her, that her symptomology remained consistent but somewhat

exacerbated or aggravated following that accident. But no differentiation in symptomology developed. For that reason, with the persistence of the same symptomology, in my expert opinion, no additional MRI imaging was recommended.

Q Okay. Are you aware that the plaintiff -- have you seen the plaintiff's deposition in this case?

A I believe I have in the past.

Q All right. So you're aware that in her deposition she said that the morning before that, July 2016 accident happened, she had no symptoms in her, her arm was fine?

A And if you look at my reports, what she had, in my opinion, is a disc injury as a result of the 2015 accident, and she could've very well aggravated that disc with this accident, with the similar symptomology again, not necessarily requiring, in my expert opinion, another MRI.

Q And did she tell you that -- didn't she tell you the chiropractic treatment had failed?

A I believe so.

Q Okay. In reviewing the chiropractor records, don't you see that her complaints were either minimal to nothing by the time she finished chiropractor treatment; no neck pain, no arm pain?

A Was that February of 2016 you're referring to?

Q January and February.

A Well, the patient also had an injection with Dr.

Rosler in January, which can also provide some transient relief for anywhere from say 4 to 8 weeks depending on how their therapeutic response is.

Q Were you here for Dr. Rosler's testimony yesterday?

A Not entirely, no.

Q Okay. Dr. Rosler testified she had minimal pain according to the chiropractic records before she got that injection.

A Well, I respectfully --

Q Isn't that consistent with the records you saw?

A Well, it's not consistent with what Dr. Rosler notes as 8 out of 10 pre-procedure, which went to a 0 out of 10 post-procedure in January of 2016.

Q Okay. And how do you explain 2 out of 10 pain, 2 out of 10 pain, 3 out of 10 pain, 2 out of 10 pain, in the days before she went to see Dr. Rosler? Much improvement, much improved, much improvement.

A Unfortunately --

Q The chiropractic treatment failed?

A I think what happens is you can have a limited benefit of chiropractic treatment but at the same time once you've sustained an injury to the disc, once you have a herniation of nuclear material outside of the annulus putting nerve root compression, you can have exacerbations and remissions of these types of pain. You can have aggravation

with activity, and it can get better either with medication and rest. It just depends.

And so I can't account for the responses generated by the chiropractor on those daily visits. Now, were those pain scores after chiropractic treatment and traction? I don't recall. But what I'm trying to explain to you is that Dr. Rosler is a very reliable pain management doctor. His pre-procedure pain score was 8 out of 10. Post-procedure, 0 out of 10, appropriately identifying the C7 nerve root being irritated by the disc herniation sustained by the October of 2015 accident.

Q Okay. Did you also review the records of Dr. Khavkin, the records of Dr. Rosler?

A Yes.

Q Did you see in those records that the plaintiff, when asked specifically, told Dr. Khavkin:

I have never had pain in my neck before. I have never been treated for my neck before. Did you see where she said that?

A I don't recall the specifics of what she actually told Dr. Khavkin. I would have reviewed those in the past. I do not have those in front of me.

Q Do you recall where she told Dr. Rosler, I have never had neck pain before, I've never been treated for neck pain before?

A I can't recall the specifics. I'm happy to review those records with you.

Q Do you believe --

A It was my understanding --

Q -- the patient --

A -- when I discussed this with the patient, she had no ongoing treatment for her cervical spine prior to the accident in question.

Q Okay. Had she had any ongoing treatment of her cervical spine in the months leading up to your accident other than one visit to Dr. Rosler?

A In the events up to when, sir?

Q July 12th, 2016.

A I don't have the specifics of the exact treatments prior to that.

Q Okay.

A I know that she had an accident before, she had had injections with Dr. Rosler in January and April of 2016.

Q Okay. Does everybody who has a disc protrusion or a disc herniation need surgery?

A No.

Q Do you refer patients with disc herniations or disc protrusion to physical therapy?

A Yes.

Q Do you refer patients with disc protrusions or disc

herniations to chiropractic?

A Yes.

Q People with disc protrusions and disc herniations often don't even know they have them?

A If you do not have symptoms, more likely than not, you don't have them.

Q Okay. If you took an -- I'm 52 -- if you took an MRI of my back and my neck, studies show that you're likely to find herniations and disc abnormalities all up and down my back, right?

A I would opine that you probably have less likely disc herniations. You may have the onset of degenerative disc disease with osteophytosis and osteophyte formation.

But the obvious frank herniation much like the two subligamentous disc material protrusions that I removed from Desire's spine, you would not have -- you would not have unless you're having paresthesias. And quite frankly, that MRI would not be arbitrarily done on you, unless you had a reason to have one done.

Q Okay. The November 2015 MRI, did that show any obvious signs of recent trauma? In other words, did you see any bone marrow contusion on any of the vertebral bodies?

A Not that I can recall.

Q Did you see any ligamentous laxity?

A But you wouldn't really see ligamentous laxity. If

you're talking about ligamentous disruption of either the anterior or longitudinal ligament or posterior there was not any there.

Q Okay.

A But a clear disc protrusion in my expert opinion was, in fact, present.

Q Okay. Do you know why Dr. Rosler, Dr. Khavkin, Dr. Schifini, Dr. Wang would all say there was no disc material coming outside the annulus on that November 2015 MRI?

A I respectfully disagree.

Q Okay.

A In fact, the confirmatory observation as I have told you were those two distinct fragments of subligamentous disc material removed intraoperatively causing nerve root compression.

Q Okay. That was intraoperatively in September of 2016; correct?

A Yes.

Q Two months after another accident when you were asked to get another MRI and you didn't; right?

A I was not asked to get another MRI.

Q The patient was asked to get another MRI by Dr. Rosler --

A I was not asked to get another MRI.

Q -- correct?

A You just said that.
Q Okay.
A So that's an error. I felt that her symptomology was consistent but aggravated with that secondary accident without any distinguishing difference in symptomology, not necessitating an MRI. That is a clinical decision. And as a doctor, Dr. Rosler may have felt to get an MRI. My clinical decision and what I felt to be clinically relevant did not warrant an MRI because of a recurrence of symptomology that was consistent with what she had before that accident, specifically, in my expert opinion within a reasonable degree of medical probability, correlating to that disc protrusion at C6-7 is a result of the October of 2015 accident.
Q Why not -- why not the July 2016 accident?
A Because we have clear identification of a disc herniation on the MRI --
Q That only you can see?
A -- prior to the 2016 accident --
Q That only you can see?
MR. PRINCE: Objection, argumentative. He keeps cutting the witness off.
THE WITNESS: That I can confirm when I did the surgery on her.
BY MR. WINNER:
Q After a second accident; correct?

A With persistence of the same demonstrable dermatomal radiation of symptoms that did not change after that second accident. No additional symptomology was noted for which I did not feel clinically another MRI was warranted.

Q Okay. Did you review the records of Dr. Khavkin?

A Yes.

Q Okay. Did you review the pain diagram she filled out for Dr. Khavkin?

A I would have reviewed that, yes.

Q Okay. Can you explain why she would have had pain down both legs, in her lower back, in her mid back, in her neck, in both shoulders, in her head and down both arms in May of 2016, when most of those symptoms were being presented for the first time?

A I do not have a distinguishing difference other than what was made clear to me in my discussions with the patient and in my review of the medical records as well.

Q Let me ask you hypothetically; if a herniation showed up after -- after July 10th, 2016, do you think that's the fault -- do you think that's the fault of Babylyn Tate?

A Would you repeat the question?

Q Yeah. If a herniation showed up for the first time in July of 2016 or September of 2016 when you did your operation, is that the fault of Babylyn Tate?

A It's -- it's my expert opinion that the --

Q That wasn't my question.

A The accident of 2015, in my expert opinion, caused the disc protrusion necessitating surgery.

Q Okay. And if that disc herniation appeared for the first time in your interoperative report in September of 2016 --

MR. PRINCE: Your Honor, can we approach, Judge? I want to talk about [inaudible].

(Bench conference)

MR. PRINCE: I'm going to move to strike all of these questions, absolutely.

We have a problem with an ongoing violation of your order. Do you have the copy of your order? I'll hand it to you. The May -- the April 22nd, 2019 order. I'm going to hand you relating to Motion in Limine No. 14, Motion in Limine No. 14 is the motion titled, "to preclude the defendant from characterizing plaintiff Desire having neck pain following the July 10th, two thousand [sic] motor vehicle collision as anything other than temporary exacerbation is granted. Defendants retain medical [indiscernible] testifying that the plaintiff experienced increase of symptoms after the motor vehicle accident so long as that opinion is articulated in the report. Defendant and her counsel are allowed to argue that neither the subject October 2015 nor the subsequent 2010, 2016, caused any need for surgery."

They can't argue that that was what brought on the need for surgery. You've foreclosed that. If anything other than a temporary exacerbation which is exactly what he's saying. So him to suggest that there's a new injury and that brought on the need for surgery that is completely foreclosed by your order. Here's a copy of it.

MR. WINNER: Well, my argument is that the herniation was only seen intraoperatively after the second accident.

MR. PRINCE: No, you foreclosed it. No, that operative note was in existence at the time a -- throughout discovery. That has been present. Those -- their experts don't say, or suggest or argue that the July 2016 caused any need for surgery, any worsening of conditions, other than a temporary exacerbation of symptoms.

MR. HENRIOD: It's not our burden to prove that the two thousand six --

MR. PRINCE: Oh don't -- hang on, no, there's two --

MR. HENRIOD: Wait, wait, wait, wait --

MR. PRINCE: -- there's two arguing.

MR. HENRIOD: Are you -- are you done or?

MR. PRINCE: The problem -- no, the problem is --

MR. HENRIOD: Okay.

MR. PRINCE: -- there's two people arguing.

MR. HENRIOD: Okay. Well, let me know when

you're --

MR. PRINCE: I know. The problem is we always have two people arguing for their side.

THE COURT: I'm not going to tell you guys who can argue your side. If you want to argue all yours, and you want to -- and you want to -- as long as you just argue one at a time I don't care.

MR. HENRIOD: It's not our burden to prove that the 2016 accident did cause this in order to cast doubt on --

MR. PRINCE: No, no.

MR. HENRIOD: -- probability that the 2015 accident did -- and we are not trying to. The issue is whether or not all of the medical data considered together makes it unreasonable to isolate the 2015 accident --

MR. PRINCE: Oh, no, no.

MR. HENRIOD: -- as the more likely than not cause. And Williams vs. District Court makes that perfectly permissible.

MR. PRINCE: Oh no, we -- the Judge -- you've already ruled on this. They can't characterize it as anything other than a temporary aggravation. They can't say worsened, that the cause of disc herniation increased anything, they only can --

THE COURT: I don't know that they have.

MR. PRINCE: With these --

MR. HENRIOD: Well, no --
MR. PRINCE: -- with these questions they are.
MR. HENRIOD: No, what we're saying is --
THE COURT: I think they're impeaching him.
MR. HENRIOD: -- in light of this happening you say it's that.
THE COURT: Right. What's the question pending that's actually objected -- that was --
MR. PRINCE: No, because he keeps asking --
THE COURT: -- that triggered the objection?
MR. WINNER: What did you object to?
MR. PRINCE: It was the question about the presence of a disc herniation only after the second accident and that's something new. That -- they don't have that evidence, they don't have that ability. Your order forecloses that.
That's why we filed that Motion in Limine, to argue that -- they can't argue that that created a new injury for which she required surgery and that was the reason why.
MR. HENRIOD: I disagree.
MR. PRINCE: That order is --
MR. HENRIOD: It does preclude --
MR. PRINCE: -- you -- you said it's only --
MR. HENRIOD: -- that and if he does --
MR. PRINCE: -- can show --
MR. HENRIOD: -- [inaudible] --

MR. PRINCE: Well, what?

MR. HENRIOD: -- [inaudible].

MR. PRINCE: Well, that's what the -- well we've been enforcing this order and this is the order that you signed.

MR. WINNER: Okay. Well, this Dr. Garber just got up on the stand and said, I can prove it was a herniation, I can prove it because I saw it in her operatively. I pulled out two pieces of disc so I can prove that there was a herniation.

MR. PRINCE: Well, that was there from the beginning.

THE COURT: Yeah, but I --

MR. WINNER: I'm not finished.

THE COURT: -- I think --

MR. WINNER: And he's not considering the possibility it was the two thousand -- July 2016 accident. I can cross-examine him on that. He can't open the door and close it behind him.

MR. HENRIOD: Mr. Prince just got a lot of latitude, a lot of latitude --

MR. PRINCE: I got no latitude.

MR. HENRIOD: -- on -- I think having on -- I think having [inaudible] on deviating from precisely what is in the reports and what is not.

MR. WINNER: And my experts will say she wasn't surgical, period. And our accident did not cause the need for a surgery.

THE COURT: No, I know. Which a lot of this is -- I don't know if the word is irrelevant but -- and that's -- give me the question again exactly what your objecting to.

MR. PRINCE: The objection is he keeps asking questions of like she's have a new injury, that these are new findings, and this brought out -- the second accident brought on the need for surgery.

THE COURT: Well, I understand.

MR. PRINCE: They can't -- they can't argue anything that -- other than a temporary aggravation.

THE COURT: My understanding is he's asking him if -- not so much these are -- but you don't know if they were new or not, so I think it's more of an impeachment kind of thing; do you know what I'm saying? He's not saying it happened, he's saying you don't know if it happened because you didn't order it.

MR. HENRIOD: That's what I'm saying.

THE COURT: Right?

MR. PRINCE: Judge --

THE COURT: I mean --

MR. PRINCE: -- she was already determined to be surgical at two levels before this.

THE COURT: Well, that's what he's saying. But they're actually [inaudible] --

MR. PRINCE: Well, and that's --

THE COURT: -- to say not.

MR. PRINCE: -- that's not what he's saying. There's a -- there's a neurosurgeon sitting right in back of the courtroom that's going to be up here in about 15 minutes who's going to say that.

MR. HENRIOD: Well, yeah, he's --

THE COURT: Okay.

MR. HENRIOD: -- it was declared surgical by somebody who said two discs needed to be removed. So he was declared surgical by somebody who was wrong [inaudible].

THE COURT: Well, okay, I'm going to overrule it. Don't -- keep this order in mind so you don't run afoul of that. But other than that, I think this is impeachment.

(End of bench conference)

THE COURT: It's overruled.

BY MR. WINNER:

Q Doctor, you would agree that different radiologists can review the same MRI or the same part of the anatomy differently; true?

A Radiologists can render different radiological interpretations of imaging studies, yes.

Q Okay. Well-trained surgeons can view spinal MRIs,

the same spinal MRIs differently; true?

A Yes.

Q Okay. So if Dr. Wang says he sees little or no pathology on that MRI I understand you disagree, do you think Dr. Wang's lying, unreasonable?

A I'm not saying he's lying. I'm saying I respectfully disagree with his interpretation.

Q Okay.

A Which is only confirmed by my interoperative findings of two subligamentous disc fragments.

Q And after that second accident you did not get another MRI; correct?

A For which the symptomology remained identical without change in quality, quantity or anything else of that nature.

Q Did the -- did the patient tell you that the Chiropractic treatment hadn't helped her?

A I believe she had transient improvement with both injections and chiropractic treatment.

Q And did you accept that as true?

A I believe she had transient improvement with both injections and chiropractic treatment.

Q Did she tell you that the injections didn't help her at all?

A Again, transient improvement for which I've noted

and encountered, number one, dated 7/12 of 2016. Injections lasted for approximately two to four weeks at times.

Q Okay. We asked you about this in your deposition. Between 2010 and 2015, you're aware that she was working at a job where she was lifting repeatedly over and over again 50 pounds --

A Yes.

Q -- at a time?

A Yes.

Q And you said that could cause what to the cervical discs?

A You could have transient aggravation of symptomology.

Q And it can cause wear and tear?

A Yes.

Q It can cause wear and tear of the discs?

A It can cause wear and tear of the spine. However, it remains my understanding she had no ongoing treatment of her cervical spine prior to the October of 2015 accident, ultimately necessitating surgery, in my opinion.

Q Do you get referrals directly from Paul Powell?

A Not that I can recall. Most of those referrals, quite frankly, go through interventional pain management doctors. And I think it's important to note, like we discussed yesterday, 15 percent or less of my practice is lien

personal injury work.

Q Okay. The letter you wrote -- you wrote a letter about adjacent segment breakdown back in 2017. Do you have that in front of you?

A Bates number, please?

Q I think Mr. Prince asked you about it. The one -- the one to four percent a year; that one.

A Yes.

Q Okay. So somewhere between one to four percent a year you used an average of two percent in your --

A And your expert --

Q -- calculation.

A -- used three; yes.

Q Okay. I think you used two in your report, but that's fine.

A Yes. And Jeff used three.

Q Where did Wang use three?

A I believe in my recollection he would have used three in some report.

Q He did not, so where --

A Okay.

Q -- did you get that number?

A It may have been another report that he generated elsewhere.

Q Or something Mr. Prince said to you this morning?

A No, because the rate of degeneration as I have said is one to four percent per year.

Q Okay. Let's assume it's one percent a year. And she's how old at -- at the time surgery was done?

A Twenty-six. Twenty --

Q So if it breaks down at the rate of one percent a year, she would have a greater than 50 percent chance of having adjacent segment breakdown at age 76; correct?

A Which is before she expires, yes.

Q Okay.

A Now, what's more important is as I have discussed yesterday in my deposition -- or in my trial testimony is the fact that there is a pathologic abnormality of disc bulge at C5-6. So that it is my expert opinion within a reasonable degree of medical probability that the need for surgery at C5-6 is going to come much sooner than that. Quite frankly, 15 to 20 years, in my estimation, as a --

Q Most of the --

A -- board certified neurological surgeon.

Q Thank you. Most of the people who develop adjacent segment breakdown, meaning, they develop some symptoms after a number of years in an adjacent disc, adjacent segment breakdown means, one, begins to have some disc breakdown and some symptoms in an adjacent disc, correct?

A Yes.

Q Most patients who develop adjacent segment breakdown whether it's in 20 or 40, or 30 or 50 years, most patients only start to develop disc disease and breakdown at that level; correct? They don't automatically need surgery?

A As we've discussed earlier, and there's a continuum of treatment that I think individuals that begin to sustain adjacent segment breakdown need to undergo.

The first thing is if there's ongoing symptomology following an initial surgery, an evaluation by a clinician interventional pain management or somebody else needs to be done. Radiological imaging, because of the documented literature, noting the risk of adjacent segment disease, and as I have said earlier, 30 percent in certain literature citations within the first 10 years.

So that radiological films should be done, MRIs, physical therapy, interventional pain management, and then if problematic and persistent, a surgical evaluation.

Q A small minority of patients, according to the literature, who get adjacent segment breakdown, a small minority of them actually go on to want the surgery for the adjacent segment breakdown; isn't that true?

A I disagree with that, respectfully.

Q You disagree with that?

A Yes.

Q So everybody who gets disc disease at an adjacent

level goes -- goes and gets surgery?
A No, I said more likely than not they would.
Q Okay.
A Not everybody. There's a distinguishing difference.
Q Degenerative disc disease is something you commonly treat; correct?
A Yes.
Q Degenerative disc disease is frequently not brought about by trauma; correct?
A No. But in the setting of degenerative disc disease, other individuals who are older that have preexisting degeneration may be asymptomatic, may be subjected to an accident and have a superimposed disc protrusion thereafter.
This scenario, however, does not apply to Desire.
Q Surgery on degenerative disc disease without a trauma, without a car accident, without somebody to blame it on is one of the most common surgeries performed in the United States every year; isn't it?
A You would have to be more specific about what type of surgery you're referring to.
Q Spine surgery on degenerative disc disease.
A That's not necessarily correct.
Q Not necessarily? Do you operate --
A In my opinion --
Q -- more on --

A -- cervical degenerative disc disease does not require an arbitrary operation. It would depend upon the pathology and whether or not anterior cervical is necessary or a posterior decompression or a microdiscectomy. But --

Q Well, let me ask you about --

A -- again --

MR. PRINCE: Hang on, he wasn't done.

THE WITNESS: -- in the presence of degenerative disc disease, the pathology and cascading are different. In the setting of a young lady who was involved in a traumatic incident, causing a disc protrusion, failing conservative management, necessitating a surgery, is relatively more common than you think.

And as I have said earlier, covering Level I trauma at UMC there are individuals that have, in fact, disrupted their spine requiring urgent operations and there's individuals that have sustained traumatic disc protrusions that come to my office following that, that ultimately require surgery.

Q Mrs. Evans also had some problems with her left shoulder, correct?

A Yes. And as we've discussed earlier yesterday, the significance of the bone contusion in my standpoint -- from my standpoint is the fact that there was a decree of impact, into that shoulder, translating forces to the cervical spine, and

in my expert opinion, more likely than not, causing that traumatic disc protrusion failing conservative management ultimately my finding intraoperative subligamentous disc material, two distinct fragments that, in fact, necessitated surgery.

Q So she impacted something in the car hard enough to cause a bruise and that transferred to the neck?

A Translational forces. When someone strikes the side of a car door or something of that nature, obviously caused a bruise that was recorded on the MRI report. That then just doesn't stop there with the translation of forces to that shoulder.

Q Okay. All right.

A There are translational forces that are then extended to the cervical spine and in my opinion, contribute those forces to what caused her traumatic disc protrusion at C6-7 necessitating the ACDF.

Q Did you ask her if she struck anything on the inside of the car?

A Not that I can recall.

Q I did. She said she didn't. Does that change your opinion at all?

A Individuals involved in car accidents don't always know when they bump up against the side of a door. Obviously, the presence of a contusion following an accident more likely

than not indicates structural injury. And that structural injury in my expert opinion is not isolated to that shoulder but rather translational forces are applied to the cervical spine as well.

Q So when she says under oath, I didn't strike anything on the inside of the car, you say we shouldn't believe her?

A I say sometimes individuals involved in car accidents may not be aware that they may have struck something on the side of their shoulder or their arm causing injury if other things are going on. Whether or not she is scared or if there's a surge of catecholamines within her body, that basically after an accident cause her not to necessarily recall that.

Q Fifty percent of your causation opinion, or I think you said more than 50 percent of your causation opinion is based on what the patient tells you; correct?

A There was multiple things involved, both what the patient tells me as we've discussed, the radiological factors, the history I obtain, the response to certain levels of treatment, and ultimately, if indeed that fails, surgical recommendation is offered.

Q Okay. Under oath she said she didn't strike anything on the inside of the car. I'll represent that to you. Okay? In reporting to you, in reporting to Dr. Khavkin,

and in reporting to Dr. Rosler, when asked repeatedly, she said she had never in her life injured her neck before and had never had any treatment for her neck before.

My question to you is do you think she forgot going to the Bonanza Back Clinic, did she forget going to get that MRI?

A She -- at 19-years of age in 2010, being involved in an accident, having an MRI done, which was unremarkable as we discussed yesterday, normal, individuals at 19-years of age sometimes may not always remember or recall the specific incidents of an accident.

I believe she may have mentioned something of her lower back being involved.

Q Yes.

A But quite frankly she may not have remembered that her cervical spine was involved. And obviously, the confirmatory fact that it wasn't injured is the clear MRI report that we reviewed yesterday from Centennial Medical Imaging indicating absolutely no structural abnormality in the cervical spine.

Q Okay. And you respectfully disagree with Dr. Wang who says that MRI report for 2015 was essentially normal also?

A I disagree with him with respect to it being normal, number one. Number two, I certainly wouldn't fire my resident if there was a disagreement regarding the review of a film as

well. I find that a bit malignant.

Q Okay. So her reporting that she didn't strike anything on the inside of the car, your opinion is she probably forgot. Her not remembering having been to the Bonanza Back Clinic for a 2010 car accident, she probably forgot. Having sat through a neck MRI five years before this accident, your opinion is she probably forgot. Her having been to a different chiropractor who treated her for the same symptoms back in 2010, she probably forgot; is that right?

A There were no ongoing symptoms as a result of that accident. She probably recalled more of lumbar spine discomfort at that time as opposed to cervical. I do not fault a 19-year old for not recalling the specifics of a injury that certainly did not linger and cause ongoing symptomology prior to the relevant accident of October 30th, of 2015.

Q And do you suppose -- and despite all of that, all of that, the surgery that you did is Babylyn Tate's fault?

A Yes.

Q And do you think that's why Paul Powell gave her your name?

A I think that's why Dr. Rosler --

MR. PRINCE: Objection, move to strike. Argumentative, Judge.

THE COURT: Granted.

MR. PRINCE: Come on.
THE WITNESS: I think that's why --
THE COURT: Sustained.
THE WITNESS: -- Dr. Rosler -- excuse me -- I think that's why Doctor --
MR. PRINCE: No, no, no, hang on.
THE COURT: It's sustained.
THE WITNESS: Okay.
MR. PRINCE: I have a few questions, Doctor.

REDIRECT EXAMINATION

BY MR. PRINCE:

Q Well, first, did any question that Mr. Winner asked you change any of your opinions, or any thoughts or feelings at all in this case?

A None whatsoever.

Q All right. And with regard to the MRI of the cervical -- of the neck, you indicted that in your mind a protrusion, based on your review, you used that term synonym with the term "herniation"; is that right?

A Yes.

Q Okay. And in this case, the radiologist found a disc protrusion at C6-7, a clear abnormality, correct?

A Yes.

Q Dr. Rosler documented the same thing; correct?

A Yes.

Q And Dr. Khavkin who is also now present in the courtroom because he's going to be the next witness, you reviewed his records before coming to court; correct?
A Yes.
Q Let's look at Bate No. 275 in Exhibit 49.
A Mr. Prince, what -- I apologize.
Q Oh, sorry. I need to put you back in Book No. 1.
A Oh, I'm sorry.
Q [Inaudible]. I'll give you back [inaudible]. Here.
A Oh, I apologize.
Q I just want to help you get [inaudible].
A Sorry about that. Yes.
Q Okay. And Dr. Khavkin, you understand that he is also a board certified fellowship trained neurosurgeon, similar training to yourself?
A Yes.
Q He trained at the University of Chicago and Johns Hopkins University, those are world renowned teaching facilities, aren't they?
A Yes.
Q Just like Baylor is, right?
A Yes.
Q And Dr. Khavkin, let's look what Dr. Khavkin wrote. Once before you saw her, Direct visualization, an independent interpretation of the MRI says showed evidence of bilateral

level disc protrusion at the C6-7 level, as well as right pain level disc bulge in C5-6 extending to the right, pain level recess. Do you see that?

A Yeah, it should be right -- yeah, lateral recess. But, yes.

Q Lateral. Yeah, I probably said [inaudible].

A Yes.

Q Did he see the similar thing that you did?

A Yes.

Q Is that consistent with also what the radiologist saw?

A Yes.

Q Did he -- Dr. Khavkin offer a surgery based on his history, examination and his review of the MRI imaging that you've been talking about for two days now?

A And failure of conservative management, yes.

Q Right. Now, that report --

MR. PRINCE: Brendon, can you give me the top? There's like a little piece of the date.

BY MR. PRINCE:

Q Well, the date of Dr. Khavkin's recommendation is May 17th, 2016. That's the date of his consult. Look on page 274. Do you see that?

A Yes.

Q All right. That's two months before the July

collision, correct?

A Yes.

Q All right. Was there any difference -- basically, did you review the records before and after the July 2016 collision?

A I would've, yes.

Q After you did them, you authored a report about it, or you --

A Yes.

Q -- summarized them. And in addition to that you have those records available to you at the time you initially saw her on July 12th, two days later, correct?

A Yes.

Q And based upon your review of those medical records, and in speaking with Desire, was there any change, clinical change in her symptoms before versus after?

A No. And as I have said before answering Mr. Winner's questions, no distinguishing difference clinically in my expert opinion regarding the symptomology necessitating surgery as a result of the October 30th, of '15 accident.

Q Did her presentation remain the same leading up to the July 10th, 2016 motor vehicle collision in terms of her pain in her neck and the symptoms in her arm and into her hand?

A Yes.

Q If we could look at Dr. Rosler's note, just immediately before that collision, so on June 21, 2016, Exhibit No. 47, Bate No. 215.

Did she have ongoing complaints of neck pain at a 9 out of 10?

A Yes.

Q Okay. Let's look at Exhibit -- Bates No. 216.

MR. PRINCE: I want to look at the sensory exam, Brendon, immediately before the -- the July 2010 collision.

BY MR. PRINCE:

Q And it says, perception of light touch and pin prick was diminished along the C7 dermatome; do you see that?

A Yes.

Q Is that the same change in sensation that you saw after the July 10 accident?

A It was consistent with what I saw, yes.

Q And it's the same what Dr. Khavkin found in his exam back in May, right?

A Yes.

Q So clinically it was her -- was she in the same position before versus after?

A Yes.

Q Is that reason you didn't order an MRI -- an updated MRI?

A Yes.

Q Did you feel there was any medical necessity in ordering an updated MRI?

A No.

Q And more -- and beyond that, just so we can put a finishing touch on this -- you read the report of Dr. Wang, and Dr. Schifini, the local pain management doctors in this case, correct?

A Yes.

Q Do they in any way attribute the need for surgery to that July 2010 collision?

A No.

Q At all, right?

A None. And they shouldn't have because the MRI from 2010 was completely unremarkable.

Q No, I meant this -- the July 2010, the second one.

A Oh, excuse --

Q No, they don't attribute any --

A July of 2016?

Q Yes. Yeah, let me rephrase the question just to finish this point.

A Please.

Q Dr. Wang -- the defense experts, Doctors Wang and Doctor Schifini --

A Yes.

Q -- you read their reports?

A Yes.
Q Do either one of them say that the July 10th, 2016 collision, did that cause the need for surgery in any way?
A No.
MR. WINNER: That was outside the scope of their reports, Your Honor.
MR. PRINCE: No, that's an order of the court that they can't -- they don't -- we're not even saying that.
MR. WINNER: Well, you're asking him to interpret orders of the Court?
MR. PRINCE: No, he read the reports --
BY MR. PRINCE:
Q Right?
A Yes.
Q Right. And that's what they said, right?
A There was no association with that accident.
Q Right. Okay. So the question regarding Mr. Winner had -- his experts don't even support that opinion; correct?
A Correct.
Q Is there any -- of all the records you reviewed, including all of the depositions, the expert reports of the defense experts, Doctors Wang and Dr. Schifini, did they say that she had some kind of work-related injury in the five years between 2010 and 2015; is there any evidence, such evidence of that?

A Thirty percent of my practice is workers compensation. I never saw a C4 form submitted to me indicating a work comp injury in question.

Q All right. No evidence of that, right?

A None whatsoever.

Q Okay. Now --

MR. PRINCE: Brendon? [Inaudible].

BY MR. PRINCE:

Q Do you remember Mr. Winner asked you about adjacent segment disease?

A Yes.

Q Do you remember he asked you -- he wanted you to assume a one percent, right?

A Yes.

Q And that Desire, if you assumed one percent, then she wouldn't have any surgery until she's like 75-years old. Do you remember that question?

A Yes.

Q All right. So let's assume -- I want to work through this now, the mathematics of it, since he asked you to use that -- using three percent a year; okay?

A Okay.

Q What Dr. Wang has used. And you've used that in your deposition, right?

A I believe I used --

Q Is that a fair --
A -- 1 to 4 percent, yes.
Q Is that a fair number to use?
A Yes.
MR. WINNER: Excuse me. Dr. Wang did not say that in his report.
MR. PRINCE: He has a -- I have a deposition of him saying that. I'll show it [inaudible].
MR. WINNER: No, but you just said he said it in his report. You can't make things up and say it's in a report when it's not.
MR. PRINCE: [Inaudible].
MR. WINNER: You have a deposition from 2006.
MR. PRINCE: I do have it.
THE COURT: Gentlemen, approach.
(Bench conference)
THE COURT: Make sure you don't talk over each other, please.
MR. PRINCE: Okay.
THE COURT: My court recorder is having a hard time. I already told you not to reference the 2006 deposition of Dr. Wang. Whatever is in this case is fine. And that should be where we are. And I assume you recognize you opened the door on this chart.
MR. WINNER: He didn't say it as a report.

MR. PRINCE: Okay.

(End of bench conference)

MR. WINNER: Sustained?

THE COURT: Yes.

MR. PRINCE: All right.

THE COURT: Sustained.

BY MR. PRINCE:

Q I want you to assume that Dr. Wang will testify that it's 3 percent a year; okay?

A Okay.

Q I want you to assume.

A Okay.

Q All right. So at year one, I want to make sure we understand what this 3 percent means. At year one, 3 percent means there's a 3 percent likelihood that a person with a cervical spine fusion surgery is going to want or require a surgery at an adjacent level; correct?

A Yes.

Q In year two, there is this now a 6 percent chance that someone who's had a single level fusion at a level in their cervical spine is going to have a need for surgery in that year; in the second year; correct?

A Yes.

Q And then a 9 percent in the third -- likelihood of in the third year?

A Yes.
Q Twelve percent in the fourth year --
A Yes.
Q -- correct? So if we go out to 20 years, in 20 years a person who had a single level fusion using a 3 percent rate, there's a --
MR. WINNER: Excuse me, Your Honor, we're -- we're assuming Dr. Wang is going to say something that I don't believe he's going to say and it's not in his report. Same objection as before.
THE COURT: Okay. Here's what I'm --
MR. PRINCE: Well, I'm using the 3 percent. I'm using 3 percent.
THE COURT: Just don't attribute it to anybody.
MR. PRINCE: I didn't. I'm using this --
THE COURT: Okay.
MR. PRINCE: -- 3 percent.
BY MR. PRINCE:
Q I want you to use 3 percent.
A Yes.
MR. WINNER: In his report he used 2 percent. Why are we using 3 percent?
MR. PRINCE: He's [inaudible]. In his deposition he said 30 percent, in ten years 3 percent, in his -- what [inaudible] conservative? What do you [inaudible]?

THE COURT: Gentlemen, gentlemen, please --

MR. WINNER: He didn't say 3 percent, he said 2 percent.

THE COURT: Gentlemen, please approach.

THE WITNESS: I actually said 1 to 4 percent per year and I use, on a regular basis, 3 -- 2 percent. Now, as I have said earlier in my deposition -- my trial yesterday and today, remember as we've discussed, she already has existing pathology at C5-6. So I wasn't asked a question about her preexisting pathology as a result of this accident of October 15, and when that actual adjacent segment disease would occur.

But if you were asking me that question it would be far sooner because of that damage to the disc at C5-6 not producing a frank herniation but a bulge that compromises the integrity of that disc.

MR. WINNER: Thank you for the speech. We're actually arguing an objection. The doctor's report says --

THE COURT: Yeah, counsel approach.

MR. WINNER: -- two percent.

THE COURT: Counsel, approach.

(Bench conference)

THE COURT: You guys are going to tick off your jury. Just --

MR. WINNER: Hum?

THE COURT: You guys are going to [inaudible] your

jury, by the way.

MR. PRINCE: He's just being argumentative. He's making speaking objections.

THE COURT: Listen, here's the deal. He still cannot do the specifics. It's open in terms of just picking a percentage. I don't care what percentage he picks --

MR. WINNER: Well --

THE COURT: It's out there 1 to 4. If he wants --

MR. WINNER: He's --

THE COURT: -- to do a chart with two and you want to come back and redirect and do a chart with 4 or 1 or whatever, I don't care.

MR. WINNER: Okay, Judge. Look at the report, what he said is, in his clinical experience it can be 1 to 4 percent. In this case, I would use 2 percent. So I'm calculating based on 2 percent and Dennis keeps telling him to use 3. That's not in his report. He used 2.

MR. PRINCE: Except he picked the number.

THE COURT: Here's what I'm saying. Just --

MR. PRINCE: Well, he opened the door to all this.

THE COURT: You can cross -- you can cross-examine, not on the specifics though --

MR. PRINCE: Yes, he did.

THE COURT: -- just generally --

MR. PRINCE: Oh, no, no, no, he asked about Desire.

Oh, no, he said use the one percent on Desire's case.

THE COURT: Just her age.

MR. PRINCE: Oh, he exactly said -- oh, no, using that because of her age, he then went and he --

THE COURT: No, just -- just --

MR. PRINCE: -- oh, 50 -- she was talking need a fusion until she's 75.

MR. HENRIOD: Well, wait --

MR. PRINCE: He opened the specific door to this, Judge.

MR. HENRIOD: So you're saying --

MR. PRINCE: Oh, no, he used --

MR. WINNER: And then you stood up and told a lie to the jury that in Dr. Wang's report it says 3 percent.

THE COURT: You guys, the jury can hear you. They can hear everything you're saying.

MR. PRINCE: He says 3 percent. He does say 3 percent.

MR. WINNER: In his report?

MR. PRINCE: In his depo. I'm using it.

MR. WINNER: No, you said it was in his report and you said it front of the jury.

MR. PRINCE: [Inaudible] I have his depo [inaudible].

MR. WINNER: Making things up does not make you

smart. He did not say it in his report. He --

THE COURT: Guys, guys, guys, guys, guys.

MR. WINNER: -- did not say it in his report and you told the jury he did.

MR. PRINCE: Wow.

THE COURT: Guys, listen --

MR. WINNER: Yeah, wow.

MR. PRINCE: I said in his deposition.

THE COURT: All right.

MR. WINNER: You said report.

THE COURT: As I said, I have already said -- I initially said you couldn't get into this, but I think because of your questioning that he can produce a chart. But we're still not going to get into the specifics.

MR. PRINCE: Why? [Inaudible].

THE COURT: Because you can --

MR. PRINCE: -- [inaudible] Desire.

THE COURT: Because he didn't give specifics.

MR. PRINCE: Yes, he did.

THE COURT: No, he did not.

MR. PRINCE: He said -- he said assuming she's 25 and she had the surgery --

THE COURT: She's 25.

MR. PRINCE: -- at one percent -- at one percent --

THE COURT: But he didn't say based upon --

MR. PRINCE: Yes, he did. She won't --
THE COURT: -- anything else, it was strictly --
MR. PRINCE: -- need her surgery.
THE COURT: -- a year thing.
MR. PRINCE: He said -- no, he said assuming he --
THE COURT: Okay. Well, I'm finding that he didn't.
MR. PRINCE: He said use one percent a year. She won't need a surgery --
THE COURT: I don't know, do you want to have him do 2 percent a year?
MR. PRINCE: -- until she's 75.
THE COURT: Fine. You want him to do 3 percent a year? Fine. And 4 percent, you guys can do all the charts you want. But it's just -- it's specific other than --
MR. PRINCE: No.
THE COURT: -- or general other than her age.
MR. PRINCE: He already gave the opinion that he thinks in 10 to 15 years she's going to be -- in response to his question, because --
THE COURT: No, they --
MR. PRINCE: -- he opened the -- yes, he did. We can -- we can -- we can go back and listen -- we should go back and listen to it. It's -- it's very clear.
THE COURT: I don't want to listen to it again. What I'm saying is, he did the one year, one percent and you

did --

MR. PRINCE: That she won't need it until she's 75.

THE COURT: -- he -- correct. And going to go right now and do 2, and you can say, so under your calculation she'll need it at 40; okay?

MR. PRINCE: Yeah.

THE COURT: That's just --

MR. HENRIOD: But hold on. Where this is -- this is not leading to a second surgery, right?

THE COURT: Right.

MR. PRINCE: What's [inaudible]?

MR. WINNER: [inaudible] not leading --

THE COURT: We're still not leading to a second surgery.

MR. WINNER: -- to a second surgery.

MR. PRINCE: Huh?

THE COURT: You're still not leading to a second surgery.

MR. PRINCE: Well, I'm going to say the -- the adjacent segment disease will start over again, I'm not going to say --

THE COURT: You can say that but that's it.

MR. HENRIOD: Whoa, whoa, whoa.

MR. PRINCE: Yeah, yeah, yeah.

MR. WINNER: And I don't appreciate the jury being

told Dr. Wang made a report in this case --

MR. HENRIOD: Hold on, hold on.

MR. WINNER: -- that it was 3 percent.

MR. HENRIOD: The whole process --

MR. WINNER: He said no such thing.

MR. HENRIOD: Well, the process with that little chart that ends with the square saying the [inaudible]?

THE COURT: Yeah, you don't put -- you're not going to put that chart back up. You can say --

MR. PRINCE: What do you mean?

THE COURT: -- then the process --

MR. PRINCE: What do you mean, I -- she's going to -- he has testified she's --

THE COURT: -- starts again.

MR. PRINCE: -- going to need a surgery. She's going to testify she [indiscernible]. I'm not going to put that up again.

THE COURT: The first surgery, yes.

MR. PRINCE: Well, yeah, I'm not going to go up again.

THE COURT: Okay. That's --

MR. PRINCE: Oh, yeah.

THE COURT: -- what I'm saying.

MR. PRINCE: No, no.

(End of bench conference)

MR. PRINCE: All right.

BY MR. PRINCE:

Q So anyway, that part is cumulative, right?

A Yes.

Q The percentage accumulates every year, whether 1, 2 percent, 3 percent, or 4 percent, whatever the number is.

A Yes. And, Mr. Prince, I want you to remember also my deposition I said that there is literature out there and I recently quote it in my deposition; 30 percent in ten years. So at ten years, if it's 30 percent, take your 2 percent and go from there.

Q Okay. And you said earlier in response to Mr. Winner's question, that in your opinion the C5-6 she's going to require an adjacent segment surgery by the time she's 40; do you recall that?

A Yes.

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

A Yes, because a structural difference with that disc is present following the accident.

Q Okay. Now, after she has that surgery, does this adjacent segment disease process start all over again?

A Yes.

Q Okay.

A It doesn't stop as I have said earlier today.

Q All right. And these percentages, whether 2, 3 or 4 or whatever the number is, would apply to Desire after -- even after the second surgery?

A Yes.

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

A Yes.

Q All right. With regard to the left shoulder, the bone contusion, even though Desire doesn't recall striking anything inside of the car, doe the MRI show evidence confirming that she had some kind of strike against her shoulder in this collision?

A Some impacted within that car --

MR. WINNER: Objection to the "in this collision".

MR. PRINCE: I mean, the October 2015.

MR. WINNER: Object to, according to the October 2015 accident.

THE COURT: Sustained.

MR. WINNER: It showed --

THE COURT: Sustain that portion of it.

MR. WINNER: -- a bruise.

MR. PRINCE: What? What's What's the objection? I don't know what the objection is.

MR. WINNER: The MRI doesn't attribute a cause.

THE COURT: Correct.

BY MR. PRINCE:

Q Oh, okay. The MRI that shows a bone contusion taken out for this collision?

A Yes.

Q Do you want me to show it to you the --

A No, no, no, I --

Q -- [inaudible] --

A -- understand.

Q Okay. Right.

A There is some degree of impact.

Q In your opinion --

A Within that collision my opinion that manifested in the identification of a bone contusion within the shoulder.

Q Correct. In your opinion, based upon the presence of a bone contusion in the shoulder, is that consistent with having some impact or trauma from this motor vehicle collision of October 30th, 2015?

A Yes.

Q Okay. In your opinion, as a Level I trauma surgeon and seeing patients in emergency rooms and trauma facilities, is it uncommon for patients not to remember to have struck something or hit something inside the car when they have other injuries or other problems?

A It's certainly common to overlook certain things that may have occurred within the context of being in a car

involved in an accident.

Q Right. Doctor, whether you call it a herniation or a protrusion, was there a nerve root irritation in Desire's case causing radiculopathy down the left arm into the hand?

A Yes.

Q Regardless of what label you put on it?

A Yes.

Q Your interoperative findings you have -- is it your opinion that those were caused by the motor vehicle collision of October 30th, 2015?

A The interoperative findings of the disc herniation, yes, in my expert opinion.

Q At C6-7?

A Yes.

Q The same level that Dr. Khavkin made a recommendation for surgery two months before?

A Yes.

Q Okay. Very good. Thank you, Doctor. Have all of your opinions been, again, stated to a reasonable degree of medical probability?

A Yes.

Q Thank you.

MR. PRINCE: No further questions.

THE COURT: Recross?

MR. WINNER: Really quick.

MR. PRINCE: Well, hang on. One second. Hang on, one second, Judge. Hang on.

(Mr. Prince/Mr. Degree conferring)

MR. PRINCE: Now, I want to do --

THE COURT: Are you not done then?

BY MR. PRINCE:

Q Doctor, in your chart, you had the records of Doctor -- Doctors Rosler and Dr. Khavkin, right?

A I believe so, yes.

Q Okay. Both of those, even though they may not identify Desire had neck pain, she's -- they both reference that she was involved in some 2010 motor vehicle collision, correct?

A I believe so.

Q And I don't -- do we -- I know we went through it yesterday in detail; is there anything about the 2010 collision, whether it's through Bonanza Back Center or anywhere else for that matter, did it in any way cause or contribute to her disc herniation or need for surgery that you performed?

A That was not -- that is not clinically relevant whatsoever.

Q Even if she didn't say one word to you at all or anybody about the 2010, said -- completely forgot it, would it make any difference in your opinions at all?

A No.
Q Why?
A The patient had no ongoing symptomology prior to the accident of October 30th, of 2015.
Q Thank you.
MR. PRINCE: No further questions.
MR. WINNER: Did she have non -- no ongoing symptomology because that's what she chose to tell --
MR. PRINCE: Oh, objection, Your Honor.
MR. WINNER: -- you, correct?
MR. PRINCE: Move to strike. Can we approach, please?
THE WITNESS: There is no medical records to support the fact that the patient saw any treating providers prior to the accident in question, specifically, the October 30th, of 2015 accident, coupled with that, the MRI --
THE COURT: When -- when they're approaching --
MR. PRINCE: Yeah.
(Bench conference)
MR. PRINCE: He can't say that -- if there's no records or anything, hypothetical medical condition, it has to be based on the evidence. He can't -- that's order number one, motion in limine number one, well, he can't even go into that. Like assuming -- she -- like suggesting she might have had symptoms and she didn't tell anybody about them. How do

you overcome that?

THE COURT: Well, I think what he's saying is --

MR. HENRIOD: It's about --

THE COURT: -- you're saying that she didn't have symptoms because --

MR. HENRIOD: -- her --

THE COURT: -- there's no record that she said anything, right?

MR. WINNER: I'm saying she's not a reliable --

MR. HENRIOD: [Inaudible] historian.

MR. WINNER: -- historian.

THE COURT: Yeah.

MR. PRINCE: Yeah, but no, it says here, hypothetical, must be based on the evidence. They don't have any evidence she was symptomatic before. So how can he ask questions?

THE COURT: No, they're saying that she said she --

MR. WINNER: I'm not going there.

THE COURT: -- she's saying that she was -- they're saying that she was -- they're saying that she said she wasn't.

MR. PRINCE: Okay.

(End of bench conference)

THE COURT: So, overruled.

BY MR. WINNER:

Q That's what she told you, correct?
A Yes.
Q Okay. She also told you that she had never in her life had neck pain before; correct?
A Correct.
Q She also told you that she had never in her life been to Bonanza Back Clinic, she didn't tell you about that, did she?
A She never told me that she didn't go there, she never told me that she did go.
Q She never told you about the neck MRI either, did she?
A Are we referring to the normal one from 2010?
Q That's cute, yeah.
A Yes.
Q The -- the MRI from 2010.
A Yes.
Q Okay. She didn't tell you about the neck MRI, she didn't tell you about seeing a doctor for neck problems; did she?
A She had transient symptoms as I have discussed earlier in my deposition -- or in my trial testimony, consistent with a strain, but without any ongoing symptomology.
Q Okay. Do you think she needed Paul Powell's help to

find -- to find a chiropractor or did she already know one?

MR. PRINCE: Objection, move to strike. Argumentative, Judge.

THE WITNESS: I'm sorry, sir?

MR. PRINCE: Object to --

THE COURT: It's argumentative. Ask it less so. Sustained.

BY MR. WINNER:

Q Okay. Last, so you recognized in response to Mr. Prince's questions that abnormalities can exist without symptoms; correct?

A They can.

Q Okay. Bulges can exist --

A Unfortunately, in her case --

Q -- without symptoms ?

A -- [inaudible].

Q Right?

A I'm sorry?

Q Bulges can exist without symptoms, even protrusions can exist without symptoms; correct?

A In a hypothetical patient, yes.

Q And in an old guy like me, herniations can exist time to time without symptoms, correct?

A I don't know if you were involved in an accident and having ongoing symptoms. I just don't know.

Q Okay. But the C5-6 disc you did not think was -- you thought it was compromised but you thought it was asymptomatic?

A It was clinically not causing ongoing radiculopathy and symptoms in my expert opinion necessitating an ACDF at that time.

Q Okay. And bulges like that or compromises like that are common in all of us and are usually asymptomatic, meaning, they usually don't cause symptoms, right?

A No, I think you're misstating whatever my testimony may have been. It remains my expert opinion she had a traumatic disc protrusion at C6-7 and derangement or abnormalities caused to the architecture of C5-6 breaching the structural integrity but without requiring surgery, because the symptoms that she exhibited following the accident of 10/30 of '15 strictly lie within the C6-7 level.

Q Okay. So a disc that doesn't have any symptoms whatsoever, that's also Babylyn Tate's fault, in your opinion?

A The structural abnormalities of both C5-6 and the subsequent disc herniation, at C6-7, in my expert opinion are directly and causally related to the accident of October 30th, 2015.

Q Last, the surgery itself, the -- a single level fusion of the cervical spine has a very, very high success rate; correct?

A Yes.
Q Some doctors do surgeries like this even on an outpatient basis? I don't think you do, but some doctors do?
A Some do; I do not.
Q Okay. It requires one night in the hospital?
A Yes.
Q It has a very, very, very high success rate at least compared --
A Yes.
Q -- to lumbar surgery?
A I think both have a very high success rate depending upon the procedure performed and the indications needed.
Q Professional athletes get those surgeries and go back on the court and back out onto the field; correct?
A And some unfortunately have to be retired medically because of that as well.
Q Okay. Professional athletes get those and go back out on the field, correct?
A And they also develop adjacent segment breakdown.
Q Yeah. She wouldn't have required more than a single night in the hospital?
A She only required one night in the hospital.
Q Okay. And that one night in the hospital in your opinion is Babylyn Tate's fault completely?
A Yes.

Q Thank you.
A The need for the surgery and the subsequent treatment thereafter and before my surgery is indeed directly and causally related to the October 30th, of 2015 accident.
Q Nothing further. Thank you.
THE COURT: Okay.
MR. PRINCE: No questions, Judge.
THE COURT: Ladies and gentlemen, anybody have any questions?
(Pause in the proceedings)

(Bench conference)
MR. HENRIOD: [Inaudible].
THE COURT: Um-hum.
MR. WINNER: Well, I'm going to object --
THE COURT: You guys --
MR. WINNER: -- to number two to extent of your ruling.
THE COURT: Okay. Let me just ask this one; okay?
MR. WINNER: Okay.
THE COURT: Deal?
MR. PRINCE: I'm fine with is.
THE COURT: Okay. This is the good pile.
MR. PRINCE: Yeah, this is -- this is exactly what he opened the door to.

MR. HENRIOD: Well, I don't think he can ask a question --

MR. PRINCE: He can. It's --

MR. HENRIOD: -- that -- that counsel [inaudible].

MR. WINNER: Oh, that's the same one I've seen. I haven't seen that one. Have you read that yet?

THE COURT: This one you guys are agreeing on, one, and disagreeing on two, right?

MR. PRINCE: I'm saying you should ask two because he opened the door to that.

THE COURT: I know, but they're saying no.

MR. HENRIOD: One, yes; two, no.

THE COURT: Okay. One is okay?

Yeah, two, I'm not going to ask it because of earlier rulings.

MR. PRINCE: I'm fine with both of these; I'm fine with all three of these questions.

THE COURT: So for the record, I'm asking Juror No. 4's question, I'm asking the first question of Juror No. 8's, but not the second. One -- I'm not asking two at the request of --

MR. PRINCE: How many more questions can --

THE COURT: -- defense but over objection by the --

MR. PRINCE: Right.

THE COURT: -- plaintiff.

MR. PRINCE: Judge, here's the issue [inaudible] stuff, we've got to talk about that, all the referrals. He can't argue the lawyer build-up and medically [inaudible].

THE COURT: No, I understand.

MR. PRINCE: I know. What do they mean? He keeps talking about these referrals. That's -- see that's why this slope is such a bad place to be.

THE COURT: Well, the problem is if you're -- if your -- if your expert had said he was referred by Dr. Rosler it --

MR. WINNER: I'm okay with this.

THE COURT: -- might have been different. But once he puts it out there --

MR. HENRIOD: And these are all fine.

MR. PRINCE: Yeah, I'm fine with them.

THE COURT: Okay. And so for the record, I'm asking all -- you guys saw the one on the back, right?

MR. PRINCE: Yeah, I did.

THE COURT: All the questions by -- I'm just talking to myself on the record, I guess. I'm asking all the questions from Juror No. 9, and Juror No. 2.

(End of bench conference)

THE COURT: Okay. Why would you be hesitant to perform surgery on the 24-year old mom versus a male of the same age without children?

THE WITNESS: There would be no distinguishing difference, in my opinion. None whatsoever.

THE COURT: Okay. Out of the 15 percent of the patients who treat who are subject to personal injury cases, what percentage of those cases do you testify in court?

THE WITNESS: I've only been in court probably less than 10 times in my career.

THE COURT: I understand that the presence of the two fragments of nuclear material confirms disc herniation. Is there anything about the fragments that can tell you how long they have been present?

THE WITNESS: Unfortunately, you cannot. They're clearly -- like I said, the onset of the symptomology of that C7 nerve root irritation parallels the location of that subligamentous disc material producing nerve pinching which was alleviated quite frankly with the outcome of the surgery with Desire having an excellent result following that surgery.

THE COURT: Is there anything visible on the MRI that shows herniation of the disc without relying on the surgical confirmation?

THE WITNESS: You know, unfortunately, the one limitation of an MRI is the fact that there are basically slices, okay, magnetic slices. And they could be, you know, five millimeters in slices. So if, for example, a disc piece of material is 4 millimeters or less you may miss part of that

in the slices that you will see.

We clearly have a disc herniation at C6-7. The extent to which you don't fully always see, because of how the slices, for example, in the sagittal or axial imaging is because they're in 5 millimeter increments. Does that make sense?

I hope that answers your question.

THE COURT: Do the sensory exams rely entirely on patient reporting?

THE WITNESS: Not necessarily. I end up doing a sensory examination on a patient and it would be hard to distinguish in a C7 distribution because I check sensory all over and then I account for where it localizes in terms of a dermatomal pattern down the arm.

THE COURT: About the bone contusion; was there any other evidence of striking something in this collision that would have caused this? Is there any direct cause and effect here?

THE WITNESS: Again, I don't know what she had impacted but something had to have been impacted, whether it was that, you know, again, the side -- you know, as a window comes down and I believe she was driving a 1998 Honda Accord, you know, there's like a little bolster there of, you know, a roll, if you will, then the window is there.

So sometimes people can impact that, and you really

don't know that. If you were involved in an accident, you're not going to fully realize and always know what's going on and there's a surge of adrenaline or catecholamines and people are scared and it's a -- it's a scary thing to be in accident, it really is.

So her entire injuries may not be fully understood until such imaging was done. And it is confirmed on the MRI that a contusion in that shoulder was, in fact, sustained, in my expert opinion, as a result of that accident of October 30th, of '15, with subsequent translational forces to the cervical spine

THE COURT: Do you have any pictures or evidence of pulling out fragments from Desire's surgery?

THE WITNESS: I didn't take pictures. I usually use loops. I use high resolution loops. Some people use microscopes. But there's no imaging or pictures taken.

THE COURT: Did the accident in 2016, before surgery, cause any extensive damage to bulging in the neck of Desire since no MRI was performed to have as evidence?

THE WITNESS: So her symptoms were clinically paralleling that which was before that July accident. And so nothing changed in terms of her clinical course. And for my reasons, nothing has changed. I would -- if there was any distinguishing difference, in my opinion, you could consider an MRI but I did not feel that it was indicated in hers.

And I felt that her consistent symptomology in that left C7 distribution that was there prior to the July accident, two days before I saw her, was consistent afterwards and, quite frankly, the proof is in the pudding. The surgery I performed at C6-7 relieved her symptomology and that left radiculopathy. It completely resolved.

So that is the confirmatory test, if you will, to prove to you that the disc at C6-7 injured before the July accident as a result of the October of '15 accident, is the pathology stemming from that accident.

THE COURT: Does the accident with the defendant have to be the cause of damage to Desire? Could there have been anything that could have caused the damage before such as falling or anything of that nature?

THE WITNESS: There is no reports or any expert or any reports at work or anything like that, that has been brought up, that indicates prior or ongoing treatment before that accident necessitating ongoing treatment. Nothing whatsoever.

And so I don't have medical records from a primary care physician. I don't have an MRI before that accident. We have it a specific point in time when Desire was injured on 10/30 of '15, not only producing a bone contusion with symptoms but in my expert opinion the disc herniation as well, necessitating surgery.

The MRI wasn't done before that and, quite frankly, there were no records to support ongoing cervical spine problems before that accident.

THE COURT: Okay. Does anybody else have anymore questions --

MR. PRINCE: No, nothing --

THE COURT: -- as a result of those questions?

MR. PRINCE: -- from us, Judge.

MR. WINNER: Just two in follow-up.

THE COURT: Okay.

RECROSS-EXAMINATION

BY MR. WINNER:

Q Doctor, at the time of the 2015 accident, is it your understand the plaintiff was facing forward in a padded seat with a seatbelt and a headrest?

A I believe she was in a seat that had a seatbelt and a headrest, yes.

Q The post-operative cervical spine MRI from 4/24/17, that still shows a 2 to 3 millimeter posterior bulge at C6-7, correct?

A I don't think so. There would be post-operative changes with metallic artifact rendering that level at C6-7 unable to be accurately reviewed. You would have to get a CT monogram to better assess if there was any neural foraminal nearing a disc bulge. But the disc was completely removed.

The two subligamentous disc fragments at 6-7 were also removed. The patient had 95 percent or had significant -- I don't remember the exact percent -- but significant improvement in her left radiculopathy after that procedure.

Q So there's no bulge, 2 to 3 millimeter bulge in addition to the anterior cervical hardware?

A That would be impossible. The entire disc was removed.

Q Thank you.

FURTHER REDIRECT EXAMINATION

BY MR. PRINCE:

Q Okay. Just quickly, just so we're clear on this so I don't [indiscernible] any confusion.

I'm going to show you Bate No. 159. It's the April 24th, 2017 MRI.

MR. PRINCE: If you could just go to the [inaudible] Brendon, from the disc height all the way through the --

THE WITNESS: Bates 159?

BY MR. PRINCE:

Q Yes.

A The Align Medical Center MRI report?

Q Yeah.

A Yes.

Q It says here, At C6-7 no significant abnormality, but up there it talks about C6-7 vertebral bodies with

metallic hardware status post-anterior fusion.

Can you have -- after you fuse can you have a disc bulge at the level we've performed a discectomy and completely remove the disc?

A No, no. As I have just said it is impossible to have any --

Q Right.

A -- disc bulge at C6-7 because the entire disc was removed in conjunction with the subligamentous disc material, in conjunction with the posterior longitudinal ligament, and the placement of the stabilization device.

Q Right. That's as diffuse posterior disc bulge [inaudible] the 2 millimeter [inaudible] spinal canal C5-6, that's the compromised disc at C5-6 you've been talking about, right?

A Yes.

Q Right.

A And there has been relatively no change in that.

Q Right. For the -- that's the -- that's where the post -- the disc --

A That's the bulge.

Q -- bulge right there?

A Yes.

Q All right. Not at C6-7?

A Correct.

Q All right. Thank you.

FURTHER RECROSS-EXAMINATION

BY MR. WINNER:

Q So there's no change in C5-6 from before the surgery?

A Well, technically, before that I think they said 1 to 2 millimeters --

Q Right.

A -- and now it's 2 millimeters, so you know, that's the --

Q Thank you.

A -- distinguishing difference.

THE COURT: Okay.

THE WITNESS: Thank you.

THE COURT: Is this witness excused? Anybody else? Going once --

MR. PRINCE: Yes, Judge. Thank you.

THE COURT: -- going twice. All right. Thank you, Doctor, for your testimony --

THE WITNESS: Thank you, ma'am.

THE COURT: -- and your time.

THE WITNESS: Thank you.

THE COURT: Do you all want to -- do you want a -- does anybody need a break? Do you want to keep going? What would you like? You would like a five-minute restroom break?

MR. WINNER: I'd request a break if you don't mind.

THE COURT: Yeah. All right. We'll just -- five minutes.

During the recess, you Are admonished not to talk to or converse among yourselves or with anyone else on any subject connected to this --

MR. WINNER: I'm waiting for something from my office, ten might be better, but that's okay.

THE COURT: Well, it's always ten. That's what I just told them.

THE COURT: Okay. I lost my place. I have to do this again now, sorry.

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 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.

(Jury exits at 2:55 P.M.)

THE COURT: So there's nothing outside the presence, right?

MR. PRINCE: Nope.

(Court recessed at 2:55 P.M., until 3:08 P.M.)

(Outside the presence of the jury)

#

(Outside the presence of the jury)

THE COURT: Okay. We're back outside the presence of the jury. You have two more witnesses today?

MR. PRINCE: I don't think I'm going to get to the defendant today. Yes. Yes.

THE COURT: Okay.

MR. PRINCE: I have to do Desire on Monday. She's going to -- or on Tuesday. They're going to induce her on Wednesday, so she's got to go Tuesday.

THE COURT: Okay. And we know we're not going late today; right?

MR. PRINCE: Yes.

THE COURT: Early would be good, actually. You know, like if we get to 4:30 and you say I've still got another hour and you know we're not going to finish, then maybe we can do that on Monday.

MR. PRINCE: Okay.

THE COURT: Okay. I just have to get in traffic --

MR. PRINCE: No problem.

THE COURT: -- to Summerlin.

MR. PRINCE: Any time you tell me. I just need to get Dr. Khavkin on today.

(Pause in the proceedings)

(Inside the presence of the jury)

THE COURT: All right. The parties stipulate to the presence of the jury?

MR. WINNER: Yes.

MR. PRINCE: Yes.

THE COURT: Okay. Proceed.

MR. PRINCE: Your Honor, our next witness will be Dr. Khavkin.

THE COURT: Okay.

YEVGENIY KHAVKIN, PLAINTIFFS' WITNESS, SWORN

THE CLERK: Please state your full name and spell your first and last name for the record.

THE WITNESS: Dr. Yevgeniy Khavkin, Y-e-v-g-e-n-i-y, Khavkin, K-h-a-v-k-i-n.

THE CLERK: You can be seated.

THE WITNESS: Thank you.

THE COURT: Thanks for coming.

THE WITNESS: Thank you.

DIRECT EXAMINATION

BY MR. PRINCE:

Q Dr. Khavkin, can you please tell the jury your area of medical specialty?

A I am a neurosurgeon. I have fellowship training -- training in spine surgery. So that's my expertise as a minimalist complex spine surgeon.

Q Okay. And how long have you been a neurosurgeon?

A I've been a physician for 20-plus years, and I finished my residency in 2005. So I've been a neurosurgeon for 14 years.

Q And when you did your residency, where did you do your residency?

A I finished my residency at the University of Chicago, then I did my spine fellowship at Johns Hopkins University. I was at Johns Hopkins, then went back to Chicago, and I was at Northwestern as a director of neurosurgical and spine service for a few years before moving to Las Vegas.

Q Okay. And when you say you did a fellowship at Johns Hopkins in spine surgery, tell the jury what you mean by that.

A So as neurosurgeons, it’s a -- it's a seven-year residency in neurosurgery, and about 70 percent of what we do as neurosurgery residents is spine, spine surgery. So most of neurosurgeons who graduated from neurosurgery residency programs, they just go straight to practicing medicine, I mean, neurosurgery and spine primarily.

If you want to get an additional level of expertise in certain field, and I chose spine surgery, then you do what’s called a fellowship. And fellowship is usually, one, your additional training where you focus on more complex

aspects of certain fields, and that's what the fellowship is. So I did the fellowship in spine neurosurgery, combined orthopedic and neurosurgical fellowship at Johns Hopkins. And then when I went back to Chicago, I was a director of spine surgery there.

Q Okay. And long have you been practicing in the state of Nevada, Mr. Khavkin?

A A little over nine years.

Q Can you describe kind of the nature of your neurosurgical practice here in Las Vegas for us, the types of patients that you see and what you do?

A Yeah. So it's a general neurosurgical practice with a focus on spine. I do the whole spectrum of complexity of spine procedures, anywhere from disc disease, discectomies, to complex spinal tumors, deformities. I do cranial work, as well, but I would say probably 80 to 90 percent of my practice is spine surgery.

Q Okay. And are you affiliated with any hospitals?

A I have affiliation with most of the hospitals here in Nevada, in Las Vegas.

Q And do you hold any positions at any of the hospitals, you know, in the areas of surgery or neurosurgery?

A Yeah, I'm a director of neurosurgical and spine service at several of the facilities. I was the chairman of surgery at Southern Hills, and I'm a chief of neurosurgery and

spine services at Spring Valley, Henderson, Summerlin, San Martin, and Centennial, I believe.

Q All right. Do you treat people who have been involved in motor vehicle collisions, falls, work-related injuries, etcetera?

A I do.

Q And do you also as part of your education, training, and experience worked in, you know, in trauma?

A Yes, absolutely.

Q And as part -- have you ever testified in court as an expert before?

A I have not testified here before. This is the first time.

Q All right. Well, welcome here.

A Thank you.

Q For the first time being here. And as part of your practice, Doctor, we're going to be talking about your examination and your treatment and your recommendations to Desire, do you use the clinical correlation methodology as part of your practice?

A Absolutely.

Q All right. And in this case you first saw Desire on May 17, 2016. In front of you is a binder. Tab 49 is your records.

MR. PRINCE: And Bates No. 274, Brandon.

THE WITNESS: Can you -- Mr. Prince, can you repeat the --

BY MR. PRINCE:

Q Yeah, let me help you.

A Okay. Oh, you said 49. I misheard you.

Q That’s all right.

A Okay.

Q Don’t spill your water. Don’t spill your water the first time. My first trial I spilled my water. It was a mess. All right.

MR. PRINCE: Now, Brandon, get me the note in history of present illness, and start with the date. Yeah. And then you can make -- bring it all the way down. Yes. There you go.

BY MR. PRINCE:

Q All right. So she sees you on May 17, 2016; is that right?

A That’s correct.

Q And what's her chief complaint that day?

A She came in after she was in a motor vehicle accident on October of 2015. And she came in with complaints of neck pain, skull pain radiating down to her shoulders on both sides, as well as the trapezius muscle, and radiating down to her arms, more on the left side than the right side.

Q Okay. Did she also have numbness? Did she report

numbness to you, as well?

A She did. She said she had intermittent numbness on the left side.

Q Did you ask her if she had any weakness in any -- in either arm?

A I did.

Q And what did she tell you?

A She said she did. She said she had difficulty using her arms, her hands. She said she was -- was dropping objects and she had weakness in her wrist grips.

Q All right. And it says she didn't have any prior history of neck pain or treatments for her neck in the past. Do you see that?

A That's correct.

Q You were here a few minutes ago when Dr. Garber was finishing testifying?

A Yes.

Q And did you learn that she had an incident, some kind of an accident in 2010 for which she received treatment?

A That's correct.

Q Based on your -- was there any evidence, have you seen any evidence, either at your deposition or now or what you heard from Dr. Garber that she was having any symptoms up until the time of the October 30, 2015, motor vehicle collision?

A No.
Q If she had had a prior accident and she had her neck pain and symptoms went away in 2010, more than five years before this, would that be clinically even relevant to you at that time?
A It would not be.
Q Why wouldn't it be?
A Because it would not make any difference as far as my recommendations or establishing causation of the symptoms.
Q And in your -- in your work as a neurosurgeon and treating patients who have been involved in traumatic events like motor vehicle collision, is it important for you to understand the onset of symptoms and the nature and the quality of the symptoms?
A Yes.
Q And is that why you asked her these questions about, you know, what happened in the collision and what symptoms have you experienced since that happened?
A Of course.
Q Okay. And who referred her to you?
A I was -- she was referred by Dr. Rosler.
Q Okay.
A Pain management doctor.
Q And how do you know Dr. Rosler?
A We know each other professionally. We work -- we

have several -- a number of patients that we co-manage together. He manages the pain management side and I manage on the surgical side.

Q And he said at one point you two worked at the Nevada Spine Clinic together, you guys were at the same facility at one --

A We did.

Q -- point in time in your career?

A That's correct.

Q Okay. And did -- did you ask Desire about what sort of conservative treatment she had up until the time of your -- seeing you on May 17, 2016?

A That's correct.

Q What did she tell you about the prior treatment she had?

A She said she has had injections. She had specifically a selective nerve root block done in April and January of two-thousand -- April 2016, specifically. And then I documented the pre-procedure score, post-procedure score. But she had a number of injections done by Dr. Rosler.

Q Okay. And you've obviously co-managed patients with Dr. Rosler before. Do you think -- do you think he's reliable in terms of results he produces for your patients in terms of making decisions as a surgeon performing these types of test, selective nerve root blocks?

A Without a question. He's taken care of a lot of both friends and family members. I have a very high regard for him professionally.

Q Okay. And was it significant to you that based upon her complaints of neck pain, pain into the arm, as well as the numbness down the arm into the hand that she had, after the injections which went from an 8 to a zero, is that clinically significant to you?

A Yes.

Q How is it clinically significant to you?

A Well, injections have both therapeutic and diagnostic purpose. Obviously, the pain doctors do injections to help the patients, but from our standpoint, the surgeon, if we consider surgical treatment, it's helpful to see how somebody responded to the injection. So if a patient has an injection in a certain nerve root and there's no change in the symptomatology, it's unlikely that this nerve root is responsible for the patient's symptoms. But if they have such a significant improvement, it tells me that most likely that's where the problem is coming from. So it does have good diagnostic value that we take into account as part of the, you know, more complex approach in our decision making.

Q All right. I mean, do you always order spinal injections when treating patients, or do you make recommendations even without them?

A Well, you know, when we have patients with spine problems, we always try to avoid surgery. I mean, this is obviously the basic approach to spine patients. We try to maximize all the non-surgical treatment options, injections, physical therapy, chiropractic treatment, and a lot of times it helps. But, unfortunately, sometimes it doesn't, and we are surgeons with our expertise to potentially recommend and not recommend surgical treatment.

Q All right. And in this case had Desire described to you that she had had chiropractic care?

A Correct.

Q Did the chiropractic care provide her any lasting or significant improvement?

A I believe she had some improvement. I'm trying to see where I can --

Q In your -- under your history of present illness.

A She had injections without significant improvement.

Q It says she had chiropractic treatment without any improvement, [inaudible].

A Yes, I see that. Correct.

Q Okay. And --

A I see that.

Q -- you know, if she had temporary relief with chiropractic, is that something that's going to resolve these problems that she was coming to you with?

A No, unfortunately not.

Q If you felt it was simply soft tissue, would you have sent her back for physical therapy or chiropractic care if that was the -- was the problem?

A Of course, because I would not be able to fix it surgically. Of course.

Q Okay. All right. Now, let's talk about your physical examination. If we can go to page 375. And can you describe your significant findings on physical examination, Dr. Khavkin?

A Well, she was in a lot of pain, so there was a significant amount of discomfort as she was moving with -- with a palpation. She had a pain with flexion, extension, rotational bending. She had crepitus noted around the range when she was trying to do -- to move her -- to move her arm.

Q What is crepitus?

A It's essentially it's a sound. You can either hear it or you can palpate this of kind of a rubbing of the bone or certain connective tissue against each other. So that's -- that's the observation that people describe as crepitus. She did not have any weakness on my examination. She did not have any signs of spinal cord compression on my examination, and negative Hoffman signs.

Q All right. Did you do -- the jury has heard from Dr. Rosler and Dr. Garber that there is decreased sensation on

their examination. Did you find a decreased sensation during the course of your examination?

A She had decreased sensation on the left side, specifically on the deltoid, lateral triceps, and down to the forearm.

Q Okay. Is that -- is that in any particular dermatome pattern?

A Yes, it actually indicates more in terms of 5-6, 6-7 distribution.

Q Okay. And so would you have done a light touch exam on both sides, I mean, on both arms to verify where -- where there is a decrease?

A Of course, yeah. I always do bilateral, and then I document whatever I find which is abnormal.

Q Okay. And the -- the decrease in sensation in that, you know, the deltoid, the triceps, down into the forearm, is that also consistent with her presenting history, that exam finding?

A Yes.

Q And let’s -- did you also ask to review the MRI that was taken before she came to see you?

A That’s correct.

Q All right. And I want to -- let’s talk about the MRI itself. Did you look at the films yourself?

A Yes.

MR. PRINCE: And this is at 275, Brandon, also the same day, on the same page.

BY MR. PRINCE:

Q All right. I want to talk about, Doctor, your training when it comes to reviewing MRI imaging. What sort of training have you received as a fellowship trained neurosurgeon in reviewing MRI imaging?

A Well, as neurosurgical residents, we're essentially required to look at the MRIs of every single patient. So I've been looking at MRIs of the cervical spine for, as a physician, for almost 21 years. Prior to that I was a medical student, but I would say that doesn't count. But as a physician for the last 21 years, I've been examining MRI of every single patient I've seen. Do I look at the reports? I usually do, but I never make my judgment based on the reports. I always make my judgments based on the MRI. Because what I realize is that I probably have more experience than most radiologists who look at the MRIs just based on how many, many thousands, tens of thousands that I've seen, and I would imagine every neurosurgeon does the same thing, every spine surgeon. We always like to look at the images ourselves. We never rely on the -- on the report of the radiologist. It's helpful, but that's definitely not the --

Q All right.

A -- the only resource.

Q So before you make recommendations or perform surgery on a patient, do you review the films directly yourself and assess the -- at least the imaging in your --

A Always.

Q -- by yourself?

A Always.

Q Always.

A Every single time.

Q And Desire was no exception in this case?

A That's correct.

Q Okay. And what did you see when you reviewed Desire's MRI from Align Medical dated November 24, 2015? What did you see?

A What I saw is that it was abnormal.

Q Okay. Abnormal where?

A It was --

Q Describe the abnormality that you directly saw.

A Right. So it was abnormal. There were two discs compromised, bulging discs, herniated discs. There's a lot of discussion of which term is better. They're all used interchangeably. That's all pretty much -- different people use different terms. But there was bulging discs at the C5-6 and C6-7. 6-7 I thought was more pronounced than 5-6, but definitely it was abnormal at both levels.

Q Okay. And I want to --

MR. PRINCE: Brandon, can you pull up the cut for us?

BY MR. PRINCE:

Q I'm going to bring up an imaging cut from that and have you identify --

MR. PRINCE: If you can just zoom in, Brandon, on this and tighten up on that.

BY MR. PRINCE:

Q Okay. Do you see the abnormalities that you described?

A That's the -- oh, that's the screen I'm looking at.

Q Yeah, you can stand up.

A Yeah, of course. Did anybody go over this MRI --

Q We did.

A -- before?

Q Yes, Dr. Garber did.

A So the idea of kind of looking from the side, the patient is facing this way, this is the [indiscernible], this is the back of the head, back of the neck, the spine. You see this space right here, and then you essentially have -- so this is more or less normal, bulging, bulging. So that's fairly straightforward. That's clearly an abnormality at both of those levels.

Q All right.

MR. WINNER: Forgive me for interrupting. Is it --

which --

MR. PRINCE: Cut 11 and 15.

MR. WINNER: -- which cut?

MR. PRINCE: 11 and 15.

MR. WINNER: 11 and 15.

MR. PRINCE: Yeah.

MR. WINNER: Thank you.

BY MR. PRINCE:

Q And the bottom one, is that the C6-7 level disc?

A Are you showing me the --

MR. PRINCE: Well, Brandon, go ahead and take the zoom out and we'll see.

THE WITNESS: Yes, that's -- okay. So this is 2, 3, 4, 5, 6, 7. This is C5-C6, C6-C7.

BY MR. PRINCE:

Q Here, let's -- I'm going to zoom that part in so you can just kind of --

A Yeah, that's actually good.

Q Okay. That's fine.

A That's actually nice.

Q Okay.

A Close enough.

Q And did you find a C6-7 protrusion?

A Absolutely.

Q Is that -- Dr. Garber said he -- to his eye and his

own read, he saw a disc herniation. Do you agree with that?

A Yeah. Protrusion, herniation, bulge, different specialists use different terminology, but essentially the same.

Q Okay.

A But this is clearly abnormal -- I don’t think it works, so as long as you guy can hear me.

Q It was working. It was working. It's more for the court reporter.

A Okay. Yeah, so basically for comparison, fairly normal, fairly normal, bulging right here, bulging right here. Now, this is one slice. Obviously, when we look at MRIs, we look at the different slices. We’ll look at the slices going like this, and we’ll look at the slices going cross-sections. So then with all of this information together, it kind of allows us to better interpret the MRIs. But this is actually a good slice. It shows abnormality in both those.

Q Okay. And so you found -- is that, in your opinion, abnormal for a 24-year-old girl?

A Absolutely.

Q Okay. Was the timing of the onset of the symptoms following this motor vehicle collision, is that consistent with the disc protrusion that we see at C6-7 and at C5-6?

A Can you repeat this?

Q Sure. Desire described for you that she was in a

motor vehicle collision, she developed neck pain and symptoms down into her arm; right?

A Correct.

Q And is this image of the disc protrusion at C6-7, is that consistent with her being involved in the motor vehicle collision and the onset of her symptoms?

A Yes.

Q Okay. Is that part of the pieces of the puzzle of clinical correlation?

A Right.

Q All right. Now, did you make a recommendation based upon the history, the physical examination, as well as the reviewing directly the MRI imaging and the medical record from Dr. Rosler?

A Correct. And the fact that she has tried multiple conservative treatment options that did not work. So that's the important pieces, as well. So all those things that you said, plus the fact that she's been through all that other modalities, and unfortunately did not get better. So then that takes me to the next step, which is surgical recommendation.

Q Right. And did you -- when you were discussing surgery or thinking about recommending surgery for Desire, did you factor in the fact of her age, that she was barely -- I think she was barely 25 years old at that time.

A Of course.

Q Is that a significant recommendation -- did you take the recommendation lightly given her age and recommending a two-level fusion?

A No.

Q And show me what considerations went into you making that recommendation for a two-level fusion. And you can -- if you want to draw and kind of describe what your thought process, I put up this pad for you so you can --

A Sure. There was something -- I was going to actually use something else, but the simple explanation is that a young woman, no symptoms prior to the accident, develops severe pain afterwards, miserable when I saw her, has been through conservative treatments, injections, therapy, chiropractor treatment, still not working, still significant amount of pain she's having.

And from the surgery standpoint, you know, as surgeons we always try to identify is there a fixable problem? Because, obviously, if we see something on the imaging studies that can be fixed and we feel based on our experience and our expertise that we would have great results, that's when we recommend surgery. You know, if the MRI was normal, it doesn't matter how much I want to help her, there's nothing I can do because there's nothing -- nothing to fix.

But clearly she had an abnormality in the MRI,

two-level pathology, and so in my experience, patients like her respond very well to the surgical treatment. It's a -- again, it's a common surgery. We perform this with a high success rate, but the key is to do the right surgery for the patient. I guess in this discussion -- I can either wait for you to ask, or I can expand on the -- my recommendation of two levels.

Q Well, let's -- why don't you talk about what recommendation you made to Desire, and you can use -- if you need the board to write, or you can use the MRI to help guide your discussion.

A So I felt, based on the representation, based on the distribution of her numbness, based on the MRI, these bulged discs are responsible for her symptoms. I felt 6-7 to be responsible to a greater extent, but I felt -- I felt both discs were contributing. So the recommendation that I made is to do what's called anterior cervical decompression and fusion, which is what she had done. Except my recommendation was actually to do this on two levels because I felt that both levels were involved, both levels show abnormality, and, therefore, she would benefit from addressing both levels.

A big part of the risk of the surgery is not just the surgery itself, it's anesthesia. So my approach is that if I see pathology on the imaging studies, I always recommend to the patient to address whatever I see abnormal to minimize

the amount of surgeries that the patient goes through in their lifetime.

Q Can you explain what you mean by that?

A Well, this is -- this is a good example, you know. Regardless of how this -- how this happened, a patient comes in, they have a problem with two different levels. One, I feel based on my experience contributing, let's say, to 80 percent of the symptoms, and the other level contributing to 20 percent. My recommendation is obviously to address both because then there's a good chance that it's going to address all of her symptoms, and so less of a chance that the patient is going to need another surgery, I don't know, maybe not -- not -- not for awhile for a level in this case.

Now, sometimes a patient decides that they want to have less of surgery done with clear understanding that because there's more than one disc involved, down the line they're going to need another disc fixed. And this is a discussion between the surgeon and the patient. The key -- there's no right or wrong approach to this.

It's a matter of a surgeon clearly having a discussion with a patient, and then making a decision between the surgeon and the patient, do they do whatever is affected right away or do they do this in more kind of a stage fashion, so to speak, addressing the worse level first with a clear understanding that the other level will need to be addressed.

So a year from now, three years from now, nobody can guess. There's statistics, there's numbers, but the reality is that nobody can really guess.

But based on experience, almost always the other level will need to be fixed, especially on a 24-year-old. If she was an 85-year-old, that's a different -- different approach, obviously, different counsel. You know, the -- the life expectancy is different, so the chances of her having another surgery obviously is different. And a young person like that, it's a very high probability that she's going to need to get it done sometime in the future.

Q Okay. And you made a recommendation to do surgery in which levels in her case?

A The C5-6 and C6-7.

Q Okay. So you recommended to do now two levels to address all of it at once. Were you thinking that the C5-6 at some point is going to require surgery at some point down the line?

A Absolutely.

Q Because it's already -- are you saying compromised?

A Correct.

Q And that were --

A Abnormal compromise affected.

Q If C5-6, let's assume it was normal, would it take longer for that segment, that C5-6, to, you know, break down

and become symptomatic as opposed to this case where you already know it's compromised?

A Of course. If this level is normal, then it falls in the category of what's called adjacent level pathology, which is where --

Q Okay. Explain what you mean by that.

A So -- well, that's where I can actually use the board. Do you guys have something to --

Q Yeah, I brought to colors. Let me bring you a little closer.

MR. WINNER: May we approach, please, Your Honor.

THE COURT: Sure.

(Bench conference)

MR. WINNER: This is, again, outside the scope of what was disclosed. He didn't have anything in his notes about additional surgery for adjacent segment breakdown, and he did write a report for the plaintiff.

MR. PRINCE: He did not write a report for us.

MR. WINNER: Here is the report he wrote for the plaintiff with the cost letter for --

MR. PRINCE: The cost.

MR. WINNER: -- one surgery. One.

MR. PRINCE: Right.

MR. WINNER: One surgery.

MR. PRINCE: True. But he's also -- I'm talking

about adjacent segment disease. That's part of his risk analysis, right. We didn't -- he didn't do that.

MR. HENRIOD: That didn't come up in his deposition.

MR. PRINCE: Right. So he's going to talk about adjacent segment disease for a two-level surgery.

THE COURT: The one he recommended that she didn't get?

MR. PRINCE: Correct. Yeah, right. Yes. And how --

THE COURT: And what's the relevance of that?

MR. PRINCE: He's saying that it's C5-6. It's not even part of adjacent segment disease because it's already compromised. So the relevance is because it's part of the risk factors he discussed with Desire, and it's in -- that's in his note that she'll need additional surgery.

MR. HENRIOD: Well, I think what he says in his note in here is the additional surgery is if --

THE COURT: Isn't he --

MR. HENRIOD: -- there's instrument --

THE COURT: -- a treating, though?

MR. HENRIOD: -- if there's instrument failure. And then the issue on adjacent segment, the whole concept is that the fusion causes that.

THE COURT: Correct.

MR. HENRIOD: And so here, it wasn't fused at that

level. Or, I'm sorry. I'm sorry. I'm sorry.

MR. WINNER: More importantly, he said these are the future costs, and this was presented to us as his opinion on future costs and all future treatment.

MR. PRINCE: Okay. Well, that includes two levels. So, right, he's also talking about she may require additional surgery in the future in her -- in his note, and he's talking about doing two levels. So he already includes that.

MR. HENRIOD: Future surgery is for --

MR. PRINCE: I'm not done.

MR. HENRIOD: -- instrument failure.

MR. PRINCE: No, it's not. No. But he's talking -- I can ask him questions about opinions he had about adjacent segment disease, need for additional surgery, did he consider that as part of his recommendations and the discussion with Desire.

MR. WINNER: If the failure -- if the symptoms fail to improve, the instruments fail, it might require additional surgery. There is nothing here about adjacent segment breakdown. We object. And this is his report saying she needed one future surgery.

MR. PRINCE: But he's a treating physician. He's not -- and that's a cost slip. That's not some --

THE COURT: Isn't -- isn't a treating physician --

MR. WINNER: So, again --

THE COURT: -- allowed to get into more than that?
MR. PRINCE: Yes.
MR. WINNER: Well, he's -- he's entitled to get into prognosis, but he's already given his prognosis. They don't get to give a different prognosis after he meets with the lawyer because he has a new theory of the case.
MR. PRINCE: No.
MR. WINNER: He's stuck with the prognosis he gave.
MR. PRINCE: No, that's a cost cited for one surgery. That was before -- that's not addressing any further surgery. That's just like -- that's the one before Dr. Garber even did one.
THE COURT: Well, this doesn't give anything. I mean, if you --
MR. PRINCE: Exactly.
THE COURT: -- say this is all he can testify to, then all he can do is the money and I don't think that's the rule; right?
MR. WINNER: Okay. He says the surgery might fail, if the hardware fails on the surgery, she might need an additional surgery.
MR. PRINCE: That's not -- that's not -- that's hi treating physician note.
THE COURT: All right. I'm going to overrule it.
MR. PRINCE: Okay.

THE COURT: Don't go too far with it, thought.
MR. PRINCE: Okay.
MR. WINNER: Thank you.
THE COURT: Thank you.
(End of bench conference)
BY MR. PRINCE:
Q Doctor, are you ready?
A Yes, of course.
Q Did you take time away from your own clinic today to come here? I we've rescheduled you actually twice, so I appreciate your time.
A Sure.
Q And when you were --
A Does anybody else need to see it besides the jury?
Q They'll -- counsel can reposition.
A Okay.
MR. WINNER: Counsel what?
THE WITNESS: Go ahead, Mr. Prince. Were you going to ask me something?
BY MR. PRINCE:
Q No. As a treating physician, did you consider the issues of, you know, the consideration of future surgery and what future surgery might be needed in Desire's case as part of your recommendation and prognosis for future -- for future in this case?

A Of course.
Q Do you do that with every patient?
A Of course.
Q Is that your custom and practice?
A Yes.
Q Okay.
A Okay. So seven vertebra in the neck, okay, and they all have discs in between them. And that's the [indiscernible], so obviously neck is the -- is the part of the spine that moves the most. And so each segment takes over a certain amount of motion in the lower spine. Now, in her case, so we have this bulging disc here, bulging disc here, okay.

So let's say what happens if you fuse a level, okay? So let's say this is fused, it has a plate right here and a cage here. This is fused. There's a plate right here, a cage right here. So now two levels are fused. Now you only have one, two, three segments that are left to basically perform the function of the flexion extension that used to be performed by five different segments, which is one, two, three, four, five.

So what happens, then, is that what's called the adjacent level, that just meant -- basically means the level right next to the fusion takes over a lot more stress. Because the reason why you develop problems with the disks is

the wear and tear changes. You know, when you move your spine, you know, over time, in the absence of trauma, in the absence trauma, when you move your spine for awhile, you know, over time you develop wear and tear changes.

So if you fuse two levels, the level next to it, it will take over a lot of the stress so the wear and tear changes will occur a lot faster. So that's the -- the concept is called adjacent level disease. And that's another step --

MR. WINNER: Excuse me, Your Honor.

THE WITNESS: -- I'm sure that talking about it as far as a --

MR. HENRIOD: Your Honor, may we approach? I'm sorry to --

THE COURT: Yeah.

(Bench conference)

MR. HENRIOD: Why are we talking about segment breakdown based on a double fusion that didn't take place?

MR. PRINCE: Oh, I'm going to --

THE COURT: That's what I asked before what the relevance was of all this.

MR. PRINCE: Oh, because --

MR. HENRIOD: It didn't take place.

MR. PRINCE: Oh, because Desire is going to say that's one of the reasons why she didn't do the surgery with him. Oh, absolutely.

MR. HENRIOD: Okay. So then --

MR. PRINCE: Absolutely.

MR. HENRIOD: Okay. So then what's going to happen is the second surgery is the one that didn't take place, the double, and then now we're talking about segment breakdown after that second fusion?

MR. PRINCE: He's already talking about that.

MR. HENRIOD: This is another arrow in --

MR. PRINCE: It's part of his treatment, it's a part of his prognosis, it's a part about we treated her, it's a part of his recommendation, it's a part of her own decision-making and who to go to have surgery with. Oh, no, it's a much broader concept than what they're talking about.

MR. HENRIOD: This is why this is in a chair facing away from you.

MR. PRINCE: No, it's not. He wanted to demonstrate it.

MR. HENRIOD: We're talking now we're assuming that there has already been a second surgery. We're assuming a double fusion that did not take place. And now we're discussion segment breakdown from the second surgery.

MR. PRINCE: Because she --

THE COURT: I'm going to sustain it.

MR. PRINCE: But, Judge, but why?

MR. WINNER: Thank you.

MR. PRINCE: Why, Judge? Well, that's what went into my client's decision-making. No.

THE COURT: About the second surgery breakdown.

MR. PRINCE: No, no, no, Judge. Well, hang on a second, Judge. She -- she's -- that's one of the reasons why she didn't do it. That's why it's this discussion. This is exactly one of the discussion points why she didn't have that surgery, why she chose to do one level, because of the risk of this. Oh, no. This goes directly to her own patient decision-making.

MR. WINNER: That's funny because the discussion about the risks of surgery, and they're rather extensive, don't mention anything about this at all.

MR. PRINCE: No. No, this -- this goes into her decision-making why I didn't want two and I opted for one level. Oh, no, it's a big deal. And he gets to discuss about what goes into his thoughts, what he thought her prognosis was. He participated in her care before there was a second accident.

THE COURT: I don't even know, what are you doing up there?

MR. PRINCE: Oh, he's just drawing out the vertebrae. And there's not a reason why, he wanted to -- he wanted to draw it.

THE COURT: With reference to what?

MR. PRINCE: What?

THE COURT: Why is he drawing it? For what purpose? How many times did he see her?

MR. PRINCE: What?

THE COURT: How many times did he see her?

MR. PRINCE: Once.

MR. WINNER: Once, but then he wrote a cost letter.

MR. PRINCE: Who cares? That's right. He did write a cost letter at that time. She couldn't have the surgery with -- you have to have a cost letter until you have the surgery to incur the actual expenses.

THE COURT: Okay. Give me the exact question you want to ask.

MR. PRINCE: No, he's explaining --

THE COURT: Okay. Well, that's what I -- that's what I'm wondering. I'm not even sure that constitutes a treating physician.

MR. PRINCE: Do you explain -- do you explain -- and I asked, do you explain the adjacent segment disease breakdown to your patients? He said yes. And then I --

THE COURT: Haven't we already gotten that from actual --

MR. PRINCE: Yeah, but he's also going to talk about what it means for a two-level. That's why she didn't -- that went into her decision making. It's part of the --

MR. WINNER: No.

MR. PRINCE: -- client's decision-making.

THE COURT: I believe the other witness already talked about that, didn't he?

MR. PRINCE: Yeah, but he's talking about now --

MR. WINNER: The surgery that she had, you allowed him to talk about that.

THE COURT: Yes.

MR. PRINCE: But why can't we ask Dr. Khavkin?

THE COURT: Because I think -- I think in that regard he is more than expert. He didn't treat her very much and I don't think it's in his report, so I'm going to sustain it.

MR. WINNER: Thank you.

MR. PRINCE: On what basis? What can I not do? I don't understand what I can't do. Judge, I don't know what I can't do right now.

THE COURT: Ask a question and if he doesn't object, you can do it.

MR. PRINCE: Okay.

(End of bench conference)

BY MR. PRINCE:

Q Dr. Khavkin.

A Yes, sir.

Q When you were -- is it your custom and practice --

do you have a -- do you have a custom and practice to discuss adjacent segment disease and breakdown with your patients?

A Of course.

Q Do you do that with every patient if you recommend a surgery?

A Of course.

Q Do you have any reason to believe you did not do that with Desire Evans-Waiau?

A No.

Q And when you were talking about adjacent segment -- potential adjacent segment surgery, what level would you have been talking about with Desire Evans, given your recommendation?

A C4-C5.

Q Okay. And why didn't you just simply do -- offer her one-level surgery?

A Good question. Because what I -- again, based on what I described before, my approach is that I want to address whatever needs to be addressed based on what's abnormal. So in her case, given the fact that she has two abnormal levels, I felt it would be beneficial for her to get both of them done at one setting, one anesthesia, one surgery, and then the C4-C5 would fall in the category of adjacent level pathology that she will need to have done down the line based on a statistical data [indiscernible]. But the 5-6 is already

affected. Now --

Q So we had -- we had a discussion with Dr. Garber today at length. I'm going to kind of turn this so you can see this way. Can everybody see that okay? About he fused C6-7. You heard that; right?

A Correct.

Q And the adjacent segment disease and the literature. Are you familiar with the adjacent segment disease and the literature and the rates of, you know, the recurrence and need for surgery?

A Very much so.

Q What's the -- what's the percentage, typically?

MR. WINNER: Cumulative, Your Honor. Not in his report and --

THE WITNESS: The one that’s most common for the --

MR. WINNER: I have an objection pending. Excuse me. Can we approach?

THE COURT: Yes.

(Bench conference)

MR. PRINCE: He doesn’t have to have a report. He’s a treating physician.

THE COURT: I’m going to let him answer the percentage thing.

MR. WINNER: What's that?

THE COURT: I'm going to let him answer what his --

is that what you're trying to get to --

MR. PRINCE: Yes. Yes.

THE COURT: -- the 1 to 4 percent --

MR. PRINCE: Yes.

THE COURT: -- question?

MR. HENRIOD: Is his -- is his theory that -- that he wanted to fuse 6-5 to avoid further adjacent segment breakdown? Because I thought that the whole process started no matter where you fuse.

MR. PRINCE: Well, I'm getting ready to -- I don't have to tell you --

MR. HENRIOD: Well, I know that's --

MR. PRINCE: -- my theory, but I'm going to --

MR. HENRIOD: -- what you're getting ready to ask.

MR. PRINCE: -- so I'm just asking what is the -- number one, is he familiar with the literature about the adjacent -- the percentage of adjacent segment surgery each year. That's the question.

THE COURT: I'm going to allow that one.

MR. WINNER: Well, what he's trying to do is get through --

THE COURT: He's going to get another opinion.

MR. WINNER: -- one witness a question that was --

MR. HENRIOD: It's an entirely new opinion.

MR. PRINCE: It's not. It's his opinion.

MR. HENRIOD: Now what he's going to say --

MR. WINNER: Or it's cumulative.

THE COURT: Which just goes to show that nobody knows, but that's okay. We've gotten out 1 percent, 2 percent, 3 percent, 4.

MR. HENRIOD: Your Honor, the point is is that he's going to say that he wanted to fuse them both because it would have broken down soon enough anyway. But the problem is --

MR. PRINCE: He already --

MR. HENRIOD: -- is that --

MR. PRINCE: -- said that.

MR. HENRIOD: But the problem is -- well --

THE COURT: He has already said that, but --

MR. HENRIOD: -- I think that's exactly what's going on here. Okay.

THE COURT: He has said that.

MR. HENRIOD: Okay. So I think --

THE COURT: Sooner versus later is what he said.

MR. HENRIOD: So now where we're going with is, well, does the process start up whether you have done that now, whether you do that now. All of this is leading --

MR. PRINCE: No.

MR. HENRIOD: -- to the need for another surgery.

MR. WINNER: You wouldn't know out of 3 percent from a treating surgeon because he didn't say that. And now

somebody who saw her once and wrote a cost letter --

MR. PRINCE: It's not a cost letter.

THE COURT: He's barely a treating.

MR. PRINCE: What?

THE COURT: Barely a treating.

MR. WINNER: He's barely a treating. He did an examination and wrote a cost letter.

MR. PRINCE: How is he a barely treating doctor? He recommended surgery.

THE COURT: How can you treat someone when you see them once? He's an examining doctor, but I don't know that he's necessarily a treating.

MR. PRINCE: Oh, no, he's considered a treating physician.

MR. WINNER: The actual doctor who said I'm averaging at 2 percent, I'm averaging at 2 percent, you allowed him to talk about that and I didn't object. Dennis would rather have 3 percent, so he's putting this guy up there who ha expressed no such opinion in a cost letter or in any of his treatment records --

THE COURT: He's already got --

MR. WINNER: --and trying to --

THE COURT: -- 1 to 4 percent in anyway.

MR. WINNER: -- he's been trying to get a different number.

MR. PRINCE: His cost letter wasn't an adjacent segment surgery. It was about the initial surgery. That's what this cost letter is for.

MR. WINNER: Oh, this is the future damages she'll need, one surgery.

MR. PRINCE: No. No, no, no, it's not. This is the initial surgery. Dr. Garber gave a cost letter for the adjacent segment surgery, so these are two different things. His cost letter was for the -- what would be the first surgery, what we have the actual bills for now. So I'm just going to ask him what the literature says, and then I'm going to move on to a new area, then I'm going to do something else.

MR. WINNER: Well, this seems to be violating --

THE COURT: Okay. Well, if he's treating, then he can't do the literature; right?

MR. PRINCE: Yes, he -- yes, he -- yes, we can because he has to make -- how did he make recommendations to the patient? He has to be familiar with the literature as part of his treatment of patients.

THE COURT: All right. Ask the question and just move on.

MR. PRINCE: All right.

THE COURT: Overruled, I guess.

(End of bench conference)

BY MR. PRINCE:

Q Dr. Khavkin, as part of your ongoing training, do you stay abreast of medical literature in the field of neurosurgery?

A Of course.

Q And do you also attend meetings around the country?

A Of course.

Q Do you also lecture in your area of neurosurgery?

A I do.

Q And you're also familiar with the literature concerning the rate of adjacent segment disease requiring a surgery at adjacent level?

A Of course.

Q All right. Is that something you need to be familiar with in order to treat patients and make recommendations to patients?

A Yes.

Q And what is the literature in your -- based on your knowledge of it supporting adjacent segment disease?

A So the most commonly quoted number is 3 percent per year.

Q Okay.

A The data range is anywhere from 2 percent to 30 percent over 10 years, so there’s quite a variability.

Q Okay. All right.

A The reason why I wanted to draw this diagram is to

show that certain concepts of medicine don’t form a category of statistics. They fall in a category of common sense.

Q Okay.

A You know, if you break a leg, you shouldn’t be skiing to you're where it heals. I mean, that’s -- you don’t need to run the studies to show that. So the adjacent level pathology kind of falls in the same category, and that’s the reason why I was showing this is to demonstrate that if you immobilize mobile segments and you have segments next to them take all of the stress, there’s a definitely increased risk in the wear and tear changes. This is a common sense, common mechanics. This is how the world works.

Again, statistically, 3 percent is a commonly used number, but in my experience there’s been patients who I thought it's going to be five, seven years before they're going to require adjacent level surgery, and they end up getting this done two years later, okay. And it's not uncommon depending on how active they are, especially for young people. So this is why -- that’s why I want to make sure that you guys understand, there’s statistics, and there also the reality and common sense and the phenomenon that occurs especially when you mobilize two segments in the -- in the spine that gives us the five segments.

Q The adjacent segment literature that you're familiar with and what you're discussing with part of your care and

treatment of patients, including Desire, is it where a level is essentially normal, the adjacent level, or where it's abnormal like in C5-6 here?

A No, that would be C4-C5.

Q C4-C5.

A C5-C6 I would not want to use the term adjacent level because, again, in our literature, adjacent level applies to a normal level next to the fused segment. That adjacent level. 5-6 in her case now that she has 5-7 -- 6-7 fused is not adjacent level, so to speak. It's a pathologically affected compromised level that Dr. Garber and the patient chose not to address at that time. It's a different concept. So it will need to be addressed.

Q Okay.

A It's not the wrong decision. Obviously, she's doing very well and Dr. Garber is a very well trained qualified neurosurgeon who discusses with the patient, and their decision was to address the worst level first with the understanding that down the line she was going to need another one addressed because it is pathologically affected. It is involved, you know, after the trial.

Q In your -- in your discussion with Desire fusing two levels, was the adjacent level subject to the risk C4-C5?

A That is correct.

Q That would require surgery at some point in her

lifetime?

A That is correct.

Q Okay. Now, ultimately, Desire didn't have the surgery performed by you; correct?

A That's correct.

Q All right. But at the time of your examination, were you -- and had she come back to you, were you willing to perform that surgery?

A The one that I recommended?

Q If she came back to you in May, you know, would you have performed that -- agreed to perform that surgery for her?

A The one that I recommended?

Q That you recommended, yes.

A Of course.

Q Yeah.

A Of course.

Q And based upon the history, the physical examination, your review of the imaging and the information you had available to you, including Dr. Rosler's treatment records, did you form an opinion as to what the cause of the need for this surgery was?

A Yes.

Q What was your -- what is your opinion?

A The accident in 2015.

Q Okay. Is that your opinion to a reasonable degree

of medical probability?

A Yes.

Q With regard to the prognosis of the disc and adjacent segment and the breakdown at C5-6 at a faster rate, is that your opinion to a reasonable degree of medical probability?

A Yes.

Q Okay. Have all the opinion you've stated here today been to a reasonable degree of medical probability?

A Yes.

Q Okay. Thank you.

MR. PRINCE: No additional questions.

THE COURT: Mr. Prince, will you move the --

MR. PRINCE: I will.

THE COURT: -- easel, please.

Mr. Winner. Or Mr. DeGree. Who is -- is Mr. DeGree doing it? I'm just --

MR. PRINCE: Now, we're just moving stuff out of the way.

THE COURT: All right. Mr. Winner.

MR. WINNER: Can I have Defendant's Exhibit S, please.

THE COURT: Were you asking us, Mr. Winner?

MR. WINNER: Pardon?

THE COURT: Were you asking us for an exhibit?

MR. WINNER: S. Yes, please.
THE CLERK: Exhibit S?
THE COURT: S as in Sam, I think. Is that admitted?
MR. WINNER: No.
THE COURT: Okay.
MR. WINNER: Does the witness have Exhibit S?
THE COURT: I don't know what Mr. Prince gave him.
MR. WINNER: Court's indulgence a moment, please. Can I approach?
THE COURT: Sure.
MR. WINNER: Doctor, do you have defense exhibits with Exhibit S in them? I'm not sure what you have here. I guess not.
THE COURT: She's going somewhere. I'm not sure where. I'm assuming she's getting them.
MR. WINNER: Okay.
(Pause in the proceedings)
MR. WINNER: Here you go, Doctor.
THE WITNESS: Okay. That's different than this one; right?
MR. WINNER: Yes. It's Exhibit No. S, please. Do you need me to move that out of there?
THE WITNESS: No, it's okay. Thanks.
MR. WINNER: Okay.
THE WITNESS: I'll just reposition this. Did you

say to go to which one?

THE COURT: S as in Sam.

THE WITNESS: S as in Sam?

MR. WINNER: S as in Sam.

CROSS-EXAMINATION

BY MR. WINNER:

Q Doctor, do you have Defendant's Exhibit S in front of you, please?

A Yes, sir.

Q Okay. Can you tell us what that is?

A It's a declaration of custodian of records.

Q Okay. And the pages following that, does that appear to be a complete copy of your chart relating to Desire Evans-Waiau?

A That is correct.

Q Okay. Were those records prepared at or near the time of the events described in them?

A Could you repeat this, please?

Q Sure. Would those records have been prepared at or near the time of the events described in those records?

A That's correct.

Q Okay. And those were kept in the ordinary course of your practices, business?

A That's correct.

Q Okay.

MR. WINNER: We offer Defense Exhibit S, Your Honor.
MR. PRINCE: It’s duplicative of 49, but I have no objection just so we can move forward.
MR. WINNER: Okay.
THE COURT: You said no objection?
MR. PRINCE: No, it’s fine.
THE COURT: Okay. They're admitted.
(Defense Exhibit S admitted)
BY MR. WINNER:
Q I'm going to ask you to look at Bates stamp 0005, Doctor.
A Yes.
Q I’ll zoom on it a little bit for you. What are we looking at there at the bottom? Is that -- is that what’s known as a pain diagram filled out by the patient?
A That’s correct.
Q For the jury, just to remind the jury, this would have been filled out on the 17th of May, 2016; correct?
A That's correct.
Q I did a little math, to my best math estimation, that would be 200 days after October 30, 2015; correct?
A That’s correct.
Q Okay. Did Ms. Evans tell you that she had had these symptoms ever since the accident happened on October 30, 2015?
A That’s correct.

Q Okay. And did you believe what she told you -- did you accept what she told you as true?

A Yes.

Q Do you see it as your role, Dr. Khavkin, to investigate whether what she was telling you was true?

A I believe my patients unless I have a reason not to.

Q Unless you have a reason not to, you believe what your patients tell you?

A That’s correct.

Q Okay. In the context of a personal injury claim, has it ever been your experience that a patient might exaggerate or say things to you that might be less than completely true?

A Sometimes.

Q Okay. If I were to tell you that these symptoms here, I'm pointing with my pen, if you can see these symptoms here down both legs, that those were not complaints that she had made, as far as we’re aware, since November of 2015, would that be news to you?

A I wouldn’t necessarily -- it wouldn’t make a difference.

Q Okay. If I were to tell you that she had never complained of pain down her right arm before May 17, 2016, would that be news to you?

A No, but you’ve got to put the context of how the

patient does this part and how we as medical professionals assess the patients.

Q Okay.

A So there's a little difference which I think is important to understand. A lot of the patients when they come in, they put in a diagram general parts of their body that hurt, neck, back, arms, legs. Now, when we talk to the patient, it's our job to narrow it down to specific parts.

Q Okay.

A So when I talked to the patient, clearly she had more symptomatology on the left side than she had on the right side. Now, if you just go by the diagram, you would know that.

Q Okay.

A And the timing between her filling this out and me talking to her was within half and hour to 40 minutes. So that's an example of how those diagrams, they help out to some degree for us to kind of get a general idea of what's bothering the patient, but we're certainly not relying on those diagrams as something clinically significant in determining whether the patient is paying this, you know, the distribution of the pain, distribution of symptoms, etcetera.

Q Do you have a document in your possession called Khavkin clinic progress note, which would have been dated 5/17 or 16.

A Yes, I do.

Q Okay. And I would just mark this with a note. Did she indicate that she was having difficulty opening bottles and difficulty with grip strength?

A That's correct.

Q Okay. Would difficulty opening bottles or difficulty with grip strength typically be associated with the C8 or the T1 nerve root?

A Not necessarily. It just means that there is a weakness in the arm.

Q Would it classically, not necessarily, would it classically be associated with the C8 or the T1 nerve root?

A No. If I find weakness on the examination in the distribution of the C8 and T1 and intrinsic muscle of the hand, then, yes, I would be concerned about this. When the patient tells me that they're having difficulty using their arms, dropping objects, having difficulty opening the bottles, it is not indicative of any nerve root.

Q Okay.

A It is indicative of patient having weakness.

Q What is the most common cause of somebody dropping things or having difficulty opening bottles medically?

A Weakness, pain.

Q Carpal tunnel?

A No.

Q Isn't that a classic symptom of carpal tunnel?
A No, it's not.
Q Did you see any abnormality whatsoever at the C8 or T1 nerve root on MRI?
A You do not see abnormality of a nerve root in the MRI. So if you're asking about the discs, no, I did not see any abnormality in the discs.
Q You did not see abnormality of the nerve root on the MRI?
A No. MRIs are not designed to see the nerve root abnormalities. They're designed to see the disc bulge herniation pressing the nerve root -
Q Okay.
A -- as they come out of the spine, but you don’t really see the abnormality within the nerve root.
Q Did you actually see, and we asked Dr. Garber about this yesterday, were you able to actually see any effacement of the nerve root at any level in the cervical spine, or did you just see some difference or abnormality in the discs themselves?
A Well, you do see displacement, absolutely. Because a bulging disc, what happens is that it creates a narrowing of what’s called foramen, which is an area where the nerve comes out. So usually we see when the disc is bulging out is narrowing the foramen opening, and it displaces the nerve root

and presses on the nerve root.

Q Okay. And at least according -- I know we talked about this before, you saw some abnormality or some bulging at you thought two levels.

A Correct.

Q You prefer to look at MRIs yourself rather than to rely on what a radiologist tells you?

A Always.

Q Okay. You did not see any significant neural foraminal narrowing at either level, but you did see the bulging or the protruding; correct?

A Both.

Q Okay. Did you see significant foraminal narrowing at either level?

A There was some foraminal narrowing.

Q I'm sorry?

A There's some foraminal narrowing. I don't know if significant is a term I would use to describe it. There was a moderate degree of foraminal narrowing.

Q Okay.

A In my assessment.

Q Why would the injection of a steroid, if it had any effect at all, the injection of a steroid wouldn't reduce the size of a disc bulge, would it?

A It would not. No.

Q Okay. Why would that cause arm pain to disappear?
A It reduces inflammation.
Q Okay.
A Pain -- pain comes usually from combination of the inflammation and the pressure. So the injection reduces inflammation, but they cannot, obviously, eliminate the pressure. Which is why, in this case, it was a temporary effect.
Q Okay. You -- you can't tell how old those bulges or protrusions are; correct?
A I cannot tell. I can tell you what I think based on my experience and my expertise, but obviously there's no way to tell for sure.
Q You gave an opinion that you believe that the bulges or abnormalities were caused by a car accident the previous October?
A I believe so.
Q Okay. And that's what the patient -- based on what the patient reported to you?
A No, based on the fact that she was a young person who has abnormal MRI of the neck. And if you get MRIs of hundreds of 24-year-olds, I would say most of them, I can't tell whether 70 or 80 percent of them, should not have any abnormalities. So the fact that --
Q Are you able to tell from looking at that pain

diagram where the arm symptoms are coming from?

A No. As I said, pain diagrams are not very useful in assessing that. This is more of a kind of general concept of where the patient's pain is located, but as surgeons and clinicians, we never rely on those diagrams. We always talk to the patient, examine the patient, and then document what we get from that. We don't do the determination based on the diagrams.

Q Okay. So the patient's pain diagram --

MR. WINNER: If I may approach, please, Your Honor.

BY MR. WINNER:

Q The patient's pain diagram showing symptoms on both sides here --

A Right.

Q -- all the way down both arms and into the hands, that might not necessarily be reflected on your testing?

A Most of the diagrams of the patients we see do not necessarily accurately correlate with exact distribution.

Q Okay.

A Again, it's more of a general description by the patients where the symptoms are. That gives us some idea what we need to focus on as far as our examination, question the patient, etcetera.

Q And you did a little pinprick testing, I think.

A Of course.

Q Yeah.
A Yes.
Q The pinprick testing, you saw some symptomatology, I think you said, in the quadricep or the triceps?
A Triceps, deltoid, forearm.
Q Okay. Triceps would be here?
A Yes, sir.
Q And where else did you say?
A The forearm.
Q The forearm.
A So it's on the left side. So we have triceps, forearm, and the deltoid. So this is --
Q The deltoid up at the shoulder?
A This part here, here, and the forearm.
Q Would those symptoms be consistent with a simple injury to the shoulder?
A No, it would not.
Q Okay. You --
A Those are radicular symptoms, so that's symptoms of a nerve compression versus a local muscular/skeletal shoulder and bone compression.
Q All right. Did you review your deposition in preparation for today?
A Yes.
Q Okay. I asked you at deposition if those particular

findings, the decreased pinprick in the deltoid and the triceps, etcetera, could that be consistent with something other than a disc injury.

A It could be.

Q You said it could be consistent with any number of things; correct?

A Correct. Any -- any kind -- number of nerve-related injury, correct.

Q Okay. What else might it be associated with?

A Just like you said, if you have carpal tunnel, you could have numbness. If you have an ulnar trapped neuropathy, you're going to have numbness. But those are not post-traumatic events.

Q What conditions might that be consistent with?

A In this specific case it would be consistent with a disc bulge. Because what we do is then we correlate exam findings on this history of physical examination as opposed to MRI to come up with explanation where the symptoms are coming from. So in this case they're coming from the disc bulges.

Q In another particular case, what might they be associated with?

A If you have a patient who does not have a history of trauma, patients may have ulnar neuropathy, they may have carpal tunnel, they may have, you know, different brachial plexus inflammation. There’s a lot of different things, MS,

ALS, there's a lot of different things that can cause numbness in the arms.

Q What can cause brachial plexus symptoms?

A Infection.

Q Pregnancy?

A Not commonly, no.

Q Infection?

A Infection can, but it has to be a very specific kind of infection.

Q Can those symptoms be associated with something other than car accidents?

A They can be associated with other than car accident, but not on a patient who did have a car accident who has bulging discs.

Q Okay.

A There's a such thing that's called differential diagnosis and the radiologist usually releases 20 different reasons why something may be happening.

Q Okay.

A But the difference between the radiologist and us is that we actually get to examine the patient, see the patient, take the history, physical, and then come up with a correlation. And so that's -- that's the key in assessing the patients.

Q In your review of the MRIs, did you -- I think we

asked you this, you saw a disc protrusion; correct?

A Bulging, protrusion, herniation, yes.

Q Okay. Do you define -- do you define protrusion as being a nuclear material that is not going all the way outside the annulus, but moving?

A I define protrusion as the disc material being outside of the disc space.

Q Did you see that on the MRI?

A Yes.

Q Do you know why nobody else did?

A Everybody else just did. Everybody on the jury just did. We just looked at this together.

Q Do you know why none of the other physicians in the case including the radiologist did?

A I think it was pretty obvious. That is why we had this MRI right here.

Q If it was -- if it was so obvious, how come the -- how come the radiologist didn't notice it?

A Again, I cannot comment. As I said before, I always examine just myself. I comment on these just myself. And I think in this case it's pretty obvious that there's two bulging discs.

Q Okay. But bulging disc -- bulging disc and a herniated disc, you use those terms the same way?

A Interchangeably, yes.

Q Okay. And your claim is that on the MRI you can see nuclear material coming outside the disc space?

A We don’t use the term nuclear material because you can't really differentiate those in MRI. It’s a -- as I said before, it’s a disc material that’s sitting outside of the disc space. So that’s the definition of a bulging protrusion and --

Q Oh, oh, oh. Okay. I misunderstood you. The disc material would include the annulus, then?

A Anything that should be inside a disc space, it was sitting outside of the disc space, then it should not be there. So it’s called bulging, herniation, different terms.

Q I apologize. I misunderstood you. Did you see -- distinguishing annular material, the outside of the disc, and the soft jelly center, the crab meat portion of the disc, you didn’t see any of the jelly center of the disc or crab meat all the way outside the annulus on this?

A You cannot differentiate those on the MRI.

Q Okay.

A All you can say on MRI is exactly what we just saw, is the fact that on a normal level it’s nice and flat. If it’s abnormal, this material that looks black on the T2 images gets pushed out and you can see something sitting inside a canal or the foramen.

Q Doctor, I -- I apologize.

A Sure.
Q I misunderstood you before. You're saying that the annulus of the disc, the outside of the disc, was bulging outside what you would expect the disc space to --
A Can we go back to the images and I will be happy to demonstrate?
Q No, that’s okay. I think I understand you now.
A Okay.
Q But the annulus of the disc was moving outside where you would have expected it to be?
A Right. So, again, I would not be using the terms annulus or nucleus because those are the pathological, histological components of the disc. You cannot see this on MRI. All you can see on the MRI is that something that’s supposed to be inside the disc space, now it gets pushed out into the canal, into the foramen.
Q Okay.
A So that’s what she had.
Q Okay.
A And that’s what the finding of the MRI is.
Q You did not see any -- just to -- I know you just answered this. You did not see any nuclear material, any nuclear material from the center of the disc outside of the annulus; correct?
A Again, you cannot differentiate annulus and nuclear

material on MRI.

Q Okay.

A We don't use those terms. You say bulging disc. That's why we don't narrow down.

Q Okay. Here's some easy questions for you. Bulging discs in any given patient are usually asymptomatic; correct?

A Most of the time.

Q Okay. Protruding discs in any given patient are usually asymptomatic; correct?

A Again, so those terms are used interchangeably.

Q All right. Is that also true of herniated disc? In other words, might I have a herniated disc or might anybody in the room have a herniated disc and not even know it?

A Most probably people who have herniated discs here in this room probably do not know about this.

Q Okay. So they are -- and, in fact, that's usually the case. Most of the herniated discs that exist, most of the protruding discs that exist, most of the bulging discs that exist exist independent of any trauma and they just happen over time?

A That's correct.

Q Okay. And I also asked you this in your deposition. You have seen patients with at least mild degeneration, bulging discs, even protruding discs in their 20s and even in their teens who have not been involved in trauma, who have not

been involved in car accidents, true?
A Very rarely. Very rarely.
Q Not uncommon?
A What's that?
Q Not uncommon?
A Less common than not seeing normal MRI. So that’s the reason why I mentioned before, I said if you got a hundred MRIs of 24-year-olds, the majority of them will not have any abnormality. They will look totally normal.
Q Okay. I'm going to ask you to now go look, if you can, still Exhibit S. Would you be able to look at Exhibit S, Bates stamp 0009.
A Yes, sir.
Q And, by the way, you saw this patient exactly one time; correct?
A That’s correct.
Q And what you did after that one visit is write a letter, a cost letter?
A I wrote a cost letter at some point based on my recommendations, yes. I don’t know exactly when.
Q So after -- and I asked you this at your deposition. You would have spent somewhere between five minutes and 30 minutes with her between you and your physician’s assistant; is that right?
A No, that not accurate. We spent about half an hour

to 40, 50 minutes with the patient.

Q Between you and your PA or you yourself?

A I usually will spend about 20 minutes, especially with a surgical patient like this, I would spend at least half an hour with the patient.

Q All right. Forgive me for --

A That's okay.

Q The purpose of your visit was to do an assessment of her?

A Correct.

Q You never saw her again?

A Correct.

Q You never saw any of the chiropractor's records, but you might have seen Dr. Rosler's records; correct?

A No, I did see Dr. Rosler's records.

Q Okay. But you saw Rosler's records, you did not see the chiropractic records?

A That is correct.

Q Okay.

A That is correct.

Q And then at the end of this you wrote a letter, it's Bates Stamp 276 from the plaintiffs' exhibit, saying after that single visit that she needed a surgery and this was the cost of the surgery addressed to whom it may concern --

A That's correct.

Q -- correct?
A That's correct.
Q After one visit?
A That's correct.
Q Without seen the chiropractic records?
A I'm not sure how the chiropractic records are relevant to me establishing recommendations or the cost letter, but that's correct.
Q That's fine. At whose request did you write this letter?
A Attorneys.
Q I'm sorry?
A Attorney's request.
Q Paul Powell?
A I believe so.
Q I'm sorry?
A Yes, I said yes. I believe so.
Q All right. Have you received referrals directly from Mr. Powell?
A Usually not.
Q Have you before?
A I don't believe so.
Q Do you remember in your deposition saying you think you had?
A Just as I said, I don't remember any direct

referrals.

Q Okay.

A There's patients that I have taken care of who have him as their attorney, but I usually get them referred from physicians.

Q And, again, I'll direct you to Exhibit S0009. And I'll represent to you that the pen marks and the highlighting are mine.

A My screen just looks all yellow. That's why I'm trying to see what's highlighted.

Q Yellow. Yes.

A The whole screen is yellow.

Q This would have been in the 30 minutes or so or hour or so you and your PA would have taken a medical history?

A That's correct.

Q Okay. In that medical history, today's visit, she denies any history of prior neck or treatments for neck in the past. She had a car accident in 2009, but lumbar pain, and was treated and discharged. Did she tell you that she had seen a doctor for neck pain back in 2010?

A She did not.

Q Did she tell you that she got an MRI of her neck back in 2010 for suspected radicular symptoms?

A She did not.

Q Did she tell you that she had seen Bonanza Back

Clinic for her neck, for neck symptoms back in 2010?

A She did not.

Q Did she tell you that she had been to Green Valley Chiropractic for neck symptoms back in 2010?

A She did not.

MR. PRINCE: Objection. There's no evidence --

THE WITNESS: She did not.

MR. PRINCE: -- she went to Green Valley Chiropractic.

MR. WINNER: Green Valley Chiropractic --

MR. PRINCE: There's no -- there's no such records.

MR. WINNER: Excuse me. My apologies. Counsel is correct.

BY MR. WINNER:

Q Did she tell you that she had seen Centennial Pain Relief Network for neck pain back in 2010?

A No, she did not.

Q Did she tell you that she had been to Bonanza Back Center for neck pain back in 2010?

A No.

Q Did she tell you that she had seen Cameron Medical Center for neck pain back in 2010?

A No.

Q And she didn't tell you that she had been sent for an MRI back in 2010?

A No, she did not.
Q Can you think of any reason that she would have forgotten all of those things?
A Probably because I didn't ask her those questions and they were irrelevant to my assessment of the patient.
Q Irrelevant to your assessment?
A Correct.
Q Are you treating Ms. -- or did you treat Ms. Evans on a lien?
A That is correct.
Q Did you say you rely on 50 to -- 50-plus percent of your opinions based on what a patient chooses to tell you?
A 50-plus percent of the opinion? No, I rely actually 100 percent --
Q Causation opinion, I mean.
A Can you repeat this, please?
Q Yeah. Will you -- will you agree that you believe 50-plus -- you rely 50-plus percent on your causation opinion on what a patient tells you.
A No. My causation opinion is based not just what a patient tells me. It's the overall assessment of the clinical picture, of a history, of my assessment of the exam, and the MRI. But part of it, obviously, is me asking the patient about her symptomatology.
Q Sure.

A And what I usually ask the patient is that, number one, whether he or she had any symptoms immediately prior to the accident, and I, obviously, rely on this information, and whether or not they've had symptoms a few years prior to that, two or three years prior, okay. If somebody had symptoms -- excuse me. If somebody had symptoms years prior, just in this case, for example, you know, you're saying that in 2010 she had an accident, there was some neck discomfort. And she was completely asymptomatic immediately prior to the accident in 2015. Does it change my opinion about the causation? No, it does not because it just wouldn't make sense.

Q Why was she able to remember for you that she had low back pain back in 2010 when she was presenting a neck claim to you?

A Why would she mention this, mention this information?

Q Yeah. I guess my question is do you have any thoughts on how she -- how she was able to remember she got the year wrong, 2009, it was 2010.

A Right.

Q How was she able to remember that she had back pain and treated for back pain back in 2010, but neglected to mention anything to you about the neck, the suspected radiculopathy --

A Yeah, I mean, if she --

Q -- the back clinic for the neck, and the MRI of the neck?

A Right. So if -- if the question was asked, specifically my examination for was based on the -- focused on the neck, your neck symptoms, because that’s what's your primary symptomatology. If she mentioned she had some symptoms prior to that, at that point I did not even have a back MRI of her at the time of the evaluation because all the evaluation was focusing on the neck.

Q Okay. If a patient gives you false or misleading information, that can affect your causation opinion; correct?

A Correct.

Q If she misleads me in response to my direct questions, yes, that would be concerning.

A And in response to your direct questions, she told you she had never had any treatment for her neck and she had never had her neck examined before in response to your direct questions.

A No, that’s not correct and that’s not what I said.

Q Isn't that what it says?

A No. What I said is that I asked the patient whether they were symptomatic or asymptomatic immediately prior to the accident, which the answer was no. I do not believe that she was misleading me. And whether or not she had any treatments or any recommendations for surgical treatment immediately

prior to that, which usually involves, you know, a year to two years. And if the answer is no, as far as I'm concerned, she was asymptomatic prior to this.

Q No, sir, she told you never. She denies any history. She told you never, didn't she?

A Well, you just asked me what questions do I ask patients --

Q Okay.

A -- at my -- at the time of examination, and I just told you what kind of questions I ask the patient. So I don't believe that she was misleading you in any way.

Q Okay. I don't think was included in your records, Doctor. I'm going to approach you with this.

MR. PRINCE: Yeah, we have to approach on this.

MR. WINNER: Okay.

(Bench conference)

THE COURT: Is that an exhibit we have? Is that an exhibit we have?

MR. PRINCE: No, it's not.

MR. WINNER: It was not included.

MR. PRINCE: It's not -- I don't have it. We don't have this document and he's just following up -- he wants to do -- this is all part of that litigation, they're following up on paying liens, the status of the claim. This is all like internal billing notes. And so he just highlighted right

there. Well, this is why he had a lawyer involved and the lawyer -- he didn't make the referral here. Dr. Rosler did. This is this whole medical buildup attorney-driven kind of stuff. It's all to suggest that.

So once you open the door that a lawyer is involved, and all of the sudden this becomes -- so now this is like the internals that they're following up on what's going on in the case after he's already seen her, like, hey, where are we, what's going on, when are we going to get paid.

THE COURT: What is this? What's on this?

MR. WINNER: This is just after he saw her all the calls his office made to Paul Powell's office on the lien trying to get paid. I'm not offering it as an exhibit. I'm going to show it to the witness and ask him about it.

MR. PRINCE: I'm objecting to relevancy. It's prejudice, it's irrelevant.

MR. WINNER: Well, I showed it to you first to make your objection.

THE COURT: Yeah, I'm going to sustain it.

MR. WINNER: Okay.

THE COURT: I don't think you need to go any further down that road.

(End of bench conference)

BY MR. WINNER:

Q Now, Dr. Khavkin, after agreeing to treat her on a

lien, that means you still have not been paid for your treatment in this case. You have a $980 bill for -- attached to a lien; correct?

A I don't believe so, but they would be able to answer any question for in billing department.

Q Here's my question. The $980 bill which we have a copy of here, would that have been to examine her, or would it have been to write this cost letter to Attorney Powell?

A Again, I don't have this bill in front of me.

Q Would you have typically charged Mr. Powell or another personal injury lawyer to write a letter like this?

A I usually would, yes.

Q How much do you charge to write a letter like this typically?

A I don't know. Again, it would be a question for my billing department.

Q You don't know what you charge for a letter like this?

A I don't.

Q Okay. And in this letter, after seeing her one time and wiling to treat her on a lien, you blamed the surgery on defendant; correct?

A Blamed --

Q On Babylyn Tate?

A Blamed the surgery on the defendant. I'm not sure I

understand that statement.

Q You blamed the need for the surgery in the cost letter on Babylyn Tate; correct?

A I did not -- if you're asking about a causation -- I'm not sure where the word blame came from. If you're asking about the causation, then I feel that her symptoms, as well as the need for the surgery, do come from the accident in 2015. That’s correct.

Q Did she tell you that her symptoms began immediately after the accident down both arms, down both legs, into the neck, and into the back?

A She said that her symptoms started after the accident.

Q Thank you. Nothing further.

REDIRECT EXAMINATION

BY MR. PRINCE:

Q Dr. Khavkin, just a few follow up questions. When you saw her in May of 2016, after you took a history, did your exam, reviewed the MRI, looked at Dr. Rosler’s records, his treatment, and her response to the injection therapy, was there anything more conservatively that was available to Desire to help treat her symptoms short of a surgery?

A I think she’s pretty much exhausted all of the other options.

Q Right. Would sending her back to the chiropractor

for more physical therapy, would that resolve the disc protrusion and the symptoms and the nerve root irritation?

A I don't believe so.

Q Tell us why that doesn't resolve the structural injury to the disc.

A Well, if she had not tried anything at that time, I definitely would have recommended that as an attempt to avoid surgery, injections, physical therapy, chiropractic treatment. Because some patients have some relief of the symptoms. Is it going to make the disc go away? No, of course not. But it may give them some temporary relief. In her case, she's already been through all of this. So for me to send her back to do the same thing that didn't work is just -- would not make any sense.

Q Is surgery essentially her stop?

A Surgery is always the last resort.

Q Right.

A No matter how you look at this, whether it's a personal injury case or not a trauma related case, we always try to avoid surgery. It's always the last resort. And the recommendation of the surgery always comes both based on the findings, but also based on how miserable the patient is. Nobody in their right mind will undergo major neck surgery unless they're miserable, unless it's dramatically affecting their quality of life. When people have light pain, when they

just have a little discomfort, they don't have neck surgeries and neck surgeries. I mean, it's just -- just not the right thing to do.

Q Was -- by definition, was Desire in chronic pain when she came to your clinic?

A She had been in severe pain ever since the accident.

Q Right.

A So a few, few months, yeah, you can say it's chronic or --

Q After six months it's chronic; right?

A It's -- it's long term.

Q Right.

A It's long enough to recommend surgery.

Q Right. And when you have patients come to see you, do they have good days and bad days who have chronic pain because of disc related issues?

A Sure.

Q And sometimes does their pain diagram look one way on one day and maybe another day -- looks like something else on another day depending on the kind of day they're having?

A That's correct. But actually on this pain diagram you can see one of the questions we ask right above it is where are you now and what is your best and what's your worse.

Q Right.

A And even at the best she said she was, I believe, 7

out of 10. I don’t have it in front of me.

Q 6.

A Oh, 6. And then -- that’s correct. 6 at the -- at the best, 10 at the worst, and 9 at the time of the evaluation. 6 out of 10 pain in a 24-year-old, that’s a miserable life.

Q Okay. And when you spoke of her, you said these diagrams, you know, they help you just kind of in a general sense, but you also take a history when you go back to the exam room. You also have like a question and answer session with the patient. You had that with Desire; right?

A Yeah. As I said, diagrams, we never rely on them of any sort of clinical value. This is more of a -- you never met the patient. You try to get an idea of what part of the body they're here for. And so they put something in the diagram. And so when you start talking to them, you focus on a specific examination based on the information they provided us in the form.

Q Right.

A We’re not recommending something based on what they put on the diagram. It’s just would not be the right thing.

Q Well, she may have been having some back discomfort or some problems with her legs.

A Which I'm sure she did.

Q The chief complaint she was seeing you for, it was

the neck and the arms; right?

A That's correct.

Q All right.

A The neck and the left arm. Correct.

Q That was her primary issue that day?

A That's the reason why she was seeing a neurosurgeon. Correct.

Q Right. And did you ask specific questions about her neck pain and about her arm pain?

A Correct.

Q Did you even examine her low back or her legs at all?

A I was examining the lower back in terms of the motor and sensor deficits.

Q Right.

A I don't want to miss if there's any weakness, but the focus of this is on the back and the arms, yes.

Q Because I looked at your examination, there's no physical examination of the lumbar spine or anything that you documented that day. I guess my point in even bringing that up is all of the focus was on the neck. There was really nothing significant going on in the low back.

MR. PRINCE: Bates No. 275, Brandon.

THE WITNESS: Actually, so when I say otherwise remaining dermatomes intact, so that means that the remainder

of the body is intact. It means that there was really no other deficits in the legs based on the exam. Yes.

BY MR. PRINCE:

Q Okay. So while we have it on a diagram, through -- through your history sitting down with her, asking her questions, doing an exam, putting your hands on her --

A Right.

Q -- the low back and the legs were really not a significant problem for her at that point?

A It's not significant problem, but it always gets examined.

Q Okay. Have you found anything or has she told you anything significant about her back, her low back and her legs, would you have recorded that?

A I definitely would have, yes.

Q Right. In this case you did not.

A Correct. It was not a primary concern of hers. Right.

Q And she wasn't asking you to do anything for her low back or her legs; right?

A No.

Q Now, Doctor, the symptoms that she came to you with, the neck pain and the symptoms down in the left arm, do you have an opinion whether those -- the most probable explanation is the disc protrusion at C6-7 and to a lesser extent C5-6?

A That's correct.
Q What's your opinion, that -- is that the cause?
A That's correct. That's the reason why she --
Q Are you able to rule out, based upon your training as a board certified -- you're board certified; right?
A Of course.
Q Board-certified, fellowship-trained neurosurgeon, that there's no carpal tunnel syndrome, other nerve related issue --
A That's correct.
Q -- that would explain the symptoms in this case?
A No. Clinically, it does not fit any of the other explanations.
Q All right. Did you feel that Dr. Garber's -- excuse me, Dr. Rosler's selective nerve root blocks confirmed the presence of a discogenic problem at C6-7, which relieved not only the neck pain, but also arm symptoms?
A It was definitely helpful.
Q Okay.
A It was definitely helpful in diagnosis, yes.
Q You heard here in court earlier with Dr. Garber -- strike that. Mr. Winner asked you have you ever heard anybody call the disc at C6-7 a herniation. Do you recall Dr. Garber sitting here earlier today when you were listening -- finishing -- he was finishing his testimony, he called it a

herniation, do you remember him saying that?

A He did, yes.

Q Do you agree with that?

A Yes, of course.

Q All right. His findings -- does Dr. Garber's findings, the interoperative of the two disc fragments, is that consistent with your own review of the MRI that there was a herniation at C6-7?

A Yes, that's what I would expect to see.

Q And at times, Dr. Khavkin, are you asked by lawyers or otherwise to provide cost estimates if you're recommending a surgery but the patient hasn't undergone that, to provide a cost estimate in case they need to come to court or something else --

A I do.

Q -- of what the medical care cost is?

A Yes.

Q Okay. Anything unusual or weird or untoward about that?

A No.

Q I mean, just by the nature of your education and training and focusing on the spine, you're going to see people who get hurt; right?

A Of course.

Q Do you see people get hurt on the job?

A Often.
Q Right. So, I mean, they're all [indiscernible]; right?
A Right.
Q Or even do you see people on an emergency basis, as well?
A Of course. Yeah.
Q So, obviously, if someone is seen in an emergency room, they got hurt someway?
A Right.
Q If Desire had a motor vehicle crash in 2010, she went for 14 chiropractic visits and had an MRI which is completely normal as read by the radiologist and did not go back for any care for more than five years, would that be clinically relevant to you in any event?
A No, it would not.
Q Okay. Why?
A Because, again, it would not make any changes as far as my recommendation, number one. But it also would not make any change as far as me establishing the causation. Because clearly she did not have any problems for several years prior to 2015. So it would not be any relevance to either recommendations or the causation of -- of her symptoms.
Q Right. And we already have your bill in evidence and Dr. Garber testified it was reasonable. I mean, you're

not here because you have some financial stake in the outcome. For $900 you really have to -- what did you have to do to get here today?

A Well, I had to miss my clinic and miss my open house. There's all that, which is --

Q Right.

A -- going to be interesting.

Q Right. So -- well, thank you for your time --

A My pleasure.

Q -- and being here and I appreciate you coming.

A No problem.

MR. PRINCE: No additional questions.

THE COURT: Mr. Winner.

MR. WINNER: Yeah, just really quickly to clear a couple things up.

RECROSS-EXAMINATION

BY MR. WINNER:

Q I just want to reiterate something you told Mr. Prince. She told you that she had been in severe pain ever since the accident; correct?

A Correct.

Q And you accepted that as true?

A That's correct.

Q Did you say in your deposition that asymptomatic degenerative conditions are very common?