IN THE SUPREME COURT OF THE STATE OF NEVADA

CAPRIATI CONSTRUCTION CORP., INC., a Nevada Corporation Appellant, v. BAHRAM YAHYAVI, an individual, Respondent.	)	Supreme Court No: 80107 District Court Case No: A718689
CAPRIATI CONSTRUCTION CORP., INC., a Nevada Corporation Appellant, v. BAHRAM YAHYAVI, an individual, Respondent.	)	Supreme Court No: 80821

APPENDIX TO
APPELLANT'S OPENING BRIEF
VOLUME 6 of 12

Appeal from the Eighth Judicial District Court
Case No. A718689

HUTCHISON & STEFFEN, PLLC

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CERTIFICATE OF SERVICE

I certify that I am an employee of HUTCHISON & STEFFEN, PLLC and that on this date the **APPENDIX TO APPELLANT'S OPENING BRIEF VOLUME 6 of 12** was filed electronically with the Clerk of the Nevada Supreme Court, and therefore electronic service was made in accordance with the master service list as follows:

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DATED this 12th day of August, 2020.

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An employee of Hutchison & Steffen, PLLC

RTRAN

DISTRICT COURT

CLARK COUNTY, NEVADA

BAHRAM YAHYAVI, Plaintiff(s), vs. CAPRIATI CONSTRUCTION CORP, INC., Defendant(s).	CASE NO: A-15-718689-C DEPT. XXVIII

BEFORE THE HONORABLE RONALD J. ISRAEL, DISTRICT COURT JUDGE

FRIDAY, SEPTEMBER 13, 2019

RECORDER'S TRANSCRIPT OF PROCEEDINGS
RE: DAY 5 EXCERPT, DR. DAVID OLIVERI

APPEARANCES:

For the Plaintiff(s): DENNIS PRINCE, ESQ.

For the Defendant(s): DAVID KAHN, ESQ.
MARK BROWN, ESQ.
MARK SEVERINO, ESQ.

RECORDED BY: JUDY CHAPPELL, COURT RECORDER

LAS VEGAS, NEVADA, FRIDAY, SEPTEMBER 13, 2019

[Proceeding commenced at 2:50 p.m.]

DAVID OLIVERI

[having been called as a witness and being first duly sworn, testified as follows:]

THE CLERK: Please have a seat and state and spell your name for the record.

THE WITNESS: Dr. David Oliveri, D-A-V-I-D; last name is O-L-I-V-E-R-I.

DIRECT EXAMINATION

BY MR. PRINCE:

Q. Dr. Oliveri, good afternoon.

A. Good afternoon.

Q. And thank you for being here. Are you a medical doctor?

A. I am.

Q. And can you please describe for us or tell us your medical specialty?

A. I'm a board-certified physician in the field of Physical Medicine and Rehabilitation.

Q. And can you describe for us the area of your subspecialty, Physical Medicine and Rehabilitation? What does that consist of?

A. It consists of a number of things. In general, it consists of evaluating, treating, and diagnosing people that have some sort of

injury or illness involving their musculoskeletal system or their nervous system.

From a practical standpoint, it has involved, for me, a combination of things over my career of over 26 years here in Las Vegas. I have taken care of patients in the hospital that have suffered from catastrophic injuries such as spinal cord injury, stroke, head injury. I've taken care of many orthopedic patients in the hospital. I've also had a very active outpatient practice for many years, taking care of individuals that have been injured outside of work, injured at work.

I've performed nerve testing, which is called electrodiagnostic medicine. I perform impairment ratings as a certified rating physician for the State of Nevada for work injuries. And I also perform medical legal work.

Q. Okay. And in treating patients and managing patients' care with musculoskeletal injuries, I think you said a minute ago that that included spinal-related injuries?

A. Of course.

Q. Does that include individuals who have not only been injured at work, but who have been injured outside of the workplace?

A. Of course.

Q. What is unique about the Physical Medicine and Rehabilitation subspecialty that allows you to, you know, evaluate, train, and manage the care of someone who has suffered a complex

spinal injury?

A. The unique aspect of my specialty is really the holistic nature of our training and experience. So from the get-go, we are trained to -- from residency and beyond -- to work in a multispecialty environment.

So we coordinate care of patients. We work with highly-trained physicians in other specialties to deal with certain areas that might be outside of our expertise. We deal with physical therapists, occupational therapists, nursing staff, pulmonary specialists, respiratory therapists -- and basically coordinate that care and have knowledge about all of those factors.

Q. Do you -- as a Physical Medicine and Rehabilitation specialist, do you also refer and manage the care of patients who are referred to, say, spinal surgeons?

A. Yes.

Q. Do you actively work with spine surgeons as part of your practice?

A. Yes.

Q. Is that part of Physical Medicine and Rehabilitation generally?

A. It is a two-way street. Spine surgeons will refer patients to me for evaluation and treatment. I will refer patients to spine surgeons if they need or are a candidate for surgery.

Q. Do you also manage the care of patients and refer

patients, as well as receive patients, and coordinate care with pain management specialists?

A. Yes.

Q. Related to identifying and treating sources of pain within the spine?

A. Yes.

Q. And I want to touch on another aspect of Physical Medicine and Rehabilitation. What is unique about that medical subspecialty relating to somebody who has been injured on the job, has a permanent disability, and in finding whether that -- or determining suitable levels of employment and/or permanent restrictions for them?

A. Almost exclusively -- especially when you're talking about a work-related injury, almost exclusively, doctors in my specialty are the ones that are relied upon to make those complicated decisions. And it goes back to the nature of our training and education.

So we are oftentimes asked to identify when a person is at a plateau in their care. We are oftentimes asked to identify whether or not there are restrictions on their physical abilities that impact how they can work. We are the ones who are relied upon by work-related entities or Social Security to make determinations regarding disability or permanent restrictions for safe return to work.

Q. Okay. And you said that you were one of the

subspecialties chosen for either work-related injuries or Social Security to make the determination of whether someone is vocationally disabled or not?

A. I would say almost exclusively those entities rely on Physical Medicine and Rehabilitation.

Q. Now, let's talk about where you went to medical school. Where did you go to medical school, Dr. Oliveri?

A. University of Southern California in Los Angeles.

Q. Okay. And after you -- how many years was your medical school?

A. Four years.

Q. And after medical school, did you go into a residency program?

A. I did my internship first at the Veterans Hospital in West Los Angeles. That's a one-year program.

Q. Okay. What's an internship?

A. Internship is where you get experience or exposure to different specialties in medicine. So over the 12 months, you would rotate through emergency medicine, intensive care medicine, pulmonary medicine, general surgery -- all of those fields to get a broad experience.

Q. Okay. And after you completed your one-year internship, did you go on to a residency program?

A. I did.

Q. What is a residency program?

A. Residency is where a physician learns or is trained to be a specialist. So you can complete an internship one year after medical school, and you can open a practice being a primary care physician, a family doctor. But if you want to do any other type of specialty, you are required to have specialty training that is a number of additional years in length.

Q. Okay. And in what area did you do your residency?

A. Physical Medicine and Rehabilitation is the name of my specialty.

Q. Okay. And how many years was that?

A. Three additional years. So from the time of medical school finishing, it was a total of four years of training after medical school.

Q. And where did you do your residency?

A. I did it at Stanford University in Palo Alto.

Q. Okay. And after you completed your residency at Stanford, did you move to Las Vegas?

A. I did.

Q. All right. And when you relocated or moved to Las Vegas, did you become affiliated with a rehabilitation hospital?

A. Yes.

Q. And what rehabilitation hospital were you affiliated with?

A. It's had a few different names over the years. The longest

name has been HealthSouth Rehabilitation Hospital, which is on Valley View near Charleston. And more recently, it was purchased by a national company called Encompass Health.

Q. All right.

A. But I've been associated with that hospital in one form or another since 1993.

Q. And describe for us, Dr. Oliveri, what a rehabilitation hospital is and what your role has been with the rehabilitation hospital since 1993.

A. Rehabilitation hospitals are set up to take patients that have been hospitalized in an acute care hospital with some sort of illness or injury or problem, and those patients that are not able to be safely discharged home for some reason are oftentimes candidates to be accepted into an inpatient rehab hospital. So these are people that have some sort of complicated medical issue that prevents them from going home, but they don't need to be in the acute care hospital. It might be that they can't take care of themselves. They can't bathe, dress, toilet. They can't walk properly. They can't communicate properly from a stroke. Whatever it might be -- those patients are admitted under the care of an attending physician in Physical Medicine and Rehabilitation. And then a treatment plan is established with all of the other individuals that are part of the team.

Q. Okay. And what has been your -- what positions have you held at the Health -- the rehabilitation hospital? I'm -- I know it as

HealthSouth for so many years. But --

A. Sure.

Q. -- [indiscernible] health center.

A. Sure. So for the first 18 years of my career with the rehab hospital, I started out as the associate medical director for the first five. And then for the next 13 years, I was the medical director and Chief of Staff at the hospital.

Q. What does that mean?

A. Both of those?

Q. Yes.

A. A medical director is responsible for every administrative decision in the hospital that deals with physicians -- so it -- responsible for credentialing doctors to be able to admit or even touch a patient in the hospital; responsible for monitoring the actions of those physicians; the safety of the patients in the hospital; setting up protocols for treatment; working with nursing staff, therapy staff, to develop protocols for treatment. Also responsible for signing off and determining which patients should be admitted and which patients should be denied or set aside pending other things.

Q. Okay. And I also note in your CV that you are the -- you were also the program director of the rehabilitation hospital?

A. So what I didn't mention earlier, I have been the president of the medical staff at the rehab hospital since 1998. I still have that position. And in that position, I oversee all of the actions of the staff

that we have. We have about, oh, probably 200 physicians on staff and maybe 50 that are active on a regular basis.

I stepped down in -- probably eight years ago, as the acting medical director, but have stayed on as the president of the medical staff. And the program directorship that you're talking about is my continued role at that hospital to advise the CEO, the administration, on all the matters that we've just discussed.

Q. And in your role as a rehabilitation physician, do you -- do you coordinate and manage the care of patients at the hospital who have suffered spinal injury or following spinal surgery?

A. Yes.

Q. How many patients, over the years, would you estimate that you have been involved with the care or treatment or plan for treatment who have suffered a spinal injury or have gone on to spinal surgery?

A. Easily multiple hundreds, maybe even a thousand.

Q. Okay. And as part of your private clinical practice, how many patients would you estimate you've treated or evaluated and/or formulated a treatment plan for who suffered some type of spinal-related injury, whether to the neck, the low back, whether it be at work, motor vehicle accident, fall, or any other matter, would you estimate?

A. Probably a few thousand.

Q. Okay. Do you consider yourself to have a certain level of

expertise in understanding and managing patients' care who have suffered spinal injuries?

A. I do.

Q. Okay. Now, you also indicated that you are -- you've been certified in the state of Nevada to perform permanent impairment ratings in connection with Worker's Compensation matters?

A. Yes.

Q. What does it mean to be certified to perform permanent impairment ratings for injured workers?

A. The certification process in Nevada involves, first of all, being a board-certified physician in your area of expertise. And then you have to take additional testing that's sponsored by the State of Nevada to make sure that you know what you're doing when you're assessing these issues of permanent disability or impairment.

Q. Okay. And are you board certified in your area of practice?

A. Yes.

Q. How long have you been board certified?

A. Since 1994.

Q. What does it mean to be board certified?

A. Board certification is the highest level of training and certification that a physician can attain. So, for example, you could finish your residency training in Physical Medicine and Rehabilitation and practice your entire career without being board certified. The

certification process ensures that you have reached the top of your field.

So you have to submit examples of your work to the medical board. You have to sit for a written examination. You have to sit for an oral examination. You have to pass all of those things to be deemed board certified for 10 years. And then every 10 years you have to repeat the certification process.

Q. Okay. And in what other areas are you board certified, Dr. Oliveri?

A. I'm certified in the area of nerve testing that I mentioned, which is called Electrodiagnostic Medicine. And I also have a certification in what's called Life Care Planning.

Q. Okay. And what is life -- we're going to be taking about life care planning in connection with this case. What is life care planning?

A. Life care planning is the process of identifying medical needs for a patient that has some sort of catastrophic injury. So specifically, for example, with Mr. Yahyavi, it would be to determine what medical needs are related to a particular incident, identify the items that are needed for the rest of his life over an average life expectancy, and then research effectively the costs associated with each of those items and present it in a report that makes sense.

Q. Okay. And I also note from your resume, Dr. Oliveri, that you're also certified as an Independent Medical Examiner. Is that

true?

A. Yes.

Q. What does it mean to be certified as an Independent Medical Examiner?

A. That is part of the certification to be a Certified Rating Physician in the state of Nevada. So that involves coursework, examination testing, and recertification every few years.

Q. I think one of the reasons why the certification is relevant for this particular case is because initially you saw Mr. Yahyavi in April of 2015, in connection with his work-related injury; right?

A. That is correct.

Q. And so in front of you, Dr. Oliveri, I have -- there's a number of binders, all -- there's three exhibit binders I have in front of you.

Exhibit No. 98, that is your actual record from April 23rd, 2015.

It's Bates No. 578, Greg.

So that's your -- that's actually your initial report related to your impairment rating. Okay?

A. Yes.

Q. So we're going to be talking about that.

And I want to first talk about, number one, what is a permanent impairment evaluation?

Just zone in at the top, Greg, with the date and

everything. Okay.

A. Permanent impairment evaluations are something that were established by the American Medical Association decades ago. The whole purpose of an impairment evaluation is it's essentially utilized exclusively in Worker's Compensation. So the purpose behind it is to take any type of injury or problem to the human body, head to toe, and there -- the textbook is about 600 pages long. And it goes through every single body part and body system. And depending on what the injury is and what the treatment was, there's a method to convert that injury into a percentage number.

So the job of the rating physician is to determine the percentage of impairment for a particular injury. And impairment specifically means an alteration to that person's body on a permanent basis.

So for example, in Mr. Yahyavi's case, in 2015, it was spinal issues with loss of motion and other findings on examination. Currently, his impairment involves the fact that he's had a multilevel instrumented fusion with titanium screws and rods.

Q. Okay. And with regard to this impairment evaluation, as part of this process, I mean, what -- did a lawyer select you? Did I -- did my firm select you to do this?

A. No.

Q. Okay. And were you appointed, I mean by the Worker's Compensation, at least the system, to be a -- an evaluator for

Mr. Yahyavi?

A. Once you're certified as a rating physician, you are on a rotation for the State. But then each individual third-party administrator has a mini list of doctors that they allow patients to choose from. So I'm -- I happen to be on that mini list of a number of different companies in Las Vegas. And the patient -- the individual patient chooses me.

Q. Okay. So just so we're clear, I played no role in your selection in April of 2015; correct?

A. Correct. The attorneys are not involved in that selection process.

Q. Okay. Would you consider that an independent selection process?

A. Yes.

Q. All right. Now, you and I certainly know one another.

A. Yes.

Q. And we have worked together more than 20 years.

A. Probably.

Q. Right? We've -- I've hired you as an expert witness; correct?

A. You have.

Q. And I've -- you've been on -- many times been on the other side of me as an expert witness?

A. I have.

Q. Well, have I represented defendants in these types of cases where you've been on the plaintiff's side; correct?

A. Yes.

Q. And I have been on the plaintiff's side where you've been hired by the defense.

A. Yep.

Q. Would that be a fair statement?

A. That is correct.

Q. Have you been -- have you been allowed to testify in court as an expert witness in your field of medicine, Physical Medicine and Rehabilitation?

A. Yes.

Q. How many times?

A. I've been doing this type of work for about 21 years, and I think probably over 200 times over that period of time.

Q. Okay. And do you make yourself available to be hired either by the defense on these personal-injury-type cases or by a plaintiff representing -- a lawyer representing a plaintiff in a personal injury case?

A. I do.

Q. Very good. And do you charge for your services to be here today?

A. I do.

Q. What do you charge to be here today?

A. I charge $1,400 an hour for the time I'm here testifying.

Q. Right. Because meanwhile, you still have your office up and running and functioning while you're here?

A. Yes.

Q. All right. Is that a usual and customary charge for someone of your medical specialty and skill set?

A. Yes.

Q. Very good. All right.

Now, I want to talk about your evaluation in April of 2015. But before we do that, I want to talk about -- we're going to be talking about an injury to the cervical spine, primarily; right?

A. Yes.

Q. The area that you rated Mr. Yahyavi, was it -- he had a permanent impairment to the cervical spine; is that correct?

A. Yes.

Q. Did you form an opinion as to what the cause of that permanent impairment was?

A. Yes.

Q. What is the -- what was your opinion that you formed back in April of 2015?

A. The June 19, 2013, motor vehicle accident.

Q. Right. In addition, after you performed your impairment evaluation in 2015, did my law firm then ask you, since you were already involved, ask you to review additional records and

re-examine Mr. Yahyavi and form additional opinions?

A. About three years later, yes.

Q. All right. Have you formed an opinion on whether or not this motor vehicle collision, based upon all the records that you've reviewed and we're going to talk about -- the history, examination, depositions -- what injuries he suffered as a result of the June 19, 2013, motor vehicle collision to his cervical spine?

A. I'm sorry. Have I determined?

Q. Yes.

A. Yes. And in fact, my diagnosis in 2015 is the same diagnosis I have today.

Q. Okay. And what is that?

A. Mr. Yahyavi sustained multiple levels of what's called motion segment injury, which means that he had injury to both the discs in between vertebral bodies in the neck, as well as the facet joints. It was a combination of those two.

Q. Okay. And do you -- the surgery that this jury learned about that was performed by Dr. Kaplan in January of 2018 in his ongoing symptoms -- did you form -- do you have an opinion what the cause of that need for surgery and ongoing symptoms are?

A. Yes. The cause was the June 19, 2013, accident.

Q. Right. Was there anything that you heard today in either my opening statement or in, more importantly, Mr. Kahn's opening statement, regarding any pre-existing related issues that changes

your opinion in any way?

A. No.

Q. Okay. Well, we're going to talk about that in a minute.

Now, was there any dates of injury, any further injury, any after June 19th, 2013, any evidence of additional trauma, any other event that would otherwise explain his symptoms or the chronicity of his symptoms or current impairment?

A. No.

Q. Are those your opinions to a reasonable degree of medical probability, Dr. Oliveri?

A. Yes.

Q. Okay. Have you also formed an opinion on whether or not Mr. Yahyavi is permanently disabled from working?

A. Yes.

Q. And what is your opinion in that regard?

A. As you know from my reporting, there's been an evolution of my assessment in that regard.

Q. Sure.

A. But my final opinion is that Mr. Yahyavi has abilities that are less than the minimum requirements for gainful employment. So sedentary is essentially the least physically demanding work. It's a desk job. And Mr. Yahyavi does not have the physical abilities to do that, so he is considered permanently and totally disabled by me and also by Social Security.

Q. Okay. Has he also been determined to be disabled by the Social Security Administration?

A. Yes.

Q. Okay. Now, I want to -- before we -- so obviously you understood that this was a work-related injury at the time?

A. Yes.

Q. And Worker's Compensation, did they accept the injury to the cervical spine that was caused by this motor vehicle collision?

A. Yes.

Q. What does it mean for the Worker's Compensation to accept an injury for treatment and rate it?

A. Worker's Comp deals with injuries based specifically on body parts. So when a person has an injury, there is an initial report -- it's called an industrial C-4 form -- that is completed in part by the injured worker and in part by the initial treating physician.

Worker's Comp makes a determination based on that reporting whether or not they will consider it a work-related injury; and if they do consider it, what body parts they will allow to be treated under -- or take responsibility for.

Q. Did Worker's Compensation take responsibility for the treatment and the interventionalist's pain management for Mr. Yahyavi's cervical spine?

A. To this day, yes.

Q. Okay. Would a Worker's Compensation case manager

had to have participated in the authorization and approval process for the care and treatment, including spinal injections and evaluation by orthopedic spine surgeons?

A. It could be the case manager with Worker's Comp; it could be the adjuster with Worker's Comp. But everything is -- has to be done before the procedure or treatment is provided.

Q. Right. And would there be any reason to rate someone with a permanent impairment if it's a simple self-limiting soft tissue injury, Dr. Oliveri?

A. Absolutely not. That would be automatically a zero percent.

Q. Right. And so we heard from Mr. Kahn today, and you've read Dr. Tung's reports that his opinion of this is a self-limiting soft tissue injury.

If that's what this was, would you have given him a permanent impairment rating in April of 2015?

A. Absolutely not. It -- first of all, he wouldn't have been in my office. And if he was, by chance -- sometimes things slip through the cracks, they don't make the right decisions. But if a person shows up to my office with a self-limiting soft tissue strain, it's a zero percent rating.

Q. Right. And so the complaint that was read to this jury today was filed on May 20th, 2015. Okay.

Well, just bring up the date and leave that there --

that whole topic?

What date did you evaluate Mr. Yahyavi?

A. April 23rd of 2015.

Q. Before any lawsuit was filed; right?

A. Yes, I would say so.

Q. According to these dates?

A. Correct.

Q. Okay. Now, Mr. -- we're going to discuss the symptom, level of detail. But as part of your evaluation in coming up with a permanent impairment, did you consider that Mr. Yahyavi had degeneration in his spine?

A. Of course.

Q. Right. So you -- that was something you knew, that would have predated this motor vehicle collision of June 2013?

A. Absolutely. I saw all of the imaging studies, the x-rays, the MRI scans. I was -- you know, I made comment on it. It was no surprise to me and it was absolutely part of my consideration.

Q. All right. So you factored that in to your evaluation?

A. Yes.

Q. Have you factored that into your opinions in this case?

A. Yes.

Q. Can you simply just look at an x-ray report -- we're going to look at that here in a few minutes -- but just look at an x-ray report that shows degeneration and say, oh, yes, that person must be

symptomatic or have pain or symptoms?

A. Absolutely not.

Q. Okay. Please explain why.

A. Sure. As was mentioned earlier today, you can -- we all, starting probably in our 30s or later, develop age-related degenerative change to our spine. It typically happens in the neck at certain levels; it also typically happens in the lower back at certain levels.

The analogy I typically tell patients is that degeneration on an x-ray is very similar to having gray hairs develop, which almost everybody does when they get older. But that doesn't mean that the gray hair is painful. It doesn't mean that the bone spurs that you see or the areas of age-related change in the spine are causing symptoms. There has to be --

Backing up, a surgeon would never look at an x-ray or an MRI scan alone and tell whoever that is that they need to have surgery. There has to be clinical correlation. There has to be input from the patient. There has to be consideration of examination findings. There has to be a consideration of imaging tests -- MRIs or x-rays. There has to be consideration of injection results when I'm talking about the spine. And then there's some other ancillary tests that need to be considered.

And then it's the physician's job, which is -- it's a complicated process, but that's what we're trained to do -- to

assimilate all of that information and come up with the correct diagnosis and the correct treatment plan.

Q. Okay. And I wanted to -- so it's not just one piece of the puzzle. It sounds like there's multiple pieces of the puzzle in formulating your opinions -- not just diagnostics x-rays or MRIs?

A. Of course.

Q. All right. And do you use clinical correlation as part of your practice as a Physical Medicine and Rehabilitation specialist?

A. Of course.

Q. Did you do that as part of your analysis in this case?

A. Of course.

Q. Okay.

[Pause in proceedings.]

BY MR. PRINCE:

Q. Dr. Oliveri, we're talking about clinical correlation. And there's a different -- there's many components to this.

Let's start with the patient history. What's critical about patient history as part of your overall clinical correlation analysis?

A. When we're talking about the spine, we know that spinal changes on an x-ray or an MRI scan can and do occur without any symptoms whatsoever, or with minor symptoms, but no actual findings on examination.

So we're looking at asking the patient what

happened? What are your symptoms? Where are they located? With spinal injuries, the location of pain is unimportant because there's a difference when a person has just neck pain, as opposed to a person has neck pain, radiating down an arm, with weakness and headaches.

So we consider that information. And then, as we're gathering that information, we're developing a list of possible explanations; and then we're either ruling in or ruling out certain possibilities. That's the process.

Q. Right. And patient history obviously plays an important role?

A. Yes.

Q. And are you documenting, like, when the symptoms started; the nature and severity of them; are they persistent; you know, do they come and go -- those type -- the quality of the symptoms? Are those important to you?

A. Yes. Quality and quantity.

Q. Okay. And whether you've had symptoms in the past or remote past, does that play a role too?

A. It could, depending on what it is.

Q. Right.

A. It's something that more information is better.

Q. Right. And Mr. Kahn said -- told this jury earlier today that the -- you know, the basis of your opinions were just because

Mr. Yahyavi told you that he had pain after this collision with the forklift.

Was that the sole basis for your opinions in this case?

A. Of course not.

Q. All right.

A. It's an oversimplification dramatically.

Q. And did you rely on your own examination findings?

A. Of course.

Q. Did you rely on the examination findings made by other medical professionals, including surgeons, pain management specialists, involved in Mr. Yahyavi's care?

A. Of course.

Q. Did you also look at his response to treatment or lack of response to treatment?

A. Yes.

Q. What -- what's the significance of response to certain treatment that a patient receives? What's significant to you as a physician in formulating an opinion as to what the cause of the problem is?

A. Very important. And it depends on the treatment.

So for example, if a person responds to chiropractic or physical therapy when they have spine pain, that would be in the category of a mild injury or a mild symptom, such as

what Dr. Tung refers to as a neck strain.

If they don't respond to those things over the course of a couple, three months, you start to rule out a simple injury that would be a strain that would resolve, and you start to consider other things.

There are injection results, that were mentioned earlier today, that include numbing medicine and a cortisone medicine. And the response to that procedure, depending on where it's injected in the spine, can tell -- can give a physician information about was it one disc? Was it more than one disc? Was it one facet joint? Or were there facet joints on the left side that were problematic? On the right side? Or both?

So the response to his individual treatments can help diagnostically in identifying what the problem is.

Q. Okay. And we also talked about x-ray and MRI imaging, how that plays a role, as well as the other testing, which are these injections you're talking about.

A. Yes.

Q. Do all of those components of the puzzle play a role, a critical role, in your evaluation and analysis in formulating the opinions that you came -- reached in this case, that Mr. Yahyavi sustained a permanent injury for which he underwent spinal surgery caused by this motor vehicle collision?

A. Absolutely.

Q. All right. I want to -- let's have --

MR. PRINCE: Your Honor, can Dr. Oliveri just step down?

BY MR. PRINCE:

Q. I'd like you to come down and explain to the jury --

THE COURT: Yes.

BY MR. PRINCE:

Q. -- and just educate us about what the various components of the spine are and the --

THE COURT: He needs to stand next to a mic, though, since you haven't made --

MR. PRINCE: Okay. Does -- do we have one?

THE COURT: Now, you can't --

MR. PRINCE: Can he stand by me?

THE COURT: I don't think you can do both.

MR. PRINCE: I'll hold -- I'll hold the microphone. I've done that before. I'm an assistant -- medical assistant with this situation.

THE COURT: Oh, you can. Okay. You can hold the hand mic.

MR. PRINCE: Okay.

MR. KAHN: Does the Court have any objection if I stand at the end of the jury box to see this?

THE COURT: If you need to see it, that's fine.

MR. KAHN: Because I'm kind of blocked.

BY MR. PRINCE:

Q. Sure. If you could kind of explain -- I kind of did it in a cursory way during the opening statement, Dr. Oliveri, and I know you're here for that. But can you please explain in some level of detail of the anatomy of the spine, the various components of the spine, and the issues we're dealing with in this case?

A. Sure. So the -- I'll stand right here.

Q. Sure.

A. So the orientation of this plastic model is just how I'm holding it here. So we're dealing with left side over here, right side over here. This is the front of the spine and then this is the back of the spine.

And as was discussed earlier, the spine is divided into the three sections. This part of the spine is three sections. And the neck or is cervical is -- involves seven vertebral bodies. And then in between those bones is one disc. And then on the back side -- on the back side, between each segment, is a little tiny joint. I think that Mr. Prince referred to them as knuckle joints. But they are literally -- I've got my fingernail in one of them, right there. There's one facet joint on the left and one facet joint on the right at every single level of the spine.

The way I like to describe the facet joints is you can see, as we bend the head -- I'm sorry -- the head and neck forward,

the facet joints open up. I've got my finger inside the joint now. When we bend the head and neck backward, they sort of close down. And they also help control rotation. So we can't spin our head all the way around -- excuse me -- in part, because these facet joints will stop the movement.

What's pertinent for Mr. Yahyavi here is that many of these structures in the spine have a nerve supply. So they can be a source of pain. The source of pain could be one or more facet joint on either side. The source could be -- well, you can see it from the front a little bit better -- is a disc, because the back side of the disc that's near the nerve roots and the spinal cord actually has the nerve supply.

So if you have injury to a disc, you can develop neck pain, headaches; or if there's an injury to or an irritation of a nerve, you can develop symptoms down an arm. So the arm symptoms might be numbness, tingling, burning, aching, weakness, or a combination of those things.

Q. And in this case with Mr. Yahyavi, does he have -- did he have, even before his surgery, pain, numbness, and tingling or paresthesia into his left arm?

A. He did. He consistently had that prior to the time that I rated him in 2015 and then ongoing. It was a -- it was a longstanding chronic problem -- and chronic just means duration. So it -- those problems with the radiating symptoms were longstanding.

Q. What caused the radiating symptoms down the left arm and into the hand?

A. Mr. Yahyavi has a number of different abnormalities in the neck that include some pinching of nerve tissue. And so he has a combination of pinching to a nerve that goes down into his pinky finger and ring finger. He also has some pinching of nerves higher up that caused the pain around the shoulder.

Q. Okay. Did -- even with the records that Mr. Kahn showed earlier -- did he have any symptoms or problems into his left arm before this motor vehicle crash?

A. No. If you're referencing the 2011 --

Q. Yeah, I am.

A. Okay.

Q. We're going to talk about that in detail --

A. Sure.

Q. -- but I wanted to do it while you were up here still.

A. So what I saw in that record was a reference to him having neck pain with no extremity symptoms.

Q. Okay. Was that significant to you in your analysis?

A. Sure.

Q. Okay. And keep going. I wanted -- and talk about the disc, the functions of the disc, and how they kind of operate within the spine --

A. Sure.

Q. -- and can become the source of pain.

A. So what also allows us to be able to move the head and neck forward and backward is that -- that disc that's in between the bones -- so I have my fingernail on one of the discs.

And the disc is actually -- I think Mr. Prince referenced it as a cushion, but it's -- or a shock absorber or something like that. But it is a -- it is a piece of tissue that does allow for some movement. And it does have a nerve supply, so if you have injury or damage to it, you can have symptoms that include neck pain, arm symptoms, and radiating pain to the head.

Q. Okay. And anything else you think is significant for us to discuss from an anatomical standpoint as part of this -- so that we have an understanding of what parts of the body we're talking about as you work through --

A. Yes. Something --

Q. -- the analysis in this case?

A. Sure. Something came up earlier, which there is a term that was referenced called lordosis.

So if you look at the spine level from the side -- so in this position -- you see that it's not straight like an arrow. It is curved. So we have a curve in the lower back, which is the small of your back. We have the opposite curve in the mid back. And then in the neck, we have a curve that goes this way. And this is sort of the normal curve that you would expect in that position.

So this curve in the neck is called lordosis. It has no other meaning other than just saying a curve. And what is important to keep in mind is that the spine isn't a static, immobile structure. It is dynamic. It moves, as we just talked about and as I showed.

So when you do an x-ray or an MRI scan, these things are done with the person laying on their back. Depending on how the person's head and neck is positioned, you can see, in this position there's remaining lordosis -- so we have a little bit of curve here. I can get my fingers through that.

But if the person happens to be positioned on the table when they're doing the x-ray with their head tilted a little bit forward, they may have a complete loss of lordosis, just by the positioning of that person during the x-ray. They're -- I think the radiologist mentioned that it could also be due to spasm of muscles. When these muscles get tight, the neck tends to be more in a straight military posture. But I just wanted to add and give the visualization that it's also dependent upon how the person is laying there.

Q. Okay. Good. And we're going to be talking about various aspects, so if you need to use the spine model during any aspect of your discussion, please let me know and I'll get it for you.

A. Great.

Q. Thanks. Okay. And we're going to go to now, Dr. Oliveri, we talked about clinical correlation. We talked about the

[indiscernible] of the spine.

Let's talk about your initial evaluation on April 23rd, 2015. We have about 30 minutes to talk -- we're going to talk about the symptoms, what information you had in 2015, and talk about the Southwest Medical records that we -- that were referenced earlier today. Okay?

A. Okay.

Q. Very good. And so Mr. Yahyavi came for -- to be evaluated for, among other things, a cervical spine; correct?

A. Yes.

Q. All right. And did he have other injuries associated with the motor vehicle collision, other than just the cervical spine, to his spine?

A. Thoracic spine was the other part.

Q. What about his lumbar spine?

A. Oh, so actually that is something that probably should be noted by me.

He did have lower back pain after the motor vehicle accident, and it was treated by the physicians, and it went away. And it went away in a short period of time, consistent with what would be considered a muscle strain, consistent with what Dr. Tung refers to as a straining injury.

Q. Okay.

A. And because it was a straining injury and because it

followed the course that you would expect, it wasn't even rated. There is -- there -- it's a -- again, as I said, it's a zero rating. And so it wasn't even on the list to do.

Q. Right. So he had a -- an injury to his cervical spine?

A. Yes.

Q. Did he have a soft tissue injury to his cervical spine?

A. Well, there's a component of it.

Q. Right.

A. But --

Q. I just wanted to talk about that.

A. Yes.

Q. And what -- what does it -- just so we're clear, what does soft tissue injury mean? Or what parts of the body are we referring to?

A. What we don't see on that spine model is that on the backside there are a number of ligaments and there are multiple layers of muscle that support the spine on both sides. There are also muscles up front in the neck, but the ones that really provide the stabilization to the spine are on the back side, left and right.

And so when we talk about soft tissues, we're typically saying it's a muscle strain. Muscles are tight or tender. Maybe the ligaments are a little irritated as well.

Q. Okay. And when -- generally speaking, if someone has a true soft tissue muscles, you know, ligament strain and sprain, how

long does it typically take for those symptoms to resolve, if it's a true soft tissue injury?

A. Could be as little as a few days. It could be as long as a few months. If it goes past three months of continuous symptoms, it probably isn't just a soft tissue injury.

Q. Okay. So then we start thinking there might be something more structural involved?

A. Of course.

Q. Is that what happened -- is that what happened in Mr. Yahyavi's case with regard to his cervical spine?

A. Yes.

Q. With regard to his lumbar spine, did that resolve in an appropriate length of time for a soft tissue muscle strain?

A. Yes.

Q. Okay. And so there was no structural problem with his lower back?

A. Correct.

Q. All right. So once you kind of get outside of the window of time that you expect a muscle strain to resolve, do you start to suspect, as a physician, that there might be something more structural going on within the spine itself?

A. Yes.

Q. Is that what happened in Mr. Yahyavi's case?

A. It's exactly what happened.

Q. All right. Now, talking about when the Worker's Compensation requested that you perform this evaluation, were you provided medical records?

A. Yes.

Q. Were you provided -- what sort of medical records were you provided?

A. I was provided that industrial form that I mentioned before, the C-4 form. I was provided that. I was provided UMC trauma notes, urgent care notes, notes from the Worker's Compensation clinic, notes from physical therapy, notes from Dr. Perry -- we saw his picture up there earlier. X-ray and MRI results. Injection results with Dr. Schifini. And additional pain management -- there was a Dr. Fischer who saw him for injections. And a -- and then lastly, physical therapy records.

Q. Okay. In addition, when you saw him again in 2018, were you provided even additional records, including more pain management, physical therapy, and surgical records?

A. Yes. Much more detailed. But everything past the point of 2015, plus medical billing, plus many other things.

Q. Do you -- in your mind, do you think Bahram Yahyavi exhausted every avenue of conservative care before surgery?

A. Oh, without a doubt.

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

A. Yes.

Q. And beyond that, are you certain?

A. Yes.

Q. Okay. And let's talk about his complaint -- your examination.

We're going to be on 578, if you'll go down to the --

You documented a proposed mechanism of injury. Do you see that?

A. Yes.

Q. So I want to have you discuss what was your understanding of the injury causing event of the cervical spine?

A. Sure. Would you like me to read it?

Q. Please. Or just summarize.

A. Sure. So I just indicated that on 6/19/13, he was driving a vehicle. He turned onto a side street. Without warning, his vehicle abruptly came to a stop. And what had occurred is that a forklift driver had pulled out from the side, with the forks elevated, and the windshield of Mr. Yahyavi's car was struck.

Q. Okay. And you were here for the opening presentations; correct?

A. Yes.

Q. You were also here for the examination of Mr. Goodrich, the safety director of the defendant.

Is his description to you consistent with the photographs of things you heard here in court today?

A. Yes.

Q. All right. In addition to that -- what were his complaints --

Let's go to page No. 579.

I'm going to talk about -- talk about the current complaints for which you're evaluating him for. And No. 1, what's the -- why did you document the current chief complaints?

A. The subjective statements of pain are an important starting point when evaluating a diagnosis or making decisions -- whether it's treating a patient or doing an impairment evaluation such as this.

Q. Okay. And what did he report to you?

A. Neck and upper back pain and left arm pain.

Q. Okay. Were those complaints, by April of 2015, chronic in nature?

A. Of course.

Q. What does it mean to be chronic in medical terms?

A. A problem that has been constant for more than six months is considered chronic. It's all about duration of the constant symptoms.

Q. And based upon your review of the records, not only from 2015, but currently, has Mr. Yahyavi's complaints of neck pain and arm pain been persistent?

A. Yes.

Q. Have they been constant?

A. Yes.

Q. Has there ever been any period of time since June of 2013 that he's not had documented ongoing neck pain or left arm symptoms?

A. No.

Q. Do you consider that not only chronic, but permanent in nature?

A. Of course.

Q. Something he'll live with for the rest of his life?

A. Yes.

Q. Are those your opinions to a reasonable degree of medical probability?

A. Yes.

Q. Now, was he still working at the time you saw him?

A. Yes.

Q. In April of 2015?

A. Yes.

Q. Do you think he gave a fair and reasonable effort to work as long as he could, given the level of his injuries and his symptoms?

A. My opinion is that he gave an impressive effort in trying to continue to work.

Q. Okay. Now, let's talk about his description of the

symptoms and how it affected him.

That's on page 579, so if you're go down to at the present time, examining -- about midway through the page.

What did you record, based upon your history for Mr. Yahyavi?

A. I clarified a little bit more about the nature of the neck and arm symptoms. I described that it was shooting pain on the left side. It would go into the upper arm, the forearm, and, as I mentioned before, into the small finger. The pain would increase, especially if he turned his head toward the left.

From a medical perspective, increased pain when you turn your head to the left is an indication that it could be the facet joint that's getting pinched and irritated causing pain, or it could be the nerve that as you're turning, it's causing more pinching and more symptoms. So that was important.

I also asked detailed questions about how this problem impacted his day-to-day life.

Q. Why did you want to know that?

A. Well, for one thing, it's important for the impairment evaluation, but it's also important to learn more about the extent of this problem.

Q. Okay. You tried to learn about the severity of his problem?

A. Right. So again, as I mentioned before, soft tissue strain

injury, zero percent. It's not going to impact a person's quality of life; it's not going to impact their level of function, their activities of daily living, their motion. And so asking these questions is meant to determine and help to differentiate between something that's really nothing versus something that is permanent and ongoing.

Q. Okay. What did he report to you in terms of his -- the effects of his neck pain and arm symptoms on his activities of daily living, including work and his social life?

A. With respect to bathing and self-care -- so self-care is bathing, dressing, toileting -- he told me that he could do all of those things, but he had difficulty because of the pain. He had no difficulty communicating. And I've seen Mr. Yahyavi probably five times now, and he, to me, is an excellent communicator.

Sitting for more than 10 or 15 minutes caused increased pain that caused him to have to change positions and move around. Walking for five or ten minutes caused an increase in the neck and upper back pain. Climbing stairs was difficult.

He was able to perform all of these activities, but had to do them in shorter intervals. And this is history that is consistent with someone who is trying to give good effort in their activities and trying to give good effort in explaining.

He had -- let's see here. His lifting ability was limited. It was difficult for him to travel in a car. He couldn't tolerate longer distance driving because of the increased neck pain. We

talked a little bit about his work at the time, where he would have to go on test drives. And it was difficult for him to go on the test drives, depending on how long they were, because it increased his symptoms.

We talked about sexual activity. Sexual activity for Mr. Yahyavi has been compromised, decreased because of the neck injury.

We talked about sleep. He had to use a neck roll to sleep. He was having difficulty getting to sleep. And he would have to take pain medication in order to have a decent night's sleep.

Q. Right. How does -- with someone who has got chronic pain, how does the lack of sleep or the sleep disruption, how does that affect the pain and the pain levels and their ability to cope with it?

A. Normal sleep is restorative. And what that means it helps restore problems that are going on in your body. When you have chronic pain, especially due to a significant structural injury, it is common for these patients to not get that restful sleep.

So they don't get 7 or 8 hours of sleep. They don't feel rested when they wake up. And then they start out their day tired, fatigued, irritable. And then on top of that, they're dealing with pain the rest of the day and the side effects of medications oftentimes.

Q. Does the fatigue, because of the sleep disruption in their

appearance, does that actually make managing the pain and coping with pain even more difficult, in your experience, Dr. Oliveri?

A. Well, by definition, that's part of what happens when you have chronic pain. So it is -- it's the -- it's one of the reasons that you have chronic pain. And it's one of the reasons that chronic pain itself, when it's constant, doesn't resolve.

Q. Okay. Why do they call chronic pain a syndrome?

A. Well, syndromes in medicine are typically multifactorial. So it means that it impacts lots of different aspects of the person's life. The chronic pain syndrome, in addition to the things that I just mentioned that affect activities of daily living and your day-to-day life, it affects your ability to have relationships with other people. It affects your concentration, because chronic pain is very distracting and it's part of that syndrome of how we sort of deal with it. It's very unusual for a person that has severe ongoing chronic pain to be able to compartmentalize it, put it aside, and carry on a normal day. It's -- it's just tough.

Q. Does it create anxiety and depression?

A. Of course. You know, depression and anxiety are a concern with chronic pain. Sometimes it can be severe. I've unfortunately had patients that have committed suicide because of severe chronic pain.

Q. Right. And is there anything in the medical history, that you're aware of, including what you learned here in court, that in any

way would explain the nature and extent and severity of these symptoms and the chronic pain syndrome that Mr. Yahyavi is experiencing, other than the motor vehicle collision of June 19, 2013?

A. No.

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

A. Yes.

Q. Okay. I want to talk about some of the records that were shown today to this jury that you were present for from Southwest Medical. Okay?

A. Okay.

Q. We're going to go to Visit No. 1, October 7th, 2011. Behind you are three binders. This will be in Binder No. 3, if you want the hard copy.

A. I might just rely on the monitor.

Q. Very good, Doctor.

Page 2113. And I want to go to the date at the top -- just show us the date, Greg -- so we're clear, Visit 1, October 7th. Okay?

Do you have that in mind, Dr. Oliveri?

A. Yes.

Q. Very good. I want to go down now to Active Problems. I want to go down to -- through Review of Systems. Okay. Keep going.

And it said he was there for a patient checkup. That was the reason for his visit. But now we're here -- he's got dermatitis, which I -- that's a skin condition?

A. Yes.

Q. Hypertension, is that high blood pressure?

A. Yes.

Q. And nicotine dependence, that's saying he's a smoker?

A. Yes.

Q. All right. And then the medications, were any -- was any of that for musculoskeletal, spinal pain, anything like that?

A. No.

Q. Okay. The Review of Systems, was that significant to you -- the date -- on this first date, the review of systems as documented by Southwest Medical?

A. Sure. And just to clarify, Review of Systems is a mandatory part of a medical -- general medical evaluation. This is where you probably have been to physicians where they'll ask you what the reason is that you're here to see the doctor.

But then they'll ask a number of additional questions. They'll ask different body systems, literally from head to toe. And the purpose of that is to identify secondary problems that may not be the main reason you're there, but still need some sort of observation or evaluation by a doctor.

Q. Okay. Now, was there anything in the review of systems

related to ongoing spinal complaints, multilevel discogenic pain or facet-related pain and symptoms into the arms?

A. No.

Q. Okay.

And go to -- going to the second page of this visit, October 7th, 2011. Under the Objective part, Examination, where it says -- I'm going to read from here.

It says: Pupils equal, round, reactive to light. Tympanic membranes are within normal limits.

What does that mean?

A. That's the eardrums. So his ears were fine.

Q. Mouth, nose, and throat are WNL. Does that mean within normal limits?

A. Yes.

Q. Yeah. Neck -- means -- that's where I'm going to focus -- is supple, has full range of motion without palpable masses. Do you see that?

A. Yes.

Q. For someone who had multilevel discogenic pain that's symptomatic for a period of years, can you have, by definition, full range of motion?

A. No. Impossible.

Q. Okay. After this motor vehicle collision, has Mr. Yahyavi ever returned to full, pain-free range of motion in his neck after

June 19, 2013?

A. No, never.

Q. Okay. Is it significant to you the day he first goes to --

Let me put that down on that [indiscernible]. I'm worried about that stick flying out of my hand. I don't want to have an industrial event here.

And so now was it significant to you in this -- that Mr. Kahn did not show this to this jury -- that on the first visit he had full range of motion, no neck pain, without any issues?

A. I'm sorry. Tell me the question again.

Q. Sure. Was it significant to you that -- Mr. Kahn did not show this to the jury. But is it significant to you, medically speaking, that he has no neck pain, has full range of motion, on the date of his first encounter with the physicians at Southwest Medical?

A. Sure. Yeah. I don't have a comment about Mr. Kahn's presentation --

Q. Yeah.

A. -- about that. But it is significant, especially in the context of the other note in 2011 that talks about several years of neck pain. The fact that there was a normal Review of Systems and a normal neck examination with no complaints voiced or documented for the neck is significant to me. It is consistent with assumptions I made that Mr. Yahyavi did not have a clinically significant problem in his neck of multilevel disc injury or facet problems prior to the accident.

Q. If someone had multilevel discogenic pain, meaning coming from multiple levels of the spine, with affecting a nerve root, would you have pain -- a pain free neck and full range of motion?

A. Again, impossible.

Q. Okay. The next visit, which is Visit No. 2. It's October 25th, 2011. That's Bates No. 2110. Go to the Subjective through the Neck Objective Exam -- 2110.

It says: Patient presents for lab results.

Is everybody oriented to the top up here? Being [indiscernible] Greg, if could you just highlight through the yellow on the Subjective and then go Objective.

It says: Patient presents for lab results. Also complains of neck pain for several years. Denies any history of neck surgery. No neck trauma. Has a well-healed surgical scar on the back of his head which is from a hair transplant.

Did Mr. Yahyavi ever tell you during your examination or any time that he had any prior neck complaints?

A. No.

Q. Okay. You've now seen this. You see this one record.

A. Yes.

Q. Is there any other records after this date, but before the collision, where he's got documented neck complaints of any kind?

A. Not that I've seen.

Q. Have you seen any records before 2011 of any kind that

document any neck complaints, any neck injuries, any problems with his neck ever before?

A. No.

Q. Okay. And what I wanted to focus on now is the exam. It says: Supple with full range of motion.

Do you see that?

A. Yes.

Q. If someone had multiple, multilevel discogenic pain and facet pain, would you have full range of motion with no pain?

A. Never.

Q. Okay. Is that -- even though he's got documented and alleged complaints for neck pain for several years, is that consistent with multilevel discogenic pain that we're talking about following this motor vehicle crash?

A. No.

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

A. Yes.

Q. And beyond that, are you certain?

A. Yes.

Q. Very good. Also, it says there's mild paraspinal discomfort with palpation of the neck.

What does that mean?

A. Palpation is the examiner is using their fingertips, and

they're touching the muscles of the neck. And they're saying that there was mild discomfort.

Q. Okay. And is that significant in terms of diagnosing multilevel discogenic and facet pain?

A. Well, in part. That entry, coupled with the last thing that's stated, which is no palpable muscle spasms -- those two things together are very important to me. Because Mr. Yahyavi, if he would have had this sort of multilevel disc, facet-type problem before the accident, there would be -- in addition to loss of motion, there would be expected muscle spasm -- which is where when you touch that muscle it is involuntarily contracted to try to support this spine that's injured.

And so when I see no spasm, mild discomfort, and full range of motion, it automatically gets put in a really minor category of not medically concerning.

Q. Right. Can people just have, Hey, my neck is stiff. I've been working a lot. I'm tense. I've got stress or pressure. Can that cause people just to feel, like, achy or discomfort?

A. Of course.

Q. And not be a discogenic problem for which you would need, you know, pain management injections or surgery?

A. Of course.

Q. Right. Now, let's keep going. And let's go to Visit No. 3, so that we're going to go through each one of these. We've got a

few minutes left before the Court has to go.

March 12th, 2012. Remember Mr. Kahn said that he had an active backache problem on March -- showed that record?

A. Yes.

Q. Did he actually show the clinical note to the jury of what the doc -- what the doctor wrote for the exam that day?

A. No.

Q. Okay. Let's make sure we do that.

2108 of Exhibit 156 for the -- just go to the Subjective and Objective.

And what was the reason for his visit that day?

A. He was skiing on Mount Charleston, and he had right knee pain.

Q. Okay. Any neck pain?

A. No.

Q. Any spinal pain?

A. No.

Q. And then under the Objective, which would be the exam part, was there any examination findings of neck pain, back pain, any kind of spinal pain?

A. No.

Q. Okay. And let's go to 219 -- at the bottom of that -- move it up a little bit, Greg. There's a part of that that I want to get to is the Assessment. Do you see where it says Assessment? Right there.

And that's part of Southwest Medical's electronic recordkeeping, the term Assessment?

A. Can you show it to me again, please?

Q. Yes. Just pull up, Greg, just the bottom part of it. No.

A. Okay. Got it. Yes. So Assessment is the physician list of diagnoses.

Q. Okay. And so -- and going to 2109, go to the next page.

What is the assessment for that day?

A. Right knee pain, status post ski injury.

Q. Okay. Mr. Yahyavi -- Mr. Kahn told them that there's some other record that said this was an active problem -- this backache. Was that an active problem on March 12th, 2012?

A. No.

Q. Okay. Because this is the actual physician record signed by -- it looks like Dr. William Celentano?

A. Right.

Q. Okay. Is there any record -- either a complaint, physical exam, finding -- consistent with any neck issue?

A. No.

Q. Okay. Let's look at Visit No. 4; November 1st, 2012; Bates No. 2106. I want to go from Reason for Visit through the Review of Systems, please.

Okay. It says: What was the reason for the visit that day?

A. Follow up on results.

Q. Okay. And then it says -- what's Subjective?

A. He was there to discuss the results, and he was feeling well without any physical complaints.

Q. Okay. Well, we just learned, I guess, from October of 2011, one year earlier, that he reported these neck complaints for ears.

I mean, did he have any ongoing neck complaints as of November 1st, 2012?

A. No complaints in the Subjective section. And then again a little bit lower is that Review of Systems, which is the inventory of all the body systems. And he had no spinal complaints.

Q. Okay. Let's go to musculoskeletal. It says: Musculoskeletal -- no joint redness, swelling, or pain. No persistent muscular pain.

Was that examination finding significant to you, medically, concerning his neck in this case?

A. It is. It's very significant to me, with all the other things that we've mentioned, when I'm asked to interpret the Southwest Medical notes before the accident.

Q. Okay. And in looking at these records, based on the fact that he had no ongoing physical complaints in November of 2012, if someone who has multilevel discogenic injury and pain, as well as facet pain, would you expect them to be without physical complaint

and no findings on an exam?

A. No. The -- this is consistent with, to me, in 2011, the reference to pain being a really insignificant problem from a medical physician standpoint. That's all.

Q. Okay. And let's go to Visit No. 6. That's one month before the motor vehicle -- or excuse me -- No. 5, excuse me. Visit 5; May 23rd, 2013, just one month before this collision; Bates No. 2104.

Okay. Again, on this visit, let's go to the Reason for Visit, and then Objective.

And was he complaining of any neck complaints that day?

A. No.

Q. And under the Review of Systems -- if you could go to that part of it, Greg. Same page, 2104, bottom.

And in the Review of Systems, is there any complaints of ongoing neck pain, spinal complaints of any kind?

A. No.

Q. Okay. Let's go to the physical exam, page 2105. It's the HEENT. There you go.

And on the exam under HEENT, that's -- what's an HEENT?

A. It's everything -- head, ears, eyes, nose, and throat.

Q. Okay. And was there any documented finding concerning the neck of any kind of?

A. No.

Q. All right. So looking at those records and the one statement taken just the -- do you -- did Mr. Yahyavi have any significant ongoing complaint of neck pain, multi discogenic pain, and facet pain, before this motor vehicle collision?

A. No.

Q. Would you have expected a different presentation had he had ongoing related issues?

A. Absolutely. I would have expected constant neck pain. I would have expected neck pain that was documented on most visits. I would have expected some sort of radiating symptoms. I would have expected findings on examination that included loss of motion, muscle spasm. I would have expected a primary care physician to recognize that this was a serious problem and get him referred to a specialist for evaluation for MRI scanning for injections, for consideration for other treatment.

Q. Okay.

A. Oh, and I would have expected pain medication.

Q. Okay. Was there any recommendation for any workup or physical therapy of any kind?

A. No.

Q. Was there any recommendation to see a pain management specialist of any kind of?

A. No.

Q. Spinal specialist of any kind of?

A. No.

Q. Is that significant to you that that did not happen -- at the absence of that?

A. Sure. And I'm not trying to diminish the fact that the 2011 note says, Neck pain for several years. But considering -- looking at it medically, the big picture with all of these notes -- it really -- what was documented as neck pain for several years was really an insignificant issue medically.

Q. Was it an outlier just because -- do you see in your work, as forensically when you're reviewing records, occasionally, there'll be statements that are made and are documented, just because doctors chart differently at different times. There might have been a misunderstanding or problem that just really doesn't fit with the overall picture?

A. Certainly that can happen. I mean, all of this is based on communication -- what the patient says, how the questions are asked, how the doctor or nurse interprets the answer, and then how they put it down on their chart.

Q. Okay.

A. So there are lots of moving parts.

Q. In your opinion, was there ongoing, chronic, cervical spine, multilevel discogenic pain complaints before June 2013?

A. Absolutely not. It's impossible.

Q. Is there any indication for the need for medical treatment, pain management intervention, or surgery before June 19th, 2013?

A. No.

Q. Okay.

MR. PRINCE: Now, Your Honor, could I have, like -- would it be okay if we take another five minutes, because I want to --

THE COURT: All right. Sure.

MR. PRINCE: Okay. Thanks.

BY MR. PRINCE:

Q. Let's go to 2119. That's the x-ray, the radiology report. 2119 of Exhibit 156, the findings.

All right. And No. 1, what are degenerative findings?

A. That's the age-related change to the spine that I mentioned earlier. As we age, there are factors -- there are -- there are things that happen to our spine that include -- you can get some spurring of the bones at those vertebral bodies. You can get where the discs lose some of their cushion or their hydration, so the disc space will become narrowed. You can get a little bit of loss of joint space and spurring at those facet joints. Or you can get a combination of all of those things.

Q. Okay. The mere fact that Mr. Yahyavi has degeneration, is that consistent with his age?

A. Yes.

Q. The mere fact that someone has degeneration, does that mean they have symptoms?

A. No. As I had mentioned earlier, you can't -- you can't look -- the only -- the only way you can look at a spinal x-ray and say that a person has symptoms is if you find a new fracture because a new fracture is always going to be painful. If you see a dislocated spine where, you know, it's -- the alignment's off, you know that person's going to have pain.

Short of those two things, you have to do the correlation between all of the other factors to determine if those problems are causing symptoms to the patient.

Q. Right. And this just kind of gets to my point with clinical correlation.

Did the radiologist tell the ordering physician, Yeah, correlate these issues clinically? Right there, it says clinically -- correlate clinically?

A. Appropriately so, they did.

Q. And we showed you that -- my pie chart called clinical correlation; right?

A. Yes.

Q. Is that why you don't just look at the x-ray alone? You have to look at all the other components of the care and the treatment and the patient's response to treatment?

A. Yes. But let me clarify. The person reading this x-ray is a

radiologist. Radiologists sit in a room before -- years ago when I was training, they were in a dark room with x-ray films on a view box, but now they look at the computer. And they've never met the patient. They've never examined the patient. They've never laid hands on the patient. They're just looking at an x-ray. So they can't, by definition, make a diagnosis clinically.

So this radiologist is being absolutely accurate by saying, here's what I see, but you've got to correlate it clinically.

Q. Okay. Using all of the records we saw from Southwest Medical, is there any clinical correlation that these levels of degeneration were symptomatic before June 19th, 2013?

A. No, absolutely not.

Q. Do you have an opinion whether those levels that are -- that we see here -- became symptomatic as a result of the traumatic collision of June 19th, 2013?

A. Because of the collision and the structural change to his spine that occurred as a result of the crash, yes, that is what occurred.

Q. Are you even able to medically rule out that -- and even with that one statement that he had neck pain for years before, that that was the -- there's any medical explanation before the June 19, 2013, that would explain the onset of these symptoms and the presence of these symptoms?

A. Could you ask that again, please?

Q. Yeah. [Indiscernible.] I totally agree.

A. I'm a little bit confused.

Q. Yeah. And I could -- I'm looking at my clock, and so I don't want to talk too fast because this is an important point.

Based upon your review of the Southwest Medical records, as well as all the medical records for more than six years after June 2013, have you been able to rule out that there was any medical condition before June 2013 that would be -- explain these symptoms, other than the motor vehicle crash?

A. Yes. Absolutely. It's ruled out. I acknowledge that he's got age-related change. I acknowledge that there's one documentation of him having pain for several years. But considering all of the other factors, I have ruled out a contributory part to this picture.

Q. Okay.

A. The injuries, symptoms, need for treatment, surgery -- were related to the fracture.

Q. Let me ask you one other question before we're ready to go. Someone who is in their 50s, 60s, whatever, who has age-related changes, are they more susceptible or vulnerable to those levels becoming symptomatic from trauma?

A. Yes. The spine that is the most resilient to injury is a normal spine, person in their 20s, normal discs, normal bones, normal facet joints, normal soft tissues. They can handle injury

better than somebody who has age-related degenerative changes.

Q. So does that make -- did that make these changes -- the degenerative changes, make Mr. Yahyavi more susceptible or prone to discogenic injury --

A. Yeah.

Q. -- than say someone with a normal healthy spine?

A. Yes.

Q. Did it aggravate that and cause those levels to become symptomatic following the collision, requiring medical treatment and surgical intervention?

A. Yes.

Q. Are those your opinions to a reasonable degree of medical probability?

A. Yes.

Q. You -- before we leave --

THE COURT: All right. I gave you --

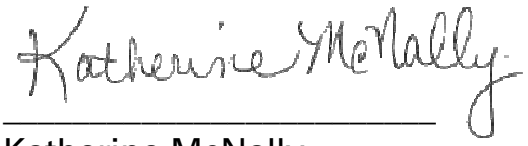
MR. PRINCE: I hear you.

THE COURT: I've got to be going.

[Proceeding concluded at 4:06 p.m.]

* * * * * * *

ATTEST: I do hereby certify that I have truly and correctly transcribed the audio/video proceedings in the above-entitled case to the best of my ability.



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RTRAN

DISTRICT COURT

CLARK COUNTY, NEVADA

BAHRAM YAHYAVI, Plaintiff, vs. CAPRIATI CONSTRUCTION CORP INC. Defendant.	CASE#: A-15-718689-C DEPT. XXVIII

BEFORE THE HONORABLE RONALD J. ISRAEL
DISTRICT COURT JUDGE
MONDAY, SEPTEMBER 16, 2019

RECORDER'S TRANSCRIPT OF JURY TRIAL - DAY 6

APPEARANCES:

For the Plaintiff:	DENNIS M. PRINCE, ESQ. KEVIN T. STRONG, ESQ.
For the Defendant:	MARK JAMES BROWN, ESQ. DAVID S. KAHN, ESQ.

RECORDED BY: JUDY CHAPPELL, COURT RECORDER

INDEX

INDEX OF EXHIBITS

FOR THE PLAINTIFF	MARKED	RECEIVED
None		

FOR THE DEFENDANT	MARKED	RECEIVED
None		

Las Vegas, Nevada, Monday, September 16, 2019

[Case called at 1:09 p.m.]

[Outside the presence of the jury.]

THE COURT: -- a juror -- but you need to know that one of the designated -- currently designated alternates, Mr. Harris, is gone. He got sick. He went to the hospital, and that's it. So we have two alternates and two weeks. And now this guy -- who is it who is not here yet? He's hopefully just late.

MR. PRINCE: Your Honor, what's an estimated start time for tomorrow, just so I can plan for my witness?

THE COURT: 10 a.m.

MR. PRINCE: Okay.

THE CLERK: I have it set for 11, but I can move it to 10.

THE COURT: Harris was Number 10. We supposedly have a small calendar.

MR. KAHN: Harris was the one who got hit by the forklift in the car.

THE COURT: He has a throat infection.

MR. KAHN: Sounds like a good reason for --

THE COURT: And I don't know who is late. I think he said Whipple [phonetic].

MR. KAHN: Dewindt [phonetic] is an older Caucasian gentleman, who was on the main jury, not an alternate. He's the one that worked for the electric company in Illinois.

THE COURT: Okay. I'm just saying he's late.

MR. KAHN: Whenever we go on the record, we do have a couple of housekeeping items.

THE COURT: We're on the record.

MR. KAHN: Oh, okay.

THE COURT: What do you need?

MR. KAHN: So I've spoken with Mr. Prince. We are planning to bring Dr. Tung, who is a neurosurgeon, in on Friday for whatever portion of our case that will be. And then Mr. Bennett [phonetic], who is a vocational expert, both will be flying in. Mr. Prince thinks that the days they'll clear, but I just want to make it clear to everybody the neurosurgeon, if for any reason he doesn't go on Friday, he's at a convention in Chicago the next week, and he's on the Board at the organization, so we may lose him for an entire week, but if -- I don't expect him to take that long on Friday, so that it would take more than a day.

Also, as far as Friday afternoon at the end of Dr. Oliver's [phonetic] testimony, we found out that his testimony is going to be split because of scheduling issues. I'm not making a big issue out of a doctor not being available, but we didn't -- just want it clear for the record, we didn't agree to that.

We filed a trial brief on the opening statement. We've received a copy, but I would still like some kind of instruction about the undisclosed photograph of the surgical scar. I don't think that was disclosed, so as a result, I don't think it should be used here.

And then I wanted to notify the Court that our forklift driver, Mr. Arbuckle [phonetic], is available in the hallway, and as soon Dr. Kaplan is done, he's here and available to testify, and he no longer works for our client, and doesn't make a lot of money. He's been on standby for days. So hopefully, we get through him today too. Thanks.

THE COURT: Okay. Did he show up?

THE MARSHAL: Yes. And, you know what, Judge, I've got to put their notebooks on the seats. I forgot.

THE COURT: But everybody is here now, right?

THE MARSHAL: Everybody is here.

THE COURT: Okay.

MR. PRINCE: You ready for me to respond to any of that, Judge, or is it necessary?

THE COURT: Sure. Yeah.

MR. PRINCE: Well, first, I think my case will be done Thursday, so I have no objection to Dr. Tung on Friday, so that's fine.

Second, with respect to Mr. Arbuckle, on right when we're done with Dr. Kaplan today, so that's -- with regard to the usage of the demonstrative photographs reflecting the scar on the Plaintiff's neck, we weren't able to find that it was produced; however, it was used for demonstrative purposes only. Clearly, the operative note from Dr. Kaplan talks about a posterior incision into the spine of Mr. Yahyavi, along with the surgical procedure and instrumentation. All that was, was demonstrative only.

Under Rule 16.1, you're not required to disclose

demonstrative evidence. I showed him in a depiction a demonstrative depiction of a posterior surgical approach, which including the rescission and the retraction of the tissues on the posterior aspect of the cervical spine, so that's not a prejudice. It's really insignificant and Mr. Yahyavi is going to show the jury, and tell the jury I have a substantial scar running the -- essentially my entire neck up into my upper thoracic region, so from those reasons, it did not have any significant impact on the Defense, in any way. It's not a surprise. It's clearly under surgery. And clear you'd have obviously a scar associated with that. So we have filed a responsive trial brief.

We've also lodged with the Court the complete copy of the opening PowerPoint. Mr. Kahn did not make any type of contemporaneous objection to any aspect of the opening statement. The only -- he then stated at the end of the day was that the picture he had never seen before. He wasn't sure it was produced. We went back and looked. It was, in fact, never produced. So we're not offering it into evidence. It was used demonstratively only. And so, I mean, you have the surgeon here today going to talk about what he did, where he did the surgery, so it's consistent with a good-faith belief that what I believe the evidence is going to show.

So for those reasons, there doesn't need to be any further action by the Court.

THE COURT: All right.

MR. KAHN: We briefed it. I don't think a photo of someone's surgical scar is demonstrative. That's a different thing. This is this

gentleman's neck. You can't just say everything is demonstrative, so it comes in. So our request is that it was never disclosed and not be used again during the course of the trial; that plain and simple.

Also, we filed a second motion today.

THE COURT: I --

MR. PRINCE: I haven't seen any --

THE COURT: -- you know, all of this -- I have haven't seen any of this, so --

MR. KAHN: We did file a second motion today. It can be addressed tomorrow, but the Dr. Oliveri -- well, it's important for Dr. Kaplan too, because Dr. Oliveri testified that, you know, our expert's opinion wasn't possible and that was never in his reports, but the reason I'm raising it today, aside from Dr. Oliveri, is I understood the Court's order from motions in limine that every time an expert got up to the stand, you wanted all of that expert's reports, and that didn't happen with Dr. Oliveri, so I didn't have them handy. And if Dr. Kaplan is going today, then all of his reports should be produced to the Court, because that's what the Court told us in motions in limine before the expert goes, I think the Court said you wanted all of the reports.

THE COURT: Well, I believe I said it for the ones -- I don't need a report if there's no objection --

MR. PRINCE: Right.

THE COURT: -- as to what he is testifying to. If you're objecting that he's not testing consistent with his report, then I absolutely need it, but assuming, as in the one I just -- well, no -- your

expert was two-inches thick of, more or less, of six reports, and somehow there's an objection regarding is it in his report, then I do need the reports. So far you hadn't made any objections for that witness that was on, on Friday. So I guess my -- if you think there's a problem, then yes, I need the reports. If there is no dispute, as to his testimony -- I mean, you have probably six doctors coming in --

MR. KAHN: Right.

THE COURT: -- and there's no general -- I mean, you've taken depos of these guys, haven't you?

MR. KAHN: No. Not all of them. No.

MR. PRINCE: No.

MR. KAHN: That's the other problem. So the issue for us is, Dr. Oliveri went. We didn't have copies of the reports.

MR. PRINCE: Yes, you did.

MR. KAHN: He was --

MR. PRINCE: Your Honor, he does have --

THE COURT: Hang on.

MR. PRINCE: -- copies of all the reports.

MR. KAHN: I copies of all of the reports, but --

MR. PRINCE: Right.

MR. KAHN: -- they weren't provided to the Court. And in his first half day of testifying he said he rendered an opinion that was outside of his written reports, and by the time it was said to the jury, then it's said to the jury, so --

MR. PRINCE: Well, with respect --

THE COURT: All right. You can't come in a day later and tell me you had an objection back then. You need to know what the reports --

MR. PRINCE: Right.

THE COURT: -- say and make a contemporaneous objection and if it's regarding the reports, which I assume that was, then provide me with the reports. If there's no dispute, as to what the doctor -- and you say now there's six or more of them -- as to what their reports say, then no, I don't need to sit here and have all, you know, six of their reports, but yes, if there's a contemporaneous -- I'm going to ask you, then show me the report.

MR. KAHN: Okay.

THE COURT: So --

MR. KAHN: You want the objecting party to have the reports available is what you're saying?

THE COURT: Well, I mean, look, we've got everything here, although, the reports aren't admitted.

MR. KAHN: We may have --

THE COURT: -- but I assume they're in there.

MR. KAHN: -- marked them.

Did we mark them?

THE COURT: I mean, they're not admitted exhibits, but aren't they here somewhere?

MR. KAHN: I don't think so.

THE COURT: Well, then they certainly should be in the

courtroom.

MR. PRINCE: I have them, but we'll make sure we have -- if it comes up, I have them for the Court.

With regard to this issue -- kind of forecasting a little bit for Dr. Kaplan, Dr. Kaplan occupies a dual role: one as a treating physician, so all the rules under *FCH1* and *Pizarro-Ortega* apply to him. In addition to that, when he was supplied with additional medical records, as well as expert reports, he authored reports, based upon the review of those related materials -- expert reports, meaning, the Defense neurosurgical expert Dr. Tung, who would be his counterpart, but Dr. Kaplan can obviously testify to opinions he formed during the course of his care, whether written down, recorded, or not. So I just want the Court to be cognizant of that.

If there's no objection, I guess we'll deal with contemporaneous objections as they occur, but Dr. Kaplan --

THE COURT: I am well aware of *FCH1*.

MR. PRINCE: Okay. Well, I'm ready with Dr. Kaplan any time the Court is ready.

MR. KAHN: And I think we did mark the expert reports. They just aren't admitted. So we may have them. Our trial tech reminded me. Thank you, Your Honor.

THE COURT: Yours -- the one you gave me regarding Tung I still have. Yes.

MR. KAHN: Dr. Tung, right.

THE COURT: Although -- yeah, they're over here, so I'm not

looking at them, but even if you made an objection, I'd have to -- you know, we're going to have to talk about it, because there are six different reports.

MR. KAHN: Right.

THE COURT: And I don't have them memorized. Nor, do I expect you to.

MR. KAHN: Understood.

THE COURT: You know, it's what it is.

All right. Is the guy here?

THE MARSHAL: Yes.

THE COURT: Okay. So who is up? Kaplan or Oliveri?

MR. PRINCE: He's here, Your Honor.

THE COURT: Okay.

THE MARSHAL: Did you want me to bring them in, Judge?

THE COURT: No, not yet.

THE CLERK: One second.

THE COURT: She's doing something. I don't know. She needed to do something.

They generally -- am I wrong, generally, if you refer to an exhibit, they're not going to need to look at those binders? You're going to have it up on --

MR. PRINCE: Correct. I'm going to have the hard binder ready for Dr. Kaplan for his record, just he has a hard copy in front of him.

THE COURT: If they need it, but mostly, you're going to

show him --

MR. PRINCE: I guess I am. I have everything electronically.

THE COURT: All right. And is Defense pretty much the same way when you --

MR. KAHN: Yes, Your Honor.

THE COURT: Okay. So although they're there, and they look really pretty, it's not likely they'll be used?

MR. PRINCE: I like to have them ready just to have them ready.

THE COURT: Fine. So be it.

Okay. Are you done?

THE CLERK: Almost done.

Mr. Prince?

MR. PRINCE: Yes.

THE CLERK: You gave the Clerk two exhibits slides. Were they for Plaintiff exhibits to be marked next? I have a little note saying that.

MR. PRINCE: No, I was --

THE CLERK: It says, "Plaintiff to provide copies of two slides." Is that the PowerPoint that she was referring to?

MR. PRINCE: Yes. It's part of the PowerPoint, right.

THE CLERK: Okay. It's not an exhibit?

MR. PRINCE: If you want, we can just mark it as a court exhibit and then --

THE CLERK: Oh, yeah, it is.

MR. PRINCE: -- what was referred to in the opening is in the PowerPoint slide.

THE CLERK: Right.

MR. PRINCE: So what they wanted marked is part of the PowerPoint slides.

THE CLERK: Okay.

MR. PRINCE: It's contained in the PowerPoint.

THE CLERK: Do we need to mark them separately too, or --

MR. PRINCE: Dave -- Mr. Kahn?

MR. KAHN: Sir.

MR. PRINCE: Yesterday, or during the opening statement you indicated you wanted certain slides from the PowerPoint identified, which mainly the demonstrative exhibits about the traffic, you know, the travel lane, the construction zone. Those are now part of the PowerPoint, which is now a court exhibit. That satisfies your request, right?

MR. KAHN: Yeah, that's fine. As long as we can refer to it --

THE CLERK: Okay.

MR. KAHN: -- or use it if I have to.

THE COURT: As long as there --

MR. PRINCE: If you have to pay for it.

THE CLERK: Court's exhibit?

MR. PRINCE: I mean, you're with that gigantic law firm, I mean --

MR. KAHN: I can just use an Elmo.

THE CLERK: But it's a court exhibit. I don't have it as a regular exhibit.

MR. KAHN: What's the exhibit number now?

THE CLERK: It's going to be Court's Exhibit 4.

[Court's Exhibit 4 marked for identification)

MR. KAHN: Court Exhibit 4. Okay. I'll mark that.

THE CLERK: But I can't -- you know, I don't know how you want to do that --

THE COURT: What?

THE CLERK: -- if he needs to use it.

MR. KAHN: So -- okay --

THE COURT: Well, the PowerPoint's a court exhibit, so I don't understand what you're asking. All right. We don't need to deal with that now. I don't think.

THE CLERK: Okay.

THE COURT: Bring them in.

MR. PRINCE: I'm ready.

THE CLERK: And I'll have a new jury list here in just a little bit.

THE COURT: So tomorrow I'm hopeful we'll start at 10. Do we need to go late?

MR. PRINCE: Dr. Schifini confirmed he could start at 10 tomorrow. I have three witnesses tomorrow, Dr. Schifini, he should take that probably the bulk of the morning, and a little bit in the afternoon probably with cross, and our redirect. I have Darian Yahyavi, and then

we're going to do a depo read of a fact witness.

THE MARSHAL: Please rise for the jury.

THE COURT: All right.

[Jury in at 1:24 p.m.]

[Inside the presence of the jury.]

THE COURT: Please be seated.

Good afternoon, ladies and gentlemen.

JURORS: Good afternoon.

THE COURT: As far as I know, and I'll probably know a little bit better, I have a light calendar, so we will be starting at 10 a.m. tomorrow -- 10 a.m.

As you can see -- it's Mr. Harris, right -- was sick, so he is off of the panel. So hopefully, 10, and I'll review that stuff. If it's 10:30, I'll tell you.

Otherwise, the parties acknowledge the presence of the jury?

MR. PRINCE: Yes, Your Honor, we do.

MR. KAHN: Yes, Your Honor.

THE COURT: Okay. Plaintiffs, call your --

MR. PRINCE: Ladies and gentlemen, good afternoon. Hope you had a nice weekend.

Your Honor, because of a scheduling issue, we're going to call Dr. Stuart Kaplan. Dr. Oliveri, who we were hearing from on Friday, will be back Wednesday morning for us, and he'll finish with Dr. Oliveri's testimony, but we're going to call Dr. Stuart Kaplan, who is our next witness, Your Honor.

THE COURT: All right.

THE MARSHAL: Watch your step, Doctor.

DR. KAPLAN: Thanks.

THE MARSHAL: If you'll remain standing, face the clerk of the court.

THE CLERK: Please raise your right hand.

STUART KAPLAN, PLAINTIFF'S WITNESS, SWORN

THE CLERK: Please be seated. Please state your name and spell it for the record.

THE WITNESS: Yeah. It's Stuart Kaplan, S-T-U-A-R-T K-A-P-L-A-N.

THE CLERK: Thank you.

THE COURT: Go ahead.

DIRECT EXAMINATION

BY MR. PRINCE:

Q Dr. Kaplan, good afternoon.

A Hi, there. How are you?

Q Good. I'll let you get situated.

A Please. Thank you.

MR. PRINCE: Your Honor, let's approach, while Dr. Kaplan is getting situated. We have one issue --

THE COURT: Uh-huh.

MR. PRINCE: -- just to bring to the Court's attention.

[Sidebar begins at 1:27 p.m.]

MR. PRINCE: Just so the Court's aware, Dr. Kaplan brought

surgical instrumentation, meaning the screws and rods, just to demonstrate, and he also brought a spinal cord stimulator to kind of demonstrate to the jury just what it is and explain its function.

MR. KAHN: As long as there's no needles and no shocks going off I'm fine.

THE COURT: I said that before.

MR. KAHN: That's all fair game.

THE COURT: Yes.

[Sidebar ends at 1:27 p.m.]

DIRECT EXAMINATION

BY MR. PRINCE:

Q Dr. Kaplan, good afternoon.

A Hi, there.

Q In front of you, I have an exhibit binder. Your medical records are part of Exhibit 105 and 106. I just wanted you to -- in case you wanted to have the hard copy. I'm going to put everything on the monitor to share with the jury, but in case you need anything to refer to, please refer to that, okay?

A Thank you. Okay.

Q Very good. Dr. Kaplan, what is your area of medical specialty?

A I'm a neurosurgeon.

Q Okay. And describe for us the medical subspecialty of neurosurgery. Tell us what it is.

A Okay. So neurosurgery is involved -- we're surgeons. We're

involved in the treatment of patients who have a variety of problems, whether it be of the brain, the spine, or the peripheral nerves. So I'll give you an example. Today -- I'm on call today for a few hospitals. I operated this morning. I operated on somebody with a neck problem, with terrible neck and arm symptoms, and I did a cervical operation. I had also to do another operation on somebody who had a herniated disc in their back, and I did that operation this morning, as well, with terrible leg pain. I'm on call today. I saw somebody with a blood clot on the surface of the brain. Fortunately, they don't need surgery, and that's a very good thing. And I also saw somebody else who herniated a very large disc in their back, as well.

So we're involved in the treatment of patients who have surgical and non-surgical issues involving the brain, the spine, and the peripheral nerve. So with regard to the brain, blood clots, brain tumors, aneurysms, things like that. The spine issues, like we're here to talk about today, people with spinal problems, spinal cord problems, nerve problems, things like that. And peripheral nerve being things like carpal tunnel ulnar nerve, some smaller type issues there that we also deal with. Other docs do that, as well. In other words, plastic surgeons, hand surgeons, et cetera, but again, that's peripheral nervous system. So we take care of patients like this with these types of maladies.

Q Okay. And I want to talk about your education first. First, where did you go to college?

A I went to Dartmouth College.

Q Dartmouth College. And where did you go to medical

school?

A I went to Harvard Medical School.

Q Okay. And how many years were you at Harvard Medical School?

A I was there from 1989 to 1994. Normally, medical school is four years. I spent five. I spent a year between my third and fourth year doing stroke research, and it was a very good year.

Q Okay. And after you completed your five years at Harvard Medical School, did you go on to a residency program?

A I did. I was at Washington University in St. Louis from 1994 to 2002.

Q And can you describe for the jury what a neurosurgical residency consists of?

A It's a little easier these days. It was brutal back in those timeframes. You know, these days, they have these residency work hours, they generally work 80 hours a week. That wasn't the rules when we were there. But essentially, what we do is we take -- we were basically taking an apprenticeship. Essentially what you're doing is you're learning from your colleagues, your professors, et cetera, how to evaluate patients appropriately, how to determine who's surgical, who's not surgical, and how to do these operations safely. So we're accumulating a large body of knowledge, and we're learning how to be what we are today.

Q Okay. And during your neurosurgical residency, are those -- how many years are they, six?

A Eight.

Q Eight years. So during that eight year residency, you're focused on the brain?

A Yes, sir.

Q You're focused on the spine?

A Yes, sir.

Q And the peripheral nerves?

A Yes, sir.

Q So those three areas?

A Yes, sir.

Q So a significant part of your training, maybe unlike an orthopedic surgeon, a primary focus of neurosurgery is almost always the spine and related issues?

A Yes, sir. In other words, we deal with spinal maladies like this from the beginning of our -- the first year is what they call a general surgery internship. We're exposed to things like trauma surgery and cardiac surgery, and all these other issues, so we learn general fund of knowledge, but we start working, and we start taking care of patients with spinal problems like this since, you know, our first year of neurosurgery residency. In other words, for six or seven years.

Q Right. After you completed your six -- excuse me, eight year residency at Washington University -- that's in St. Louis?

A Yes, sir.

Q Missouri, right?

A Yes, sir.

Q Would you consider that a world renowned medical school?
A I would. I mean, not to sound arrogant --
Q I know you're bias, but --
A -- and cocky. I mean, you know, with all due respect, it is one of the finer institutions in the world.
Q Right. It's like a UCLA, John Hopkins. It's at that level.
A It is at that level.
Q All right. And after you completed your residency training, did you go on to a fellowship?
A I did. I spent the eighth year there at Washington University for an extra year of training.
Q Okay. In what area?
A Actually, I did a pediatric neurosurgery fellowship.
Q Okay. So in addition to taking care of adults, you have an additional year of taking care of pediatrics?
A Right, because I wanted to take care of both, kids, as well as adults, and that's what I wanted my practice to be.
Q Okay. And have you done that so far?
A I have.
Q Very good. And how long have you been practicing in the State of Nevada, Dr. Kaplan?
A Fifteen years.
Q Okay. And describe the types of patients that you see in your clinical practice and in your surgical practice here in Clark County, Nevada.

A So basically, just like we described earlier, I take care of patients who have both, brain, spine, and peripheral nerve problems, so brain tumors, hemorrhages, spinal issues like we're here to talk about today, like the patients that I've talked about that I operated on today and I've seen today. Those are the kinds of issues that we deal with. Obviously, only a small subset of patients that we see actually need our services. In other words, need surgery. The majority, 90 plus percent of the people we see, fortunately enough, don't require surgical intervention.

Q Okay. And as part of your neurosurgical practice, Dr. Kaplan, do you treat patients who have been injured or have suffered some kind of traumatic injury in some way?

A All the time. I mean, part of neurosurgery -- I just mentioned earlier, I saw somebody with a subdural hematoma. That was traumatic. That was from a fall. That's part and parcel of neurosurgery. We see trauma all the time. I used to take call at UMC Hospital, University Medical Center over here.

Q At the trauma facility?

A At the trauma center; yes, sir.

Q And that's where Mr. Yahyavi was seen following this collision, right?

A Yes, sir.

Q Okay. And so you see trauma patients at UMC. Well, number one, we didn't quite get there with Dr. Oliveri, tell us what the UMC Trauma Center is.

A Well, the UMC Trauma Center is the only level one trauma center we have here in Clark County.

Q And what does it mean to be a level one trauma center?

A Well, it's part of the -- there's an academic component. Essentially, that's the difference between a level one and a level two, but essentially, they have dedicated people on staff, ready to go, when people have issues -- you know, significant, traumatic issues. They go to the trauma center, it's all ready to go, there are people there, there's nurses there. They take critically ill patients, CAT scans are done, you know, very expeditiously, the operating room is right over there, so they're prepared to take care of critically ill traumatic patients.

Q Right. A level one trauma center is different than simply just an emergency room, right?

A Absolutely.

Q Right. And in this case, in addition to taking care of Mr. Yahyavi and doing surgery on him, you've also had an opportunity to review all of the medical records associated with his care and treatment following his June 2013 crash?

A Yes, sir. And like you said, he went right to UMC Trauma.

Q Trauma. Right.

A Yes, sir.

Q Right.

A Which was appropriate.

Q Now, you also treat patients in your practice who have suffered industrial or work related injuries to their spine?

A All the time.

Q All right. How many -- just again, to get an understanding of your surgical experience. So here, we're going to be talking about a multi-level cervical spine fusion that you did in January 2018. How many cervical spine surgeries would you estimate you've done over the course of your career, Dr. Kaplan?

A I probably do three or four cervical spine surgeries a week.

Q Okay.

A So you're talking four times however many weeks. Let's call it 50. We'll call it 200 a year, times -- we'll call it 15 years here.

Q So in the thousands?

A Thousands.

Q And how many lumbar spine surgeries would you estimate you've performed?

A Similar.

Q A similar number?

A Yes, sir.

Q So you've done thousands of neck cervical surgeries, as well as thousands of lumbar and low back surgeries over the course of your career?

A Yes, sir.

Q Very well. Now, I know that your Mr. Yahyavi's treating neurosurgeon who performed the surgery, but in addition to taking care of him and treating him, as part of your role in this case, did we supply you with all of the medical records, imaging studies, following his June

19th, 2013 motor vehicle crash?

A Yes, sir.

Q All right. So you, in addition to having your information you collected during the course of your care, you also have the benefit of reviewing all of these medical records, as well?

A Yes, sir.

Q All right. And you also -- have you reviewed the Defendant's medical expert, Dr. Tung from California, his expert reports?

A Yes, sir.

Q All right. And based upon that information, have you formulated opinions concerning what was the cause and the need for Mr. Yahyavi's multi-level spine surgery which we're going to be talking about with you here today?

A Yes, sir.

Q And what is your opinion?

A My opinion is that this man sustained a traumatic cervical injury as it relates to the accident we're here to talk about from 2013.

Q And based upon your review of the medical records, including expert reports, have you been able to rule out that there's any other more likely or more probable cause, other than this forklift crash we're here talking about?

A There's nothing else.

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

A Yes, sir.

Q Do you have an opinion whether Mr. Yahyavi -- we're going to talk about this -- whether he exhausted, meaning did everything he could, of conservative care, before he finally elected to have surgery with you in January of 2018?

A Oh, there's no question. I mean, this man in looking at the records during my -- when I saw the man -- I saw the man initially in 2017, late 2017. I think, specifically, August. And when he came in -- you know, when he came and saw me, obviously, he told me the history, he told me what happened, et cetera. He told me he'd seen another orthopedic surgeon before, Dr. Perry. He told me he'd seen Dr. Schifini. I know he's seen a variety of other pain docs, as well. I think this man has undergone more injections in order to avoid surgery than anyone else in my career, to be honest.

Q Okay. So do you think he then exhausted every available conservative option before turning to surgery with you?

A Oh, there's no question.

Q Do you think all of the care and treatment that he received, including the chiropractic care, the physical therapy, the spinal injections performed by several different pain management specialists, as well as neurosurgery, do you have an opinion whether all of that was caused and needed as a result of the injury he suffered in this June 19th, 2013 collision?

A Yeah. The answer is yes.

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

A Yes, sir.

Q Now, I want to -- before we get going here, I want to -- as part of your analysis in this case, Dr. Kaplan, did you utilize clinical correlation as part of your, not only care and treatment of Mr. Yahyavi, but also your reaching your expert conclusions in this case?

A You have to.

Q All right. And let's bring up the correlation slide. It's Demonstrative 101. I'm going to put it on the monitor for you. Very good. And I've heard it said, Dr. Kaplan, that, you know, listen to your patients carefully, because they're telling you their diagnosis. The founder of John Hopkins said that.

A No question. That's exactly right.

Q So patient history. Is that an important aspect of the clinical correlation analysis?

A It's the foundation.

Q Okay.

A You make it 50 percent, but actually, in my mind, it's even greater than that, actually.

Q Okay.

A I mean, history is the foundation for everything.

Q Tell us why.

A Because the patient -- as you said before, the patient is telling us what we need to do. We just need to listen carefully, and spend enough years learning what to do, but essentially, they are telling us what their problems are. We can look at films -- and I'm sure -- I see you

have diagnostic imaging. Diagnostic imaging and isolation is meaningless in merely -- in almost all cases. I mean, obviously, you have a broken arm and you see a, you know, big break, it's obvious what's going on there, but in most of the patients we take care of on a daily basis, that's only one piece of the puzzle, but the history is the foundation for which we do everything.

Q For example, when you're treating somebody who has been -- you've seen either in the trauma center or in your clinic, do you start with the history every time?

A Every time.

Q In fact, every field of medicine starts with a history, right?

A Absolutely.

Q And when you're talking about history, what types of questions are you asking? Like when did the symptoms start? Do you ask that?

A Obviously, the most important is why are you here. I mean, that's question number one. Why are you here, what bugs you, when did it start, what makes it better, what makes it worse. Those are the basic foundations.

Q Yeah. Do you try to -- based upon your own specific credentials, meaning as a -- obviously -- are you board certified?

A Of course.

Q You're board certified, fellowship training in neurosurgery. You obviously know some specific questions to ask some of your patients to understand from them kind of the nature and extent, and the

quality of their symptoms, as well; isn't that fair to say?

A That is true.

Q Why do you ask detailed questions of your patients about the nature and extent, and the qualities of their symptoms?

A Because obviously, we're trying to do what's right. Obviously, you're trying to diagnose what the problem is, and you're trying to do what's right by the patient. Obviously -- I'll give you an example, and again, it's not relevant to this case here, but again, we have a lot of patients with neck complaints. Is it neck versus shoulder, is it back versus hip, versus SI joint. In other words there's masqueraders. And our job is to properly diagnose the problem and take care of the issue.

Q Okay.

A And obviously, we need to understand how long it's been going on, what have they done, what treatment have they done, and again, as we talked about earlier, have they exhausted all forms of conservative therapy, because any surgery we do carries risks. Every surgery we do carries risks.

Q Okay.

A I don't care if it's a carpal tunnel surgery. There's risk of bleeding, infection, heart attack, stroke. I mean, all these things, significant complications.

Q Right.

A So it's a risk benefit profile that we deal with on a day-to-day basis.

Q And examination findings. In particular, let's say we're focusing to the spine. Are examination findings an important part of your not only diagnosis and treatment, but also your clinical correlation analysis?

A Absolutely. In a case like this, you're looking for, does somebody have a neurologic deficit. In other words, we're trained to identify based on certain nerve route patterns, do they have a neurologic deficit? In this case, fortunately enough, prior to surgery, he didn't. Unfortunately, after surgery, he did. I'm sure we'll get into that, but essentially, he had spasms, and he had decreased range of motion on exam prior to surgery.

Q Right. And also, did you look at his response -- like Mr. Yahyavi, specifically, his response to the overall treatment, both if you learned during the course of your treatment of him, as well as the records that we've provided to you as part of this case?

A Yes, sir. I mean, I know he's undergone a very extensive course of chiro/physical therapy, and he's undergone a very extensive course of injection therapy. Obviously, both for what we call diagnostic, as well as therapeutic purposes.

Q But I've heard it said for some patients after they undergo these conservative care, chiropractic care, physical therapy, medications, as well as injections, that they -- before they go to surgery, they've failed conservative care. I've heard that --

A Yeah.

Q -- term. Even used by you, I think.

A That's a term we use all the time.

Q Did Mr. Yahyavi fail conservative care in this case?

A Oh, no question.

Q Now, we also want to talk about diagnostic imaging. We're talking about x-rays, MRIs, CT scans. Does an x-ray tell the whole story?

A No, it doesn't, because an x-ray, in isolation, is just a picture in time. It doesn't tell you if you hurt or not. It doesn't tell you what your complaints are. We all know -- I mean, this man is, I think, five years older than myself. I'm 52. He's 57 now, so he probably was around his young 50s when this accident occurred. We all have degeneration over the course of time, but just because you have degeneration on x-rays is clinically insignificant.

Q Right. You need to put all the other pieces of the puzzle together?

A This is the puzzle to create an algorithm or a treatment paragon. If you have one piece of the puzzle without the others, there's no -- there's no pizza.

Q So you need to look at the whole thing to understand the full story?

A Absolutely.

Q All right. All right. What I'd like to do now, Dr. Kaplan, is to turn to your first visit, which is August 11th, 2017. In front of you, I have open for you Exhibit 105, and it's the Bate number 1012, for the record. It's going to be your first visit with Mr. Yahyavi.

MR. PRINCE: So, Greg, what I'd like you to do is start at the

top, where it says history and physical report, and go through the whole history of present illness.

THE WITNESS: So essentially --

MR. PRINCE: Hold on a second.

THE WITNESS: I apologize.

MR. PRINCE: Let me catch up here with my tech. Okay.

BY MR. PRINCE:

Q So first off, the first thing you document in your chart note is history of present illness. Is that what you just talked about a minute ago, why the history it's important, why are you there?

A Yes. Yes, sir.

Q So you asked him, Mr. Yahyavi, why are you here today?

A Yes, sir.

Q And what did he tell you that day?

A So it's interesting. The conversation here is only about the neck, nothing about the back.

Q Right.

A So I think his back got better. I read in my reports over here, he had some back complaints initially. By the time in which I see him, the back is gone.

Q You know since -- that's a good point. We're talking about, in this case, a structural injury to the spine; is that fair to say?

A Yes.

Q To the cervical spine, to the neck?

A Yes.

Q So there's something going on with the discs in his neck, right?

A Yes.

Q That are causing him pain and symptoms, yeah?

A Yes.

Q And we also are going to talk about the facet pain, right?

A Yes.

Q With regard to the lower back, did he have any structural injury to his lower back as a result of this collision?

A No.

Q Did he have a soft tissue strain as a result of this collision?

A Yeah, and it makes sense, and I'll tell you why.

Q Tell us why.

A The man had an accident, and he described to me when I saw him that day, and you know, I'm not very good with names, and I'm not very good with faces, but I remember him very well, and I remember him sitting with me and showing me pictures because it was very dramatic to me.

Q The pictures were?

A The pictures were; yeah. He showed me the pictures of his forklift, he showed me the pictures of his car and glass, and all this kind of stuff, and whatever. It was very dramatic to me. So the way I look at these things, especially in car accidents like this, obviously, you're wearing a seatbelt. Okay, so obviously, the seatbelt is protecting your lumbar spine much better than it does your neck, but your neck,

obviously, you have much more freedom of motion, and I suspect this car was going -- whatever speed it was -- I think I heard -- one report, I read 15, one I read 30 miles an hour. So at some --

Q Does it matter?

A It doesn't really matter, to be truthful. But the bottom -- I see he was moving, and now all the sudden, he's not moving. So to me, when you're going -- when you're moving and not moving, your neck is going to be thrown forward and back.

Q Okay.

A So I mean, it makes sense to me.

Q And in terms of understanding this case, we're going to be talking about degeneration in some detail here in a moment. Is the timing of the onset of the symptoms an important part of your analysis?

A In terms of causation?

Q Yes.

A To the causation analysis? Absolutely.

Q In fact, that's the cornerstone of it, right?

A That's the basis for it.

Q Yeah. Okay. So let's start here. Mr. Yahyavi comes to see you on August 11th, 2017. Number one, who refers him to you?

A The chiropractor, Dr. Bahoora.

Q Okay. And it says that the patient is a 55-year-old male who presents with complaint of neck pain, numbness, tingling, dizziness, and weakness. What's significant about those complaints to you?

A Well, we, as neurosurgeons, are always very attuned when

patients describe arm symptoms. That's very important to us, because we can localize things based upon our neuroanatomy, our known neuroanatomy. So what he described to me is he described neck pain. Now, neck pain could be multi-factorial. Neck pain could be from the discs of the neck, it could be from the joints of the neck. So the discs are in the front between the two bones, the joints are in the back, in the back portion of your neck, right near what they call the spinous processes. If you push hard, you'll feel your spinous processes.

So neck pain you can't -- sometimes you can't isolate it just based on history and films, but arm pain, that's really good for us because we have basic neuroanatomy. So this man described pain going down the arm into his third, fourth, and fifth fingers, and he also had pain in his shoulder region, too. So I felt he had probably a multi-factorial cause of his pain in the arm. One being a C5 nerve root, potentially even a C6, and also what we call the C8. The C8 is the nerve between what we call the C7 and the T1 level. The C8 nerve root causes pain all the way down to the pinky, ring, and a portion of the middle finger.

Q Yeah, we're going to talk about that in detail in a moment, but in terms of -- it's not just he came to you with neck pain. He also came to you with significant arm complaints?

A Yes, sir.

Q Where they significant to you as a neurosurgeon?

A Absolutely.

Q And in terms of your overall review of this case, and including all the medical care, were those arm complaints consistently

present?

A Yeah, I mean, if you look at the --

Q From the beginning?

A Yeah. If you look at the records, the first note after being seen at UMC -- appreciate at UMC, things are a little hairy, you know. You know, at UMC, we just got to make sure -- they got to make sure you're alive and breathing, not, you know -- not -- UMC doesn't go into all the details of every specific thing. You know, they do a head CT, a CT of the neck. There's no fractures, no blood, go home, see your doc, but the first person they see was the chiropractor over at the neck and back clinic, and the first visit a couple days later, neck and left arm. So he was having neck and left arm symptoms right from the beginning.

Q Yeah, I'd like to look -- just to kind of like -- just honing in on that because we're talking about the onset of the left arm symptom. We're going to go to Exhibit 87, page number 191. Kind of like --

A Yeah.

Q This is just part of the neck and back chiropractic records, which you reviewed?

A Yes, sir.

MR. PRINCE: And if you could bring up the bottom third of the course of treatment for the injury. And bring that down and bring up the date, just so the jury is clear on the date.

THE WITNESS: It was four or five days later.

BY MR. PRINCE:

Q So he's seen five days later after being seen at UMC Trauma. He's talking about his neck pain, and then it says -- you see where it says, he reports --

A Yes.

Q -- the quality of the pain as achy and constant?

MR. PRINCE: You see that, Greg? Can you highlight that in the middle?

BY MR. PRINCE:

Q He reports radiation type of pain in the left arm below the elbow; do you see that?

A I do.

Q Okay. Is that clinically significant to you as a neurosurgeon that these symptoms, not only in the neck, but also in the arm, were present from the beginning?

A Yeah.

Q And during -- based upon the records that you reviewed, was the pain in the neck constant from June 19th, 2013, all the way to the present?

A It's been consistent the whole time.

Q Has he ever been pain free in his neck or his arm from June 19th, 2013?

A No.

Q All right. Let's go back to your note of August 11th, 2017, 1012.

MR. PRINCE: And bring up the history.

BY MR. PRINCE:

Q Okay. And then did he describe to you the event that caused the onset of these symptoms?

A Yeah. I mean, it says right here, he describes how a forklift came in the road with the forklift up. He said the forklift actually came right through the front of his windshield.

Q Okay.

A So he actually filled out -- when patients come and see us, they fill out, also, another form where they describe the nature of the accidents that occur, and he described that, and I vividly remember him showing me pictures that day.

Q Right. Then he goes on to say, he states he cannot turn his neck well. He has neck pain all the time. He notes it shoots down the left arm, and he gets numbness involving the pinky and ring finger.

A Yes, sir.

Q Was that specific distribution important for you to understand in this case?

A Absolutely.

Q All right. What I'd like to do is kind of talk about nerve distribution, okay?

A Okay.

Q And I'm going to show you a diagram.

A I mean, just to-- I mean for me as a neurosurgeon, that's classic C8. That's classically the disc level between the Chapter 7-T1. To me, it's pretty classic.

MR. PRINCE: One second. Court's indulgence. There's one specifically I was looking for. I wanted to number the neck, if I could. Oh, here we go. Yep. All right. Let's go to Demonstrative 83. We're going to start there.

BY MR. PRINCE:

Q Okay. What I'd like you to do, Dr. Kaplan, maybe you can come down to show the jury while I have --

MR. PRINCE: -- Your Honor, can Dr. Kaplan step down?

THE COURT: That's fine.

BY MR. PRINCE:

Q What I'd like you to do, Dr. Kaplan is -- Dr. Oliveri did a little bit on Friday, but I want you to talk about the different segments of the cervical spine, how many there are. We're talking about a C8 nerve distribution. If you could kind of give us another quick tutorial, and I'll hold the microphone for you.

A Okay. So this is a model --

THE MARSHAL: Push it and hold it until the light turns green.

MR. PRINCE: Got it.

THE WITNESS: This is a model of the spine. So basically what we're looking at is the base of the skull, the skull here. It goes cervical, thoracic, lumbar, sacral, okay. Cervical neck, thoracic chest, essentially, lumbar back, sacral in the pelvic area.

So the most common areas that we deal with as surgeons, cervical and lumbar. What happens is we have 8 cervical levels, 12

thoracis, generally 5 lumbar in general, and then 5 sacral, and then the coccyx as well as your tailbone there.

So in between each bone apart from the C1-C2 level is a disc. So the disc serves as a shock absorber, it allows for motion. It basically allows less motion between the levels there.

So when we talk about discectomies, we're talking about discs, okay? So it goes bone, disc, bone, disc, bone. The most common levels that we deal with, 5-6, 6-7. Much less common C7-T1. But essentially as we talked about earlier, the C7-T1 level, you'll have a disc, and if you herniate a disc or there's some problem there, it causes damage to what they call the C8 nerve root.

BY MR. PRINCE:

Q Right. Maybe we can look at this model. There's a reason why I put this part of it on the screen is because it demonstrates kind of a C6-7, there's the disc. And then coming off of it is the C8 nerve root.

A Yes.

Q And we're going be talking about the C8 nerve root in this case, right?

A Right.

Q Okay. Now, what in -- you're saying he had a distribution in connection with a C8 nerve root, right?

A Yes, sir.

Q And can you tell the jury what a dermatome pattern is?

A Basically, that's the representation on the skin of a particular nerve. So, for instance, the C5-6 level generally causes pain that goes to

the thumb and index side. People have numbness in that distribution.

THE CLERK: He needs a microphone.

THE WITNESS: Oh, sorry.

MR. PRINCE: One second. I'm going to get another demonstrative up for us. Sorry, that's my fault. We're going to go to demonstrative 3, Greg. I think this will help you. I hope anyway.

BY MR. PRINCE:

Q What do we see here, Dr. Kaplan?

A Classic. So what you're describing here, these are the dermatomal distributions of pain numbness, et cetera. So a classic C6 nerve root causes pain, numbness and tingling to the thumb side. C7, the second and third fingers. C8, the pinky and the ring finger which is the level that I believe he was symptomatic.

So that's the distribution of the pain. And you also get numbness in that area as well. Sometimes you can get reflex changes, but that goes beyond the scope. And you can also have weakness in a distribution as well.

Q Right. Now with regard to those nerve roots, it's the same on each side, right? Both right and left.

A Absolutely. You have the right side. You have the left side. We have one for each side.

Q I kind of learned -- I remember, it was a neurosurgeon, I worked with him when I was really young. Think of the spine and the nerve is kind of like an index. You follow the dermatome and it's like an index if you have a probable like the C7-T1, it'll be in CA distribution. It

kind of shows you anatomically the distribution of the stuff, either pain numbness or the tingling.

A They're telling you -- they're giving you the map. In other words, they don't know the map, but they're giving it to us.

Q Did Mr. Yahyavi, since we have this up here, did he also complain of pain radiating from the neck, consistent with the C5 problem?

A Right. He had pain from the neck to the shoulder region, too. So I felt he had a multifactorial process was.

Q What does that mean?

A That means multiple levels.

Q So multiple levels of pain and symptoms?

A Right.

Q Okay. And is this dermatome chart important to understanding kind of your role as a neurosurgeon and how your treatment recommendation went for Mr. Yahyavi specifically?

A Absolutely. Every patient. I mean, this is cornerstone of how we treat people. We think about this on a day to day basis because again, you don't want to hop around someone's neck if they have a shoulder problem.

Q Right. This way you can differentiate --

A Absolutely.

Q -- where the problem is coming from?

A Absolutely.

Q Does it also help you identify where the source of the pain or

numbness or tingling is coming from?

A Absolutely.

Q What we call the pain generator?

A Yes, sir.

Q Did you do that in this case?

A I did.

Q Very good. Thank you. All right. And in your history, going back to 1012, did Mr. Yahyavi tell you he'd seen a Dr. Archie Perry, an orthopedic spine surgeon?

A He did.

Q Do you know Dr. Perry?

A I do.

Q And were you aware from Mr. Yahyavi as will a review of the records of Dr. Perry had recommended a surgery?

A I did.

Q Was that a multi-level surgery?

A He did.

Q And obviously Mr. Yahyavi did not undergo that before seeing you?

A He did not.

Q Are you critical of him for not having surgery sooner?

A No. I mean, here's what I tell -- we tell all of our patients every day. You should live with it as long as you can. I mean, that's critical because, again, as we talked about before, surgery carries risks. Number one, and I'm sure we'll get into that later on there --

Q Yup.

A -- but I tell people to live with it as long as they can.

Q Okay.

A And again, we have other patients. I have certain patients who I recommend surgery for. They can have weakness in a nerve or distribution or whatever. Number one, they're scared to death. I mean, we see this all the time. I mean, unfortunately, you know, a lot of people know people who've had surgery and things haven't "gone as well as people hope." Doctors will say, am I going to be paralyzed -- patients would say, am I going to be paralyzed from this?

You know, there's so many factors out there. There's personal issues. Time off of work. There's so many factors that we deal with on a daily basis.

Q Do you educate patients, like I recommend you hold off as long as possible?

A I say it every day. I say it every day.

Q It's a common recommendation, right?

A Well, I mean it's the right thing to do with all due respect. I mean, the bottom line is you should live with it as long as you can. And when you've exhausted everything, and you're at wits end, that's when you do surgery.

Obviously, if somebody has got a neurologic deficit in there, you know, they got a foot drop or they have weakness, I always recommend surgery earlier because in that situation the earlier you deal with it, the better off you are, the better chance for recovery.

That wasn't the case in this man's situation, in other words, he had strength -- he had good strength, you know, initially, prior to surgery. Unfortunately, not post-op and I'm sure we'll talk about that.

Q We are.

A But the answer is, I always encourage people to live with it as long as they can. It's the right thing to do.

Q Okay. And as part of your evaluation in this case, did you also look at the X-rays?

A Of course.

Q As well as MRI's?

A Even a CT. I ordered a CT also.

Q Right. And did you look at those, not only the ones done in 2013, but all the way up through the time of your surgery?

A Yes, sir.

Q Okay. But let's just focus our time in 2013. Did Mr. Yahyavi have degeneration?

A Oh, of course.

Q Right. Is degeneration common for someone in their early 50s?

A All the time.

Q Would you consider that an age related change?

A It is. It is.

Q The mere fact that someone has degeneration, does that mean they're symptomatic?

A It's clinically meaningless.

Q Right. Just because someone has degeneration, that mean they'll ever be symptomatic in their cervical spine.

A No. Think about everybody, you know, we all know people older than us. And just because as we all get older, we all have degenerative changes in the spine. Just because you have degenerative changes in the spine, does not mean you have any symptoms.

Q Just because you have degeneration by itself, Dr. Kaplan, does that mean that someone will ultimately require medical treatment or even going to have some kind of a spinal surgery?

A No.

Q You still have to put youth of clinical correlation like we talked about earlier?

A Exactly right.

Q Now, I do want to ask you this question. The fact that someone does have degeneration, whether it be in the 50s, 60s or otherwise, does that make them more susceptible to becoming symptomatic or developing symptoms after a traumatic event?

A Oh, no question. And here's the example I give, and I'll tell you, the way I view this is imagine grandma and grandson walking down the street, there's water on the ground and grandma on grandson both slip. Grandson gets right up, no problem, bounces right back because again, they have more -- their discs are better, their muscles are better, everything's better.

When grandma falls, she breaks her hip. Why'd she break her hip? Because she had osteoporosis. So in other words, we come the way we

come. So the same forces in somebody that's got I dare call it, degeneration, versus somebody that has a normal spine, you need a lot less forces for I dare call it a degenerated spine and I don't want to call it abnormal spine, that's not a fair term. But I think you know what I'm saying.

Q Right. I mean, can even minor trauma cause someone who has disc degeneration become symptomatic requiring medical care intervention, including surgical intervention?

A Absolutely right.

Q Right. And in this case, when you formed your opinion regarding causation, did you consider that yes, he had degeneration that would have predated this motor vehicle collision?

A Of course I did.

Q Right.

A You have to.

Q And in fact, in every case that you're involved in, if someone's in their 30s, 40s or beyond, degeneration is always a factor, right?

A It's always there.

Q Right. And so you have to use that as one piece of the puzzle?

A I mean, that's why we don't see too many kids in our practice with spinal type issues because their discs have a nice amount of water content, they have a lot more plasticity, et cetera.

MR. PRINCE: Greg, I'd like you to put demonstrative 102. It's

a little bit --

BY MR. PRINCE:

Q Degeneration, we talked about that that's a normal aging process, right?

A Yes, sir.

Q And then we add trauma to that. Then that person can become symptomatic?

A Yes, sir.

Q And in your opinion, did that happen in this case involving the collision with the forklift for Mr. Yahyavi?

A That's what happened.

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

A Yes, sir.

Q Is he chronically symptomatic as result of that?

A He's still symptomatic from it.

Q Will he be symptomatic for the rest of his life as a result of this?

A Oh, no question.

Q And I'm not talking about degeneration. I'm talking about what the trauma did to the underlying pre-existing degeneration.

A Yeah.

Q Did that make that become permanently symptomatic?

A Oh, sure. Because by the time in which I saw him was four years later, he's still having significant problems. And at that time for

him he says to me, look, I've done therapy, I've done all these injections. I'm done. I'm done. And I ultimately did surgery. I'm sure. Yeah. I don't want to get ahead of you.

Q Yup. And let's go to your initial evaluation. We're just going to talk about your examination of the neck and then your assessment and then your plan. 1013.

A Yeah.

Q We're going to talk about your cervical spine assessment.

MR. PRINCE: Greg, that's two-thirds down the page. And then also include the assessment. Maybe take out the bottom part for now. Just where it says, assessment and plan. Just the cervical spine inspection and then the assessment. Just the three lines of the assessment. Okay.

BY MR. PRINCE:

Q So as part of your initial evaluation, you have examined the next?

A Of course.

Q And one of the things you found was a spasm. What is a spasm?

A A spasm is something that can palpate. Essentially, the muscles are tight and they're, we'll call it quivering, whatever it may be.

So essentially this guy's got decreased range of motion of his neck, significantly decreased range of motion of his neck with spasms or tightness and focal areas of tightness in his neck.

Q Right. And for example, just because someone has disc

degeneration, would that just by itself cause someone to have spasm or reduction of range of motion?

A No.

Q Right. If someone did have multi-level disc degeneration that was causing pain and symptoms, would you expect someone to have a normal range of motion and no spasm?

A No.

Q That'd be inconsistent with that?

A Correct.

Q And so what was your assessment based upon your history, your physical examination and review of the imaging studies in this case?

A I felt this man had intractable, meaning, he's not tolerated any forms like we talked about before, of conservative therapy. Whether it be physical therapy, chiro, injections. So he was at wit's end with regard to his pain. He had terrible neck pain. He had arm pain that I felt was probably multiple levels. The most prominent was the C8 level, however.

But what I recommended prior to doing surgery, I knew the surgical first visit. I mean, I talked about with him, but I wanted to get a little more information prior to surgery. I wanted to get a CAT Scan because a CAT Scan is a good picture of the bones itself. MRI scans are good for the spinal cord and the nerves. CAT Scan is a little better for looking at bones.

So I want to get a CAT Scan of the back -- I'm sorry, neck. I

apologize. I ordered, I believe some X-rays also of his neck because again, I wanted to see his alignment as well.

So all of these things complement each other. I also ordered an updated EMG nerve conduction study of the arms.

Q Okay. We're going to talk about that. It says your assessment was cervical radiculitis. What is cervical radiculitis?

A Cervical being neck. Radiculitis because he didn't have, frank, weakness in the arm. I called it radiculitis rather than radiculopathy.

Q Is that nerve root irritation?

A Yes, sir.

Q So when we see radiculitis, we know that to be nerve root irritation?

A Absolutely.

Q Caused by what?

A The nerve's irritated because the disc is abnormal, the disc has been damaged.

Q Okay. So now the disc is painful and now causing nerve root irritation?

A Yes, sir.

Q Okay. Now, Dr. Perry, did he also find cervical radiculitis or nerve root irritation?

A Absolutely.

Q Okay.

MR. PRINCE: If we can turn to -- I'm just going to show this

to the jury as part of our discussion. Exhibit 91, page 289. Bate Number 289. One of Dr. Perry's notes. That's from October 2013. The visit and then the diagnosis. Number 5. See the 5 under diagnosis?

BY MR. PRINCE:

Q It says one of the diagnosis is a left greater than right upper extremity, radicular symptoms, is that what you found?

A Yes.

Q And that was from October of 2013?

A Yes.

Q Okay. Also, Dr. Perry recommended surgery.

MR. PRINCE: Let's look at Exhibit Number 91, page number 294, Greg. The second last paragraph.

BY MR. PRINCE:

Q It says right there, it says, "Dr. Perry and I do believe the patient would benefit from a surgical intervention directed at the levels of C3-4 and C6-7 as previously discussed, given these have been identified possibly as pain generators." Is that similar to your own conclusion?

A C3-5, reasonable. C6-7, reasonable. C7-T1, very important.

Q Right. That you need to include because that's the symptoms down the arm into the pinky and this ring finger?

A That's what I believe. Yes, sir.

Q So you needed to go all the way down?

A Yes, sir.

Q Okay. But more I'm just talking about the similarity of his

analysis in 2013 and '14 to yours in 2017 and '18.

A It's the same.

Q Dr. Kaplan, I'd like you to -- I'm going to put on the screen here your next office visit, which is now October 12th, 2017. You got some additional information I wanted to discuss with the jury.

MR. PRINCE: That's Bate Number 1016 of Exhibit Number 105. Just under the history section, please.

BY MR. PRINCE:

Q It says that the patient is a 55 year old male who presents for a follow visit. I saw him in August for a neck and left arm pain. The last time he underwent X-rays of the neck, a CT as well as a nerve test. I said he had pheromonal narrowing at C5-6 and C6-7. He saw Dr. Dixit and was found to have on the EMG bilateral C5-6 radiculopathy.

Number one, did you order the neurological testing by Dr. Dixit?

A Yeah, that's why I did. I ordered the X-rays -- I ordered X-rays, the CAT Scan and the nerve study because I wanted all these pieces of the puzzle, so I thought I have every piece of information I possibly could have.

Q And tell the jury what an EMG nerve conduction study is and how you use that information?

A I use that, truthfully. And you'll ask Dr. Allavera [phonetic], because he's the one who does these kind of studies. He can go over the intricacies and the details of them a lot better than me.

But essentially, when I use these studies to be truthful, I'm looking for peripheral causes. That's why. I mean, I knew the guy had a problem

in his neck and it was obvious to me. But I want to make sure I'm not getting fooled like we talked about before. You don't want to operate on a carpal tunnel. You don't operate on someone's neck when they have carpal tunnel. You want to operate on someone's neck when they have ulnar nerve compression at the elbow.

So I use as a test of exclusion. He found positive findings. I'm not surprised.

Q Right. Was a C5-6 consistent with finding on this electro diagnostic study. consistent with Mr. Yahyavi's complaints of pain from the neck radiating to the shoulder area?

A Neck to the shoulder. Yeah.

Q Neck to the shoulder. So we had clinical signs and symptoms confirmed by EMG nerve conduction studies?

A Yeah.

Q Now let's look at your exam from that day and your impression. That's 1017.

A I don't think I -- to be truthful, in the pre-op period, I don't think I did anymore exams because, you know, essentially what's happening is a person's -- I did my exam the first time and he's coming back. Unless he's going to tell me something different.

Q Okay.

A He doesn't have neurologic deficit. We know he's got spasms to the neck. We know he's got decreasing range of motion of his neck. He didn't have a weakness of his grip. In other words, of that C8 distribution that we talked about.

But really the most important thing on this follow up visit here, look at the films, look at the data, make a final determination as to what I think is appropriate.

Q Okay. I want to talk about -- you made some comments regarding some imaging. If we can look at 1017. It's going to relate to degeneration.

MR. PRINCE: Just the review of diagnostic tests, right there, Greg, first couple lines. They've highlighted those with yellow. Comments on the CT.

BY MR. PRINCE:

Q If you can tell us, you know, what your findings were in your review of the CT scan of the neck.

A Essentially, as we talked about earlier, there's no question the man had pre-existing degeneration. We talked about that.

Q Was it symptomatic based upon the clinical evidence that you reviewed in this case?

A No. But again, this is anatomic picture of what I'm seeing here. So essentially, the C6-7 level had a very rudimentary disc, a very small one. So I called it nearly almost fused.

Q We've heard the term in the records called auto fused.

A Yeah. And I noticed Dr. Perry talked about the exact same thing in his records after I looked at mine.

Q Right. The symptoms in the neck that's found on EMG testing, that's the nerve about, right? That's actually C4-5, right?

A And it's important, and I think this is very important, because

if one level is essentially -- the way I look at this, if that level is essentially fused, it puts more strain on the level above or below. And that's the -- the level below, the level above would be the one that would be more likely to be hurt. So it actually make clinical sense.

Q Okay.

A And it was ready graphically in his clinical symptoms. Made good sense.

Q Right. And so just with that, the mere fact that he was auto fused, does that mean that he was symptomatic and needed any intervention ever before this collision?

A No.

Q Okay. Now he indicated that he states his pain is terrible. Do you see that?

A Right.

Q Right. Then we can talk about the -- did you discuss surgical options that day?

A Oh, yeah.

Q And I want to talk about the risk of surgery for a moment.

MR. PRINCE: Greg, if you could go to the surgical risk. Highlight that for me. Those two sentences below.

BY MR. PRINCE:

Q And, I mean, there's a sundry of risks if you talk about infection, bleeding, a CSF leak, that's spinal fluid leak, right?

A Yes.

Q And the next one is called neurologic injury. I want to spend

my time there for a minute. What type of risk were you talking about when you're discussing a multi-level fusion with a patient? What kind of neurologic injury are you're referring to?

A You're talking about damage to the nerves or damage the spinal cord itself.

Q Okay. And why is that a risk of surgery?

A You're right there. You're working right over there. And you know what? You're taking off bone on top of the spinal cord. You know, we're using high power equipment, drills, punches, all these kind of things. Things happen. You know what, I mean, we all live in the real world here. Things can happen without even looking for it.

So the answer is -- and complications can happen. People can have hematomas post-op after surgery and become paralyzed, too, even if the operation goes well. So, so many things can happen.

Q Right. As spine surgeries go, would you consider this a big or large spinal surgery?

A This is a significant one. The reason being is because you have to move the muscles off the back of the neck and imagine, we make an incision to the back of the neck. We make it from what we call the C2 level and you can probably feel that spinous process all the way down in this case, to the T1 levels. So it's a very long incision.

You have to move the muscles off the spine, and you have to expose the muscles very far laterally off the spine, because you have to expose what they call the spinous process, the lamina and the facet joints. This hurts a lot. This hurts a lot.

And post-op, people are miserable because again, this is -- I mean, imagine we bruise ourselves, what happens? It hurts, but that gets better relatively quickly.

Imagine when you got to move all these big muscles off the spine. This is a real big operation.

Q Okay.

A So this is a significant one and we take very, very, very, very -- we got to be very cautious in our approach.

Q Now how many levels are you talking about taking down with this?

A Well, I took off the bones of what they call C3, C4, C5, C6 and C7. So 1, 2, 3, 4, 5. And I put screws into what we call C3.

Q Why don't we do this? What I'd like you to do is maybe come down -- we could put up the hardware X-ray and I'm going to lay the spine model out like if it would be a patient. And if you could kind of tell the jury, you know, or indicate to the jury about what you did, the things that, you know, the hardware you placed. Did you bring some examples of the hardware you did?

A I did. I did.

Q Was he laying face down?

A Here's how we did this operation just from the beginning.

Q Let me get the --

A So essentially what we do, obviously, before you do any operation, you have to go to sleep. So obviously, you have an anesthesiologist there present. Endotracheal tube, appropriate lines,

whatever, the IV lines, central, peripheral, whatever it may be, arterial lines. So someone has to be obviously I dare call it, all lined up.

You get IV fluids, IV antibiotics, medications, et cetera. You're asleep. What we then do is we then put a skull clamp onto the head, because what we do is we position them what they call prone. And what prone means is lying on your stomach.

So you essentially, we put the clamp on the head, we then turn them over so we're staring at the back of their neck, okay, like this.

So what we then do is we get into position appropriately and secure it on the operating room table. We then bring intraoperative fluoroscopy. Basically, X-rays, intraoperative X-rays into the field so we can identify the levels that we're trying to operate on.

So what we do then is I knew in this case here I was going to be operating between the C3 level to the T1 level. So we'll make our incision from the spinous process of C2 through the spinous process of T1.

So we make an incision, we move the muscles off the spine, we expose the spine. So that's what this looks like here. So spinous process, you can feel that on you. Lamina. These are the joints of the back of the neck and I'm sure maybe you've talked about facet mediated pain prior.

Q Did Mr. Yahyavi have also facet pain?

A He did.

Q In addition to disc pain?

A He did.

Q So multiple sources of pain?

A Yes, sir.

Q Okay.

A So what I then did was I exposed all the bone. I put screws in there and actually I brought a couple of them for you all just to get an idea what it looks like.

So essentially, I put screws into what they call the lateral mass of C3, C4, C5, C6 and C7. I'm sorry, I skipped C7 because I had to get what they call a T1 pedicle screw in just because anatomically it just doesn't work out well.

So I put it screws in the spine, that's what these look like here. And then basically you have a screw there and then we have a rod and then we put a locking nut on top.

MR. KAHN: Your Honor, may we approach?

THE COURT: Yes.

[Sidebar begins at 2:19 p.m.]

MR. KAHN: I agreed he could use them as demonstratives. I didn't agree he could start handing things to the jury because he happened to be in front of them.

MR. PRINCE: What's the big deal? Why can't they see it and touch it? What prevents them from doing that?

THE COURT: Well, you should at least --

MR. PRINCE: I didn't know he was doing it. But --

THE COURT: Yeah.

MR. PRINCE: -- I don't think there's anything that prevents

that.

MR. KAHN: There's nothing that prevents him from doing it after they go in to deliberate. But right now, having an expert hand them --

THE COURT: Well, they're not exhibits, so they're not going back.

MR. KAHN: -- his demonstrative -- right.

THE COURT: But if he wants to show them, I agree, you didn't --

MR. KAHN: I'm fine with him showing.

THE COURT: -- you didn't agree to that. But they are demonstrative. He can show it to them. I don't think they need to pass them around. I don't know if they're sharp or not, but I don't want --

MR. PRINCE: They're not.

THE COURT: -- anybody hurt.

MR. PRINCE: Okay. Thank you.

THE COURT: So show them. That's it.

[Sidebar ends at 2:20 p.m.]

MR. PRINCE: Okay. All right, Doctor. And so --

THE COURT: Just show them. Let's not --

MR. PRINCE: That's fine. Yeah.

THE COURT: -- pass things around.

MR. PRINCE: Okay. Yeah. No problem.

THE WITNESS: Okay. So basically, we -- I said we -- I take off the bone. So what I did then was we put -- I put in the screws

appropriately in the positions I want to put them in. And we're using intraoperative neuromonitoring, so we're using EMGs, and what they call somatosensory evoked potentials. In other words, we're checking to make sure we're not damaging anything to the best of our abilities. So I put all the screws in appropriately, and then I decompressed all the levels, and I decompressed the nerves to the best of my ability.

BY MR. PRINCE:

Q What do you mean by decompress?

A So basically, I took off all the bone here. So essentially, I did what they call a laminectomy, which means take off the bone like this.

Q Why are you doing that?

A Because I want to decompress the spinal cord.

Q You want to give it more room?

A Yes, sir. And I -- also, what I want to do is I want to give the nerves more room because remember before we talked about this man had problems in the C8 nerve for distribution on the left side. So that was at the minimum. I mean, that one was the most important one in my view.

So what I then did is I then took off all this bone to make sure the nerve was I dare call it floating in the breeze if you know what I'm saying. There was -- we want to give it room.

Q Right. And sir, in your review of the medical records, was there any evidence, even including the defense expert reports, that Mr. Yahyavi had severe ongoing neck symptoms, including arm symptoms in the C5-6, or even the C7-T1, or the C8 distribution ever before this

collision?

A It's not in the records, sir.

Q No. Okay. And so did he -- any indication he even needed any medical treatment to his neck before this collision occurred?

A Not what I saw. No.

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

A Yes, sir.

Q Okay. I'm going to have you move up now.

A Thank you.

Q So now, did he spend a few days in the hospital?

A He spent a couple days. Yeah.

Q Okay. And during the hospital course, did he have an uncomplicated hospital course? Any problems?

A Well, essentially, he -- actually, he did to some degree. He developed -- obviously, he had terrible pain. And that's no terrible surprise, at least in the perioperative period. But right after surgery he developed some weakness of his left arm.

Q Okay. Was that incidental to the surgery?

A It was related to the surgery.

Q In what way was it related to the surgery? So he developed -- so it sounds like he had another issue that developed after the surgery?

A Right.

Q Let's go to your February 14th, 2018 note. It's your first op --

post-op note; you see him in your office. And it's at 1020.

A Right.

[Witness reviews document]

BY MR. PRINCE:

Q You do the history of present illness. It says, this is a 56-year-old male who presents for a post-operative appointment. He was taken to surgery for PCDF. What does that mean?

A That's the operation I described. So that's the terminology we use. So PCDF means, P is posterior --

Q That's the back, right? Posterior is the back?

A The back of the neck. Posterior, back of the neck. C, cervical neck. D, decompression, taken off the bone, like we described. Taken off the bone, decompressing the spinal cord, decompressing all the nerves. Fusion, putting in the screws like we talked about, and bone graft material to allow for the fusion to occur.

Q So it said he had significant neck pain, as well as bilateral arm pain. He was having problems with his shoulder. The wound looks fine. The muscles are tight. He is having troubles with his left arm. He states that it is weaker now than it was. What problem developed following the surgery with his left arm?

A This is -- this is why we talk about risks of surgery. This is unfortunate. In our literature -- in our neurosurgery literature, this happens anywhere from six to ten percent of the time. And what I believe happened is -- and again, six to ten percent of the time this happens. You decompress the spinal cord. You decompress the nerves.

What happens then when you remove the bone, the spinal cord moves back. And when the spinal cord moves back, the nerves are still tethered in there, because obviously they're attached to where they're going.

So the spinal cord doesn't have to move very much, but it moves enough, and it really -- I dare call it ticks off the nerve. And when you tick off a nerve, it doesn't like it. And this is exactly what happened to this man. This man developed deltoid weakness, bicep weakness, and tricep weakness after his surgery. So multi-level nerve -- I dare call it injury, after this operation. So six to ten percent of the time. Unfortunately, he was in that six to ten percent.

Q And in your records, I note that you describe it as a neuropraxia?

A Right.

Q A C5 neuropraxia.

A It was -- I called it a C5. C5 is deltoid. It was more than that. C5 is -- it was actually multi-nerve actually. But at the minimum, C5. So neuropraxia, let's just mean -- let's just call it nerve damage.

Q Okay. So he actually developed -- incidental to the surgery, which is just the risk of the surgery, he actually developed a new problem?

A Yes, sir.

Q Can that happen in spinal surgery, even if you use the utmost care?

A Six to ten percent of the time it does.

Q And six percent -- just from doing medical malpractice and

this type of work for so many years, I mean, six -- one to two percent, or six to ten percent doesn't seem like a high percentage. But medically speaking, is six to ten percent a high incident rate?

A Absolutely right. I mean, we worry about this. This is what I worry about. And that's why again, you avoid surgery as long as you can because things happen. Despite doing what you believe to be right, and with no untoward complications per se related to the surgery itself, things can happen. And that's what happened here. It's unfortunate.

Q And this nerve injury, this multiple nerve injuries, did it affect his range of motion of his arm?

A Oh yeah.

Q Has it affected it now permanently?

A Yeah, because -- and again, I'm sure you'll talk with other people here who have seen him contemporaneously with me. He's got --

MR. KAHN: Your Honor --

THE WITNESS: -- weakness, he's got --

MR. KAHN: -- I would object and ask to approach.

THE COURT: Approach. Well, this is a good time to take a break. I was just asking my staff if -- so we're going to take ten minutes.

During this recess, you're admonished; do not talk or converse amongst yourselves or with anyone else on any subject connected with 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, radio, or internet. Do not form or express any opinion on any

subject connected with this trial until the case is finally submitted to you. We'll take ten minutes.

THE MARSHAL: Please leave your notebooks and things.

[Jury out at 2:27 p.m.]

[Outside the presence of the jury.]

THE COURT: Okay. We're on the record outside of the presence.

THE MARSHAL: Please be seated.

MR. KAHN: So briefly, you have the -- I believe that there are three reports. If I'm wrong about that, then I'd ask Plaintiff's counsel to provide any others. And in none of those three reports am I seeing an opinion that there's permanent -- what the witness said was a permanent problem with the left arm, and an inability to ever move his left arm the same way, and the shoulder problems.

He's identified neuropraxia. That's in some of the records he reviewed. But he's not opining as to lifelong permanent injuries of the arm and shoulder. That wasn't in those three reports. And if Plaintiff can find it, then fine. Otherwise, he's in violation of what the Court's rule is, that the Court --

MR. PRINCE: Well --

MR. KAHN: -- discussed with us this morning.

MR. PRINCE: -- and this is what we had a very specific discussion about this morning when we got started. Dr. Kaplan is a treating physician, as well as somebody who's reviewed expert -- or medical records. He formed these opinions during the course of his

care.

THE COURT: Wait a second. He needs to go in the anteroom.

MR. PRINCE: If you could step outside.

THE WITNESS: Of course.

MR. PRINCE: And so he doesn't have to have all --

THE COURT: Wait. Wait a second.

All right. He's outside the presence. Go on.

MR. PRINCE: And so with respect to the left arm, the neuropraxia, he diagnosed that during the course of his care. He has continued to treat Mr. Yahyavi up through March of 2019. He still has ongoing problems with the left arm, and inability to -- it says he has pretty significant pain and numbness in the left arm. That's in March of 2019. He documents the difficulty of his weakness, as well as the inability to move it fully. That's consistent with his neuropraxic injury.

So it doesn't have to be in the written report. This is part of the opinions he formed during the course of his care and treatment. I can also look for it in the reports if necessary. But as long as he formed the opinion during the course of his care, since he is a treating physician, under *FCH1* in *Pizarro-Ortega*, he's allowed to express those opinions.

MR. KAHN: So it's pretty simple. Yes, he's a treating doctor. He's also a retained expert. That six months ago he certainly could've repaired a report and told us he's opining that this gentleman has a certain future permanent damage that isn't in any of his three reports. He had an obligation to do that as a retained expert before he starting

waxing poetic about it here a few minutes ago.

MR. PRINCE: Okay. I'm -- even in his April 2018 report, which you had up, he says he suffered a C5 neuropraxic injury to the spinal cord. Unfortunately, this is a known conversation. I'm hopeful this will improve over time, albeit it is relatively recent in the post-perioperative period. He is clearly talking about that. He talks about it again, the neuropraxic injury, in his August 19th, 2018 report.

And so that is part of his ongoing issue. He still has ongoing issues. And he also has discussions regarding the spinal cord stimulator for the nerve issues. That is -- the spinal cord stimulator is to address the neuropraxia and the ongoing left shoulder issues. So it's part of the analysis.

And so it is clear that that's part not only of his expert opinion and included within that, but also, it's in his opinions that he formed in the capacity as a treating physician under *FCH1* in *Pizzaro-Ortega*.

THE COURT: All right. Well, this is your objection --

MR. KAHN: May I have the last word?

THE COURT: -- so I'll give you the last word.

MR. KAHN: My last word is essentially if counsel can find something in the records that have been disclosed from his treatment that say this gentleman has a permanent neuropraxic injury, then I will reconsider my objection. But until and unless something in writing says that, he doesn't get to say he's a retained expert, he's a non-retained expert. I can live by the rules of a retained expert, but because he's a

treating physician and he saw him six months ago, he can say whatever he wants up on the witness stand in front of a jury. That's not the way it works.

THE COURT: All right. Well, his reports, which you just handed me, are replete with references. And I'm talking -- here, page 21 of 27, where he talks about neuro -- I'm not sure I know how to pronounce it -- neuropraxia once, twice, I think three times on this one-page alone. Let me see if -- but I think I saw somewhere -- I should've just -- where he said it's ongoing.

MR. KAHN: Ongoing is one thing. Permanent is different.

THE COURT: Well, I --

MR. KAHN: Ongoing is today, Your Honor.

THE COURT: I think maybe that you could certainly argue that. But if you are saying that that's somehow grounds to exclude it, I don't think that line seems too fine to me to be drawn to exclude his opinions. Let me find it.

MR. KAHN: I would submit it --

MR. PRINCE: August --

MR. KAHN: -- but I would ask that the three reports be marked as the next court exhibit. Not admitted, but just marked so they're in the record.

THE COURT: That's fine.

MR. PRINCE: That's fine. Thanks, Judge.

THE CLERK: You'll have those for me?

MR. PRINCE: I believe the judge has them.

THE COURT: I'm going to hand them to you right now.

THE CLERK: Oh, okay.

MR. PRINCE: And when does the Court need us back here? I need five or ten minutes.

THE COURT: Ten minutes. Go ahead.

MR. PRINCE: Oh, thank you, Your Honor.

[Recess at 2:34 p.m., recommencing at 2:49 p.m.]

THE MARSHAL: Remain seated. Come to order. Department 28 is again in session.

THE COURT: You ready?

MR. PRINCE: Ready, Your Honor.

MR. KAHN: Yes, Your Honor.

THE COURT: All right. Bring them in.

[Pause]

THE MARSHAL: Please rise for the jury.

[Jury in at 2:52 p.m.]

[Inside the presence of the jury.]

THE COURT: Please be seated. Parties acknowledge the presence of the jury?

MR. PRINCE: We do, Your Honor.

MR. KAHN: Yes, Your Honor.

MR. PRINCE: Thank you.

THE COURT: Please proceed.

MR. PRINCE: Thank you.

DIRECT EXAMINATION CONTINUED

BY MR. PRINCE:

Q Dr. Kaplan, when we took our break, we were talking about the nerve injury that was associated with the surgery, the contraction of the spinal cord?

A Yes, sir.

Q The neuropraxia?

A Yes, sir.

Q And in general, does neuropraxia improve with time?

A Some do. That's why we follow people out over the course of time. We worry that it will not. And in this case, I don't think it did. Actually, I know it didn't.

Q Didn't improve?

A No, it did not. Actually, it improved to some degree. He got some strength back. But he's been left impairment. He's been left with atrophy of some of his muscles and those nerve redistributions consistent with nerve damage. So he's able to raise his arm up better than he could before, but it's not -- it's not ideal. It's not the way it was, you know, prior to surgery.

Q Okay. And so when he came back to your post-operatively, in addition, did he also have arm weakness?

A He did. That's what I'm saying. Yeah, he --

Q He had arm symptoms, right?

A Yeah.

Q We talked about that. You also document post-operatively in June of 2018, he was also suffering from anxiety. He had anxiety. You

reported it in your review. Let me show you part of your note, June 1st, 2018. Let's fast-forward six months after your surgery. Okay. That's 1039 is the date of that note. And I want to go to the review of symptoms, which is 1040.

MR. KAHN: Your Honor, can we approach briefly?

THE COURT: Yes.

[Sidebar begins at 2:55 p.m.]

MR. KAHN: I had a printout of what you were using. It went to 1,038, so I'd like to maybe check with the Clerk and see what you have. I don't have a problem with it, but I didn't have it in the exhibits.

THE COURT: Okay.

MR. PRINCE: We've gone past the --

MR. PRINCE: It's 1,039. Go back now and it's 106 -- part of 106. The next -- we have two charts. For Western Regional and --

MR. KAHN: Okay. I have one. Okay. That's fine.

[Sidebar ends at 2:55 p.m.]

BY MR. PRINCE:

Q We're now on Exhibit 106 for the record. You went from Western Regional to Las Vegas Neurosurgical Institute?

A Yeah.

Q You just renamed your group?

A We renamed our group. One of our partners essentially moved along, and he kept the names. So it's the same players, minus one.

Q Okay.

A New name.

Q All right. So your chart, just for our record and our jury, is Exhibit 105 and 106 just for the record, we're now -- I'm talking about your June 1st, 2018 note at LVNI, and I'm going to go to 1040 under the review of systems. It says, of course, neck pain, arm pain, arm weakness, but in the end it says head -- excuse me, headaches and anxiety. Do you see that?

A Yeah.

Q I mean, Mr. Yahyavi --

MR. PRINCE: -- well, strike that. Let me ask a different question.

BY MR. PRINCE:

Q Do you believe that as a result of the traumatic injuries caused by the June 2013 collision with the forklift, that he developed chronic pain in his --

A Yes.

Q -- neck?

A Yes.

Q And do you have an opinion whether that will be lifelong?

A It is.

Q Okay.

A It is.

Q And when someone suffers chronic pain, in your experience, can they -- is it common, associated with chronic pain, to have anxiety?

A Anxiety and depression, actually. I mean, I'm not a

psychologist or a psychiatrist, but I'll tell you on my day to day basis. And think about -- all of us -- all of us should think about when you have pain, it makes you very upset. I mean, I -- you know, again, I don't believe he had anxiety and depression with a formal diagnosis beforehand, but the answer is, I will tell you, chronic pain can lead to anxiety and depression. We see it all the time. It's a secondary phenomenon.

Q Okay. Associated with --

A That's what I believe it to be. I mean, if a psychologist or psychiatrist told me otherwise, obviously, I would defer to them, but you know, again, this is a common scenario all the time.

Q Right. And you see patients in chronic pain daily in your office, right?

A We see this all the time.

Q And let me look at kind of your exam findings six months later, 141, in your assessment.

A Yeah, look in the assessment and plan.

Q I am. I'm putting that there, I believe. It says his x-rays looked good, his shoulder function and deltoid function was improving to some degree. His deltoid function appeared to be good, but he's still having trouble raising his arm over his head. What do you mean by that?

A Here's what happened. So again, just to back up a little bit. Post-op, we -- I identified this. I ordered a CAT scan to make sure things are where I want it to be. In other words, you want to make sure that

there's no screws mal-aligned or mal-placed or anything like that. Fortunately, that wasn't the case. So in a situation like this, what I did was I sent him to see a shoulder doctor. I didn't think that was the problem, but sometimes when we position people on the table, we have to tape their shoulders down so we can see, and you can irritate the shoulders some. I wasn't thinking -- I didn't think that was the problem, but -- and the principle, being as cautious as I could be, I sent her -- I sent him for an evaluation. It wasn't the case, but again, it was a thought process, and you always do these things to be sure.

So I did that, I ordered a CT, I ordered x-rays. I sent him for physical therapy and occupational therapy, because I felt tincture of time would be all that we could do. In other words, with a neurologic injury, all you can do is give it time, and basically in our world, after a year or so, you are where you're going to be. In other words, if it's going to get better, it's going to get better, and over the course of time, he's better, but still, he's got some atrophy in the muscles, and he's got some decreased strength.

Q Okay.

A I mean, it's grading any gravity. In other words, in our world, we call it -- we call it a zero to five scale. It's in the four range, which is grading any gravity. You can -- you know, it can do some -- again, some degree of resistance, but it's not the same as it is on the right side. It's just not.

Q Okay. And by February -- let's go to your note of February 2019, that's Bate number 1047 of Exhibit 106.

A I'm sorry, what day?
Q December 13th, 2019. So now we're a year out from the surgery.
A December 7 of 2018?
Q No, excuse me. February. My apologies. Let me clarify the record. February 13, 2019.
A I'm there, I'm there.
Q About one year after the surgery.
A Yes.
Q I think you said a minute ago that after about a year, you're about as good as you're going to be --
A Yes, sir.
Q -- post-operatively?
A Yes, sir.
Q And did have ongoing significant neck pain?
A Yes.
Q Significant arm pain?
A Yes.
Q Did he have muscle atrophy, which is consistent with the nerve injury?
A He did.
Q The nerve injury associated with the surgery?
A Yes.
Q And now he comes to you, and he says, the last time he told me he was going to see Dr. Thalgott for an IME. Did you have an

understanding that the worker's compensation administrator requested that he go see Dr. Thalgott for a second opinion?

A Yes.

Q And is Dr. Thalgott a spine surgeon?

A He's an orthopedic spine surgeon. He's just like Dr. Perry.

Q Right. And Dr. Thalgott saw him. Did Dr. Thalgott think that his need for surgery was caused by this motor vehicle collision?

A He did.

Q He agreed with you?

A He did.

Q So Dr. Perry -- did Dr. Perry, based upon your review of the records, believe that the surgical recommendation was associated with the motor vehicle collision?

A He did.

Q And you obviously testified that way, and so Dr. Thalgott has also expressed that opinion, as well?

A Yes.

Q Now, one of the things it says here, it says, he was seen by Dr. Thalgott. It says he did have an FCE done at ATI Physical Therapy. Do you see that --

A Yes.

Q -- in your note? Okay. What's a functional capacity evaluation or FCE?

A Here's what happens in the work comp world. What we're trying to do is we're trying to sort out what "deficits" they have, and what

happens in the work comp world, they want to figure out, can you go back to work and what function can you go back to work. In other words, if you're doing X job after an injury and after a surgery, can you do that job or not.

So a physical therapist will do those procedures, and he or she will make you lift -- you know, lift a certain amount of things, do a certain amount of tests, whatever it may be. You can ask Dr. Oliveri the specifics of those --

Q Uh-huh.

A -- specific things, but essentially what happens is they're trying to figure out what you can and cannot do. So that's, in other words, objectively define what you can and cannot do. The problem is, and I've seen this before, FCEs can be determined -- can be deemed what they call valid or invalid, and it's at the discretion of the physical therapists. I tell all my patients when you go to get this FCE done, I don't care if it hurts you, just push through it. And even if you believe as though it hurts, do the best that you can because there's a subjective component and sometimes, people will say it's "invalid". And when it's deemed to be invalid, people are sometimes taken to be fakers, or malingerers, or something like that.

Q Okay.

A So I'm always very conscious of this, and I tell our patients, I don't care -- well, I don't want to say I don't care if it hurts. You know what I'm saying. In other words, if it hurts you, still fight your way through and do the best that you possibly can.

Q Right.
A Don't -- I dare call it, don't give up, even if it hurts you.
Q Yeah. And you've also discussed this case with Dr. David Oliveri, correct?
A Of course.
Q And Dr. -- if you go to page 1049 of your February 13th note, let's kind of review that. And it says -- the first sentence says, I discussed the situation with Dr. Oliveri, as well. Do you see that?
A I do.
Q Are you aware that Dr. Oliveri was the rating physician who did the apparent rating for worker's comp way back in April 2015?
A I am.
Q And there was a -- remember, an invalid FCE in 2015. Do you recall seeing that, as well?
A I do.
Q Does that mean that Mr. Yahyavi is lying or faking or anything like that?
A It's like I said to you before, I've seen so many patients where it's "invalid", and I tell the patients, it came back invalid. Either I give them restrictions going forward. I've done quite a few patients, I say, listen, let's do it again, and understand -- and then people will tell me, well, I didn't do the stuff they asked me to do because it was hurting me. So it's one of those things where different -- you know, there's different expectations of different people. In other words, the expectation of the patient versus the expectation of the, I dare call it, the examiner, and

sometimes, they're not lined up.

Q Right. And one of the other things, did you discuss with Dr. Oliveri that Mr. Yahyavi, he's vocationally disabled? You know that through Dr. Oliveri?

A I've seen it.

Q Okay. And do you agree with that assessment, even though he can do some things physically, but given his overall clinical picture, he's vocationally disabled?

A I'll defer to -- you know, I'll defer to David on the extent of that. There's no question the guy has got neck pain. He's got chronic neck pain and weakness. Dr. Oliveri has disabled him, and I'll defer to him on that.

Q Very good. Now, Dr. Oliveri, he's a physical medicine rehabilitation expert?

A Yes.

Q Is he an expert in vocational disabilities, whether someone is disabled or not disabled?

A That is what he does. In other words, he's much more qualified in that arena than I am. I will defer to David because he has the expertise in that area.

Q Now, with regard to Dr. Oliveri, is he someone that you professionally respect and know well?

A He's -- in my opinion, he's probably the best PMNR doctor in town. I mean, in other words, I would send my family to him, no question.

Q Have you co-managed patients with Dr. Oliveri over the years, when he has treated them, and you kind of participated in the care?

A All the time.

Q Okay.

A All the time.

Q Is he someone that you collaborate with and discuss patient care with?

A I trust him. I trust him. I like him. I think he's an excellent doctor. You know, look, you know, we all know, we all work with people that you have -- you know, I dare say, you have to work with. There are certain people that you believe are on the top, if you know what I'm saying. He's on the top.

Q Right. Also, it says here -- let's kind of go through the notes. I reviewed over the report from Dr. Thalgott dated November 29th, 2018. He felt the surgery was related to his worker's compensation injury. He discussed spinal cord stimulator implant, as well. Do you see that?

A I do.

Q Okay. And now we're going to talk about the spinal cord. Do you agree, or have any opinion whether or not Mr. Yahyavi needs a spinal cord stimulator?

A I recommended it.

Q And can you tell the jury what a spinal cord stimulator is?

A So a spinal cord stimulator is the only option we have for this man going forward. Essentially, I did what I dare call the definitive

operation, which was to decompress the nerves, stabilize the spine. He's been left with persistent neck pain, arm pain. The spinal cord stimulator is going to do nothing about the weakness. I mean, that's not even related because that's nerve damage. The goal here would be to help the neck pain and the arm pain.

So what we do in this situation, a lot of times we do what they call a spinal cord stimulator trial. What happens is the pain management doctor feeds the electrode over the surface of the spinal cord, and we see how it makes their neck and their arm feel. A lot of times, people are sent for psychology clearance prior, as well, but the bottom line is, we see how well it works, and if it works, we then do the implant. So it's like a two-step process.

In this case here, you can't. The reason being is the pain management doctor cannot thread the electrode from below up. The reason being is I did surgery here from C3 to -- we'll call it T1. You can't go from below, because if you go from below, you're going to nail all the scar tissue from the surgery. The pain management docs don't want to go from above because number one, it's technically very, very, very difficult, and what's the greatest risk is that you can impale the spinal cord with a needle. We don't want to do that. That's bad, obviously. That's not what you want to do.

So in my experience of situations like this, and I do have some, I've done -- I've basically taken somebody to surgery, I've done what they call a C1 laminectomy, which means take off the bone high up, and I thread the electrode with what they call retrograde behind the body of

C2. And it works very effectively in patients with intractable neck and arm symptoms, despite doing what I believe to be an appropriate surgery.

Q Okay. So I want to talk about what a spinal cord stimulator actually is and kind of how it functions. Did you bring a spinal cord stimulator and like a battery source?

A I did.

MR. PRINCE: Okay. Your Honor, can he -- Dr. Kaplan step down to demonstrate for the jury?

THE COURT: Okay.

MR. PRINCE: Thank you.

THE COURT: That's fine.

THE WITNESS: So what happens is there's an electrode that sits --

MR. PRINCE: Let me get the microphone to you.

THE COURT: Yeah.

THE WITNESS: There's an electrode that sits on the surface of the spinal cord, and it looks something like this, in the cervical region. A little shorter than this one, a little narrower, but essentially, it's an electrode that sits on the surface of the spinal cord. This is the end of it, and essentially what we do is we attach it to a battery. The battery, we generally position right near the buttock area. And nobody -- there's a lot of theories as to how it works, but essentially what you're doing is you're stimulating the spinal cord, overriding the pain signals and the pain threshold, and so basically, the body -- I dare call it a palliative

operation. What I mean by palliative is you're not fixing the problem per say, but you're changing the brain's perception of the pain, and overrides the pain signals that go through the spinal cord, up to the brain stem.

So this is a very effective procedure. We use this not uncommonly. We use it a lot more commonly in lumbar patients who we've done lumbar fusions, and they have persistent back, as well as leg issues, but I do do this, as well, in patients such as this. I think it's an excellent option for him.

BY MR. PRINCE:

Q Is it to deal with the neck pain or the arm pain, or both?

A It's both. The main -- the goal is certainly to get the arm symptoms. We may get neck benefit, as well. We may not, but time will tell in that situation, but the main goal is to help the -- what they call the radicular symptoms, meaning the nerve symptoms in the arm, but a lot of times, we do get some benefit from the neck. The problem now is, like we talked about before, he's got neck pain, and part of that is post-surgical pain, and this doesn't work for post-surgical type pain. In other words, scarring, you know, muscle damage related to retraction, et cetera.

Q Okay. Can you place the stimulator leads on the spine and kind of show us kind of generally what you'd be -- where they'd be placed and what you --

A So we're placing it up high. So in other words, we make an incision higher up than his incision, so up in this region here, at the base

of the skull. I would take off the bone, the back of the bone called the lamina of C1, and you then thread it down. So you see the yellow here? The yellow is what they call the dura, which is the lining of the spinal cord, the lining of the nerves, and we thread it down. So it sits on the surface of the spinal cord. If anything, we cheat a little bit to the left, because the symptoms are on the left, if we have to. Most times, we generally place it midline. In other words, right in the middle, but if there's any way to cheat, we'd try to cheat a little more on the left because his pain is on the left.

Q Right.

A So that would be -- that's the goal here.

Q All right. Would that be a permanent implantation?

A Oh, yeah.

Q Okay. And the goal is -- is it to improve pain and function, and help maybe the quality of your life?

A The goal of spinal cord stimulation, the reason why it was designed and approved by the FDA, is we know it improves a patient's quality of life, it reduces their pain med requirements, it improves their perception of the pain. Sometimes, patients will tell us, you know, I feel kind of like a general buzzing in the area where I felt my pain before, but it feels fine.

Q Right.

A That's really the goal of what we're trying to accomplish.

Q Okay, thank you. Has the worker's compensation administrator approved this, to your knowledge?

A My understanding -- I haven't seen him since March, and I've been recommending it for a while.

Q Okay.

A So my understanding is he went through the work comp arena. This is where things get a little confusing because, whatever, I mean, he -- my understanding is he had to see a psychologist first.

Q Yep.

A That's what work comp wanted. I have not done the implant yet.

Q Okay, but are you --

A It's possible Dr. Thalgott --

Q Are you ready and available to do that?

A I want to do it.

Q Okay.

A I mean, obviously, I did the man's surgery. Obviously, that's what -- I want to take care of him.

Q Of course.

A It's possible they may be sending him to see Dr. Thalgott. You know, they play by their rules sometimes.

Q Right.

A I don't know.

Q But regardless of that, do you believe, in your opinion, that Mr. Yahyavi is a reasonable candidate for that implantation?

A He's an ideal candidate.

Q And further, what is required to maintain -- and Dr. Oliveri

will talk about the cost of this -- but generally speaking, since you're here and you showed us the stimulator, what is required to maintain a stimulator?

A Imagine -- here's how I handle -- in other words, when I see people in the office. So I have a post-op MR, so I know behind --

Q What's an MR?

A MRI scan. I'm sorry. I know behind the body of C2, which is where I put that electrode, there's enough room, because again, the greatest concern when you do an operation like this is you can damage the spinal cord. If you damage the spinal cord up high at C2, this -- that's not a good thing. This is paralysis, can't breathe. I mean, all of these bad things if you know what I'm saying, so we won't talk about that too much, but I know he has -- anatomically, we can do the procedure.

So what I then do is I take somebody to surgery. I see them post-op that week or so later, get the staples and stitches out, et cetera, and then we get the stimulator turned on. We generally wait about a week or so because we like all of the blood products to go away, just allow everyone to recover from surgery, then we turn it on. And then what generally happens is that they -- the spinal cord stimulator will adjust the stimulation parameters in order to get the coverage to the arm that you want.

And then generally what happens is, they often continue to follow up either with myself or more commonly, someone like Dr. Oliveri, or a pain management doctor. Sometimes, it needs to be adjustments to the battery, but understand, this is a battery, and batteries, like our cars, only

last so long. And it's all based upon the degree of stimulation that you do. In other words, how much, I dare say, you crank it up. In other words, what we generally say is these batteries last -- we'll call it five to seven years on average.

Q Okay. And then you have to replace the batteries?

A Yes, sir.

Q And then do you ever have to replace the actual lead that you put on the spine?

A Fortunately enough in my experience, I've only had one or two cases like that. So if you're asking me more likely than not, do I think that he would need to have the electrode replaced, I think the answer would be no. I think, though, that if you place a battery in there, you've got to be prepared, and patients have to understand -- I've had a couple patients where it's only lasted two to three years because their pain was so significant, I dare say they juiced it up so much --

Q Right.

A -- that they had to have these batteries changed more frequently, but I think it's fair and safe to say if you place a stimulator in there, you have to assume every five to seven years, you're going to have to replace the battery.

Q Would this be something that would be -- need to be maintained for the remainder of Mr. Yahyavi's life, Dr. Kaplan?

A Yes, sir.

Q Okay.

A Yes, sir.

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

A Yes, sir.

Q According to the -- my chart is the billing from Western Regional Center for Brain and Spine is $83,557.60. That's the charge associated with your care and the surgery?

A Makes sense.

Q Are those usual and customary for the services that you provide in this community?

A Yes, sir.

Q And more than that, do you believe that those expenses were incurred as a result of the injuries suffered in the June 2013 motor vehicle collision?

A Yes, sir.

Q Are those your opinions to a reasonable degree of medical probability?

A Yes, sir.

Q And beyond that, are you certain?

A I am.

Q Very good. Your other charges, from Las Vegas Neurosurgical Institute, LVNI, are $1,750, for the services that you provided and seeing Mr. Yahyavi post-operatively at your new office, are those usual and customary charges for those services?

A Yes, sir.

Q Are those -- were they caused by the injuries suffered in the

June 2013 motor vehicle collision?

A Yes, sir.

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

A Yes, sir.

Q Very well. When I've -- we're almost done. With regard to this case, you also read all of the reports from Dr. Tung, right?

A I did.

Q And Dr. Tung, he's also a neurosurgeon similar to yourself?

A Yes.

Q And first off, in your -- when you spoke with Mr. Yahyavi, did he talk about any significant pre-existing, or any pain he had before?

A No.

Q Did you see in Dr. Tung's report, he talked about some Southwest Medical Associate's records from 2011?

A Yes.

MR. KAHN: Your Honor, I'm going to object. May we approach?

THE COURT: Yes.

[Sidebar begins at 3:16 p.m.]

MR. KAHN: That's not in any of his reports.

MR. PRINCE: It is --

MR. KAHN: It's not in the first treatment.

MR. PRINCE: What?

MR. KAHN: It's not in the first treatment, it's not in his

report.

MR. PRINCE: It's -- he read Dr. Tung's reports.

MR. KAHN: But he didn't render opinions about --

MR. PRINCE: He said he read Dr. Tung's reports, and he disagreed with them.

MR. KAHN: That's true. He read Dr. Tung's reports.

MR. PRINCE: And he disagreed with them.

MR. KAHN: But he did not read the Southwest Medical --

MR. PRINCE: I'm talking about Dr. Tung.

THE COURT: All right. One at time. What's your objection?

MR. KAHN: That he didn't review the reports he's being asked about from Southwest Medical before the accident.

MR. PRINCE: I said he read Dr. Tung's reports. He summarized it. And he does talk about that.

MR. KAHN: That I would agree with.

MR. PRINCE: And I'm talking about using Dr. Tung's commentary.

THE COURT: Are you saying he didn't read the Southwest Medical from 2011?

MR. KAHN: Correct.

MR. PRINCE: I'm saying he read Dr. Tung's reports who comments -- who discusses that. And he kind of deals with responding to Tung, and how he disagrees with Tung. So I'm using it in that fashion. He didn't summarize specific --

THE COURT: And you agree -- the Defense you agree that he

did read Tung's report --

MR. KAHN: Right.

THE COURT: -- and comment on it?

MR. KAHN: I believe that's in there, yes. That's fair.

THE COURT: Well, I'll let him comment on Dr. Tung's report.

MR. KAHN: Okay.

THE COURT: Where is it, for that matter? Do you know offhand?

MR. KAHN: In there, no.

MR. PRINCE: It's in there. He read his reports in there.

MR. KAHN: It's going to be towards the end on this. It's going to be the last --

THE COURT: All right. Well, if you are agree --

MR. PRINCE: I'm not going to spend a lot of time on it, but --

THE COURT: -- he read Dr. Tung's report, then he can comment on what Dr. Tung said.

MR. PRINCE: Yeah.

THE COURT: That's --

MR. KAHN: Okay, I just want to double-check, because I -- I just got these because of these rulings.

MR. PRINCE: That's part of it, that last paragraph.

THE COURT: Well, the paragraph before is really what precipitated the paragraph. I do note the independent medical exam neck --

MR. KAHN: I'm fine with him talking about Dr. Tung. I don't

want him talking about the records that he never reviewed for the first time --

MR. PRINCE: No, I'm just going to use -- I'm going to use Tung.

THE COURT: All right.

MR. KAHN: That seems fair.

THE COURT: All right.

[Sidebar ends at 3:19 p.m.]

BY MR. PRINCE:

Q All right. You read Dr. Tung's reports?

A I have.

Q And you talked -- he summarized a bunch of care. You reviewed that, right?

A I did.

Q And he commented on some 2011 Southwest Medical records. He reviewed, summarized that and commented on it, right?

A He did.

Q All right. Based upon your review of those records, understanding of the treatment of Southwest Medical, that there was an isolated complaint of neck complaints for a -- it says a period of years in the 2011 records from Southwest, but nothing after that date, do you believe that there was any ongoing symptoms that predated this June 2013 motor vehicle collision that would explain the onset of these symptoms in the neck and the arm, for which he underwent surgery?

A No.

Q Based upon -- is that your opinion to a reasonable degree of medical probability?

A Yes, sir.

Q If someone were to have multilevel discogenic pain, like you've diagnosed Mr. Yahyavi as well as facet joint paint with the abnormal range of motion?

A No.

Q Would there be recommendations in your experience for either -- for like physical therapy, chiropractic treatment, pain management, or even a surgical recommendation if it was significant ongoing complaints for years, affecting your condition?

A Yeah, to be clear, if someone comes to a primary doc and has significant -- these are hypotheticals here. Any patient. And comes to see their doc and says, look, my neck is killing me, whatever it may be. In my experience there are medications. They're sent for physical therapy, and/or chiro. An MRI scan is ordered. They're sent to pain management. They're sent to a surgeon. And they have stigmata of the problem.

In other words, they're generally on some medication. Whether it be muscle relaxers. Some pain pills, we'll call it. Whether it be narcotics or non-steroidals. They'll have some clinical stigmata, consistent with such. In other words, range of motion issues. Those kinds of things. Neurologic deficits. Obviously if someone's got arm issues, you would hope and expect that their primary doc would document such.

Q Right. And in this case, in your review of the -- from Dr.

Tung's reports and those actual medical records, was there any ongoing consistent neck complaints prior to 2013, including arm symptoms?

A No, and my understanding -- and I have Dr. Tung's report here in front of me here. My understanding is that he saw Dr. Tung -- I'm sorry, he saw his primary doc at Southwest Medical. The doc saw the person -- saw him, ordered some x-rays, and then he continued to see Southwest Medical over the course of time, and nothing else happened.

Q Okay. Was there any -- if someone -- if someone has multilevel discogenic pain and facet pain, would you have normal range of motion?

A No. You can't.

Q Okay. Why not?

A Because --

Q If it's symptomatic?

A -- your facet joins are inflamed, they're irritated. When you have discogenic problems, you're going to have -- you're going to have impaired range of motion. You're going to have spasms. Decreased range of motion. Just has to be.

Q Right. And Dr. Tung's -- given his own defense analysis, Dr. Tung, hired by the Defense, does he say that given the pain, that Mr. Yahyavi was suffering from pre-existing neck symptoms up until the time of the accident?

A He doesn't say that. All he says is that the reason for the surgery was related to degenerative changes. That's what he says.

Q Right. Do you believe that -- did you do the surgery solely

because of the degeneration?

A No, of course not. And not only that, remember we talked about earlier today, you can have degenerative changes in your x-rays, but have no symptoms, because we all have degenerative changes. What I found interesting too is that what Dr. Tung stated in his report, the two main things I noted were he said it's because of degenerative changes, because he had degenerative changes. And then number two, he said the treatment was reasonable for 14 months. So to me, 14 months he was doing all the stuff. He was doing injections. He -- he saw a surgeon then, too. The surgeons were talking about surgery there, too.

It seems to me, if you think it's a sprain -- we'll call it -- dare call it a sprain-strain, normally the treatment for that are things like chiropractor or physical therapy for three to four months. Maybe an MRI scan, but no injections. No evaluation by surgeons. Things like that. So he stated the first 14 months were related, but to me that seems inconsistent.

Q Okay. And I want to kind of talk about -- let's just -- that 14 month window, just to use that for a minute. Number one, in that 14 months, was Mr. Yahyavi consistently symptomatic, significantly in his neck and his arm?

A Yes.

Q Okay. Did -- was there any period of time those symptoms resolved in the 14 months?

A No.

Q During that 14 month window, did he have any spinal

injections?

A He did.

Q Would you do any type of injections, if you have simply a soft tissue self-limiting strain?

A That would be malpractice.

Q Okay. So you don't think --

A The answer is no, we don't do that.

Q Do you even order an MRI if it's a self-limiting soft tissue strain?

A Generally what happens if something is a soft limiting -- self-limiting sprain/strain, it tends to get better within three or four months. Your range of motion will be back to normal. You'll be back to normal. There's no reason to get an MRI scan, because you're back to normal.

Q And Dr. Oliveri testified on Friday that duration of pain of six months or longer would be characterized as chronic.

A I use a little less -- I use a little less. I say about four to six. So that's fine.

Q Okay.

A Six months is fine.

Q So this is the outermost time period.

A Yes, right.

Q That's using the outermost time period in medicine of six months, and at -- after six months, even by Dr. Tung's analysis, Mr. Yahyavi's already in chronic pain, right?

A Yes, sir. Yeah.

Q And so that's not consistent with a soft tissue self-limiting injury, right?

A No, it's not.

Q All right. And one final thing on this point. Looking -- let's look at Dr. Archie Perry's record of July 7th, 2014, which would be within that 14 month window?

A Yes, sir.

MR. PRINCE: 294. Exhibit 91, big number 294. I'm going to put it up there for you. Greg bring me the date and then the second to the last paragraph.

BY MR. PRINCE:

Q We looked at this earlier, but I want to just dial in the timeframe, okay. The 14 months. Our event happened in June 2013. Okay.

A Yes, sir.

Q Dr. Tung says the treatment and the symptoms for 14 months are reasonable.

A Yes, sir.

Q And within that 14 month window, it says Dr. Perry and I do believe the patient would benefit from a cervical intervention directed at Level C3-4 C6-7. Do you see that?

A I do.

Q Would you ever recommend a multi-level spine surgery for simply a soft tissue injury?

A Again malpractice. You don't do that.

Q Right. And at any -- do you believe that the picking of 14 months, do you think that's arbitrary based upon your other opinions and conclusions in this case?

A I do. I think what happened was he saw a note, and they were talking about surgery, and then he decided not to have it.

Q Yeah.

A And I think that -- I suspect that's where he -- must be another note away. In other words, at 14 months, Dr. Perry then must have discussed surgery. He didn't have the surgery, so, therefore, that's where he drew the line.

Q Okay. Yeah. Let's look at -- let's look at that for a minute. We're going to go to the November 10th, 2014 note of Dr. Perry.

MR. PRINCE: That's big number 299 on Exhibit 91.

BY MR. PRINCE:

Q Let's talk about this, as the patient returns. Since his last visit he's seen Dr. Schifini and undergone some facet injections. He had a 33 percent reduction in pain. Little bit more relief. Then he says in this: "Overall I reviewed the patient's diagnostics, as well as his injections. In my opinion, I do not feel confident that surgical intervention will result in any significant clinical improvement of this patient. I have recommended the patient follow-up with pain management. In fact transfer of care and obtain additional non-operative treatment." Do you see that?

A I do.

Q And based upon your education, training and experience,

and the way this note is written, does it mean that he's not surgical?

A I don't think so. I think the man was surgical the whole time.

Q Right.

A And I think what happened was that Dr. Perry and Dr. Schifini were doing a variety of injections. Some were helping him, some were not helping him there. And I think he -- I think Mr. Yahyavi stated he was apprehensive about surgery.

Q Right.

A And I suspect what probably happened is Dr. Perry and Dr. Schifini, and I hear Dr. Schifini, I heard you say today, he can talk about the specifics of the conversations he's had, but I can imagine the man got pretty frustrated here, and said look, you had these nerve blocks done, you got this much benefit. You had the facet blocks, and you got this much benefit. So I think Dr. Perry probably said, look, I just can't guarantee how much better you're going to get. And he probably said, well, then why should I have the surgery if you can't guarantee it to me.

Q Right.

A And that's what I think I would do if I was him. But that's my -- that's my -- in reading the records, that's kind of my take of the gestalt of the conversations that appeared as though they occurred.

Q Yeah. And I mean, obviously, he's talking in the final paragraph about he's limited at work, right. It says the duration of time, I can't really work greater than 6 to 8 hours a day. He's having difficulty working, even in 2014.

A Yeah, I mean to me the month -- a couple of months before

he's recommending surgery, or saying we've got a surgical problem, now he said -- now he's backing up a little bit. And I think what's happened is, you know, I dare say he did all these injections, and he's trying -- you know, I'm sure Mr. Yahyavi is like how much better do you think I'm going to get. And I think Dr. Perry then said, look, I just don't know, you've got a lot of things going on here. In other words, you have facet media pain, you have discogenic pain, you have arm pain. I just don't know. And I think that's when he said, look, let's just hold off.

Q Right.

A I mean understand, too, I did surgery, and look what's happened, with all due respect. You know, the guy had neck and arm pain. I thought I did what was right, and now he's got weakness and pain. So --

Q His picture is complicated as a result of his injuries. Would that be fair to say?

A I think that's very fair.

Q Okay. In your opinion, will Mr. Yahyavi, for the duration of his life, suffer pain, limitation, as well as -- in other, physical neck pain, but also nerve pain, for the balance of his life?

A Well, you know, it depends again. If we do the stimulator, I think we can palliate him to some degree. Again, he's not going to be perfect. I think -- but I think potentially we can make him better than he is today.

Q Okay. And is there any certainty that a stimulator would help at all?

A That's -- no, it's possible. And like I told you before -- or at least I told him, I said, look -- and I told the jury earlier. Normally we do a trial first to see if it works. If you do the trial, then we do the implant, but we can't -- in this case we can't try it out first. In other words, we can't do a trial basis first, because you physically can't do it. So it's possible -- possible, I think it will help him, but it's possible you can do it, and it may not help.

Q Okay.

A It's true.

Q Or it could get worse, right? He could have another complication with this -- with the placement of the stem.

A I hope not. I mean potentially, I -- you know, like I told you before the complication that occurred to him, happens six to ten percent of the time. In our world large, but not greater than 50 percent, like in your world there.

Q Yeah.

A But what I'm saying is it's possible -- it's possible it could be worse. I don't think that's likely, but it's possible.

Q Right. And even with the stimulator will he -- in your opinion, will Mr. Yahyavi remain symptomatic in his neck and his arm, for the duration of his life?

A No question. Like I told you earlier, the goal is to make the arm better. We might get some neck benefit there. I wouldn't bet it. I wouldn't bet on it. But -- are those your opinions to a reasonable degree of medical probability?

A Yes, sir.

Q All right. Very good.

MR. PRINCE: Your Honor, thank you. I don't have any additional questions. I pass the witness.

THE COURT: Cross exam?

CROSS-EXAMINATION

BY MR. KAHN:

Q Good afternoon, Dr. Kaplan.

A Hi, there.

Q My name is David Kahn. I'm the attorney for the Defendant, Capriati Construction. You and I have never met, correct?

A No, we've not.

Q I've never retained you for another case, right?

A No.

Q You've never had reason to come to my law office, for any reason, correct? For any professional reason other than maybe a deposition or two?

A I don't even know what your office is, to be truthful.

Q That's even better.

A I've never seen your face. I don't -- I don't know who you are to be honest with you.

Q Mr. Prince, how many times have you worked with him?

A I don't know. And here's --

Q Give me your best estimate, please.

A I can't. And I'll tell you why. Here's the issue. Mr. Prince, I

know, used to work with Mr. Eglet. And they have a different kind of practice. And Mr. Prince is in the kind of practice where people will be injured, they'll have -- they'll have an attorney. I'm more than happy -- and I see all different types of patients, so I see personal injury patients. And a lot of times after people have treatment, or whatever it may be, and Mr. Eglet's and Mr. Prince's firms have been hired. So in other words, they're like a lawyer to the lawyers. So have I worked with, as Mr. Prince's firm previously asked me to look at cases, or have I've seen cases that he's representing, absolutely. The numbers, I just can't tell you. I just can't.

Q Okay. Now the Plaintiff told you that he was going 30 miles an hour at the time of this accident; didn't he?

A I didn't -- I'd have to look at my first note there. I think --

Q Well, I can help you if you want.

A Okay.

Q Let me pull up an admitted document. And if you could highlight the handwritten portion above the diagram.

A I see what you're saying. Yeah.

Q Okay. Are you able to read that handwritten sentence at the top? Are you able to read it?

A I can.

Q Can you please read it out loud, so the jury can hear what it says?

A So when he saw me, we ask patients to fill out intake forms. And one of the intake forms we ask them to fill out is something like this

one. And then basically, where he describes the accident in detail. And it says ran into a forklift with -- I can't read what that word says. Something forks at 30 miles an hour.

Q Would that be erect?

A Could be. And then he's drawing a picture. And it looks like you've got a circle with what looks like to be forks So he says a forklift, and he's describing his car. And it looks like an arrow going forward. That's my take. That's the best I got.

Q Okay. So as part of his documentation to your office, he represented to you that he was going 30 miles an hour when this accident happened, correct?

A That's -- that's what it says.

Q What did Mr. Yahyavi tell you about whether he was a smoker or not, when he came to see you?

MR. PRINCE: Objection. Relevancy.

THE WITNESS: It says over here.

THE COURT: Wait, wait, counsel, approach.

MR. KAHN: I can lay a foundation, Your Honor. I'll withdraw it and lay a foundation.

THE COURT: All right. Go ahead.

BY MR. KAHN:

Q Dr. Kaplan, is smoking a risk factor for degenerative disc disease?

A It is.

Q So is it important to you in treating somebody with

degenerative disc disease, to know whether or not they're a smoker?

A Yes and no. The more important thing when we deal with smoking issues, look we all have vices, and I try not to be judgmental if you know what I mean? The older I get the less I am. We all are. Smoking, when I deal -- when I deal with patients who are smokers, I tell patients smoking interferes with bone fusion. Smoking also interferes with wound healing, and you're a higher risk for infection. So those are the things I worry about in our smoking patients. But to answer your question, smoking -- patients who smoke can have enhanced degeneration, that is true.

Q Okay. So if this gentleman were a smoker, you would expect there's at least a medical probability that he could have enhanced degeneration over the course of his life?

A As compared to non-smokers, yes, sir.

Q Correct. And what did he tell you about whether or not he smoked? You ask every patient that when they come to see you, right?

A Well, it's part of the form, actually. So what happens is they'll check off yes or no.

Q And what did he check?

A My form says never smoker.

Q Never a smoker. So Mr. Yahyavi, the Plaintiff in this case told you, or your office staff, that he was never a smoker his entire life, right?

A Well, he didn't tell anybody. I'm going to tell you what likely happened is they fill out -- I dare call -- we call it a yellow form, like an

intake form, so he checks off non-smoker.

Q Do you take a personal medical history verbally from a patient when they come to see you?

A Yeah, so the history -- in other words, if you look on the first encounter where it says history or present illness, that's what he's telling me. The other stuff here, in other words, that his mother's deceased and his father's in good health, I'm not going to ask him that. I'm just not going to. I'm not going to ask him about his HIV risk factors either. It's just not relevant.

MR. KAHN: Give me one second. Excuse me, I'm looking for a specific document.

BY MR. KAHN:

Q Can you check your records? Your encounter number one, 10/12/17; can you please look at that record? You have his records with you, correct?

A I'm staring at it, but my encounter number one was 8/11 of '17, so I'm confused what --

Q You have bates P001016?

A Oh, that's not my first encounter though.

Q Okay. I'm looking at that document. On the top it has the word encounter, then a little number sign and hashtag then one.

A Oh, you're right actually. That's interesting. I apologize for that. Yeah, obviously the computer didn't do its thing. It should be two.

Q Okay. So that's the second encounter, but it says encounter one, right?

A You're right. You're 100 percent right.

Q Okay. Well, that's fine. Just understand the jury is -- this is all new to them, so I need to make it clear. Do you see, if you go about a few inches down, it says social history?

A Yeah.

Q Can you read the words after that in the parenthesis?

A It says -- here's what happens, when you --

Q Can you please read the words in the parenthesis? That's the question, sir.

A It says, Stuart Kaplan, M.D. That's me.

Q Right. Does that mean you made that notation?

A No.

Q What does it mean?

A These are EMR, so the jury understands, these are EMR records. I'm going to tell you, I never talked about smoking with this guy again.

Q Okay.

A These things are going to follow through. In other words, we have EMR records. Everything is electronic medical records here. Data is input. Patients will check off things on their intake form. It goes into a template and it's then now EMR formats for the government. In other words, we're all -- the government is watching. So bottom line is I never talked about smoking again. It's just not going to happen.

Q But the information provided to your office was that he was never a smoker, right?

A On the first visit, yeah.

Q And that didn't change, as far as you know, in your other records?

A I never would have asked again, to be truthful. It may -- it may -- it may carry through record after record after record because that's the basis of electronic medical records, but I'll tell you as a fact, I'll never ask him again.

Q He also told you nothing else ever happened to his neck, didn't he?

A That's my understanding.

Q If you look at P001023.

MR. KAHN: I'll help her to pull that up. If you could highlight the last two lines or the end of the second to the last line and then the last line on the bottom. That's fine. That will work. We don't need the whole thing, just the last two lines is fine. Thank you. And can you highlight this part? Are you able to do that? Yeah, that next part, yes.

Q So that says, "He tells me nothing else happened to his neck apart from this," doesn't it?

A Yep.

Q So your information about Mr. Yahyavi wasn't just based on generic history that was provided to your office, this is a notation that this patient, this Plaintiff is telling you directly he never had another issue with his neck, right?

A The way I'm looking at the note there is, you know, appreciate, this is a long time. In other words, I saw the man initially in, I

think it was August of '17. The acts that you're talking about is June of '13. That's four years later. He tells me Dr. Perry talked about surgery with him, and I think what that really means is nothing else happened in the intervening time. That's how I read it.

Q That's not what that says. That says he told you nothing else happened to his neck. Isn't that a part from this? Isn't that what he told you?

A I guess if you -- I guess I see how you're looking at it. I guess nothing else happened -- I guess you would have to say also beforehand too. I guess that's fair.

Q On November 18, 2017, the Plaintiff failed to call back to schedule an appointment he was supposed to schedule with you; isn't that right?

A Say that one more time.

Q November 18th, 2017, he was supposed to schedule some other kind of appointment and he did not?

A I don't know.

Q Okay.

MR. KAHN: I'll withdraw that one.

BY MR. KAHN:

Q What -- you ask your patients whether they play contact sports or have played contact sports; isn't that correct?

A It's -- I don't ask them. It's part of our standard form. In other words, it's part of our standard intake form, what level of sports you've played. I don't know why it's there to be truthful. It's been there

for the last 15, 20 years since I've been here.

Q And why is that important?

A In some ways, yes. You know, the problem is if you played contact sports in your life, I don't think it matters, to be honest with you. I think it's a dumb question.

Q Do you know whether or not Mr. Yahyavi did play any contact sports?

A I don't recall. I think it's a dumb question to be honest. We probably should remove it, but what can I tell you? It's been there for 15, 20 years.

Q Well, somebody who plays football for a number of years, they're more likely to suffer spinal problems than somebody who never plays a contact sport; isn't that fair?

A You're talking about back or neck?

Q I'm talking about anything with the spine. If you're smashing your head into other people who have helmets on, your spine is going to be in worse shape than people who never do that; isn't that fair?

A Potentially. I think that's fair, potentially.

Q How do you -- you said you define chronic pain as four months?

A Greater than four to six months, yeah.

Q And isn't there a standard in your profession that it's -- that other people believe it's six months?

A Some people say greater than three. I use four to six. I'm not going to quibble over six.

Q Okay. Six would be the -- like the rehabilitation society or something like that?

A I don't know what the rehabilitation society says. I'm a neurosurgeon. I tend to say four to six months. I think most of us believe that.

Q And then --

A If you want to say six months, I'm fine with that.

Q And that's based on subjective pain reports from a patient, correct?

A Pain is subjective.

Q All pain is subjective?

A You're right.

Q If I told you this arm was hurting ten out of ten, and this arm was hurting zero out of ten, and I was telling you -- and really it was the opposite, this arm hurt ten out of ten and this arms hurt zero out of ten, and you felt them, looked at x-rays, looked at MRIs, palpated them and couldn't feel spasms or muscle tightness, you wouldn't know which was correct? You wouldn't have any way to backstop me; is that correct?

A You have to look for objective signs of correlative symptoms. In other words, you look for things that seem to make sense. But if you had no spasms, full range of motion of neck and you said you had neck and arm symptoms, number one, ten out of ten, I tell our patients ten out of ten means you're ripping my arm off. In other words, you're four quartering me.

So -- but the problem is different patients have different

perceptions of pain. I can view the same pain stimulus as a three and you can view it as a seven, or vise-versa. I had a marine once who told me the pain was a three and he was miserable. I did surgery. I got him down to a one to a two, and he was thrilled. His wife said it was a nine. You know what I mean?

So everybody's perception is different. That's the problem with pain scores. But you have to look for objective signs that make sense. You can't just take someone's word for it like that.

Q So medicine, as sophisticated as it is, has no real way to measure pain; is that correct?

A We cannot measure it internally. In other words, we don't have the ability to look in someone's brain and say -- you know, and look at the pain signals, if you know what I mean, and identify it when talking to a patient in the office. It just don't happen.

Q So if a patient says they are a ten out of ten, and they're not ten out of ten, you have no way to confirm that or determine that it's incorrect, right? You have to take their word for it?

A Well, we have to take the patient's word for it in general because again, as we talked about before, history is the foundation for what we do. We look for things that corroborate that history.

Q So if a patient were to say I have had neck pain for several years. By your definition that you just gave of chronic pain of three to six months, that patient would have chronic pain; isn't that correct?

A If you have pain that lasts for three years continually, the answer is yes.

Q Okay. Well, that's not what you said before. You said an excess of three to six months, correct?

A Yeah, but --

Q So if a patient is a --

MR. PRINCE: Objection. Objection. The witness wasn't finished with his response.

THE COURT: Go ahead and answer.

THE WITNESS: If you have pain that lasts continually for three months, there's a difference between on and off pain there too. In other words, you can go to the gym, hurt your neck or tweak your neck, you can have pain for a day or two or three, whatever it may be, and the pain goes away and then you go back the next month, the same thing happens, the answer is -- we're talking about continual pain.

BY MR. KAHN:

Q If a person has continual pain for years in their neck, it is chronic pain, correct?

A Yes.

Q So if this patient -- this Plaintiff, Mr. Yahyavi, had pain in his neck for years, before this accident, 21 months before this accident to be precise, he would have had chronic pain prior to this accident; isn't that correct?

A Based on your -- what you're describing, yes.

Q Okay. What about the functional capacity exam? You agree that he had an invalid functional capacity exam?

A He did.

Q That a physical therapist determined when he was trying to figure out what jobs Mr. Yahyavi could do, that Mr. Yahyavi's effort in that test was determined by the physical therapist to be essentially subpar, inadequate; isn't that right?

A That's what I said.

Q So had you rendered an opinion before today in any of your written reports that were disclosed as to whether the Plaintiff was able to work again in his life?

A I don't think I wrote that because, number one, I know Dave Oliveri is a PM&R doctor, physical medicine and rehabilitation doctor. I know he was here the other day and I know he's coming back. He is much more qualified to discuss those issues than I am.

Q But your opinion is in line with his. You think Mr. Yahyavi can never work again?

A I'm going to defer Dave Oliveri in terms of his opinions on that issue.

Q What do you know about Stephen Hawking, the famous scientist?

A We all know -- I think he recently passed away, unfortunately. There's no -- the guy obviously was a genius, and obviously we all know he has been wheelchair bound for I don't know how many years.

Q Right.

A Second -- I believe it was ALS. So obviously his -- he is a -- he's on the far end of the spectrum, I dare say. With regard to what he can and cannot do, I'm going to refer to Dave Oliveri.

Q What about osteophytes. Can you explain to the jury what osteophytes are, please?

A Osteophytes are basically growths of bone, that's basically bone. It's bone. It's part of the -- I dare call it the degenerative process.

Q Osteophytes don't occur spontaneously in the event of a traumatic injury, right?

A No, they occur over time.

Q So if Mr. Yahyavi had osteophytes documented in x-rays -- well, let me back up. Your testimony here for the Plaintiff's attorney about the Southwest Medical records, the records relating to this Plaintiff before his accident were based on your reading of the Defense expert neurosurgeon, Dr. Tung's, reports and opinions in this case, right?

A I have a -- yeah.

Q You have not ever seen the Southwest Medical associate's records; is that correct?

A No, I think I have actually.

Q Well, they're not documented in any of your reports, correct?

A No, it's not in my report. I think they were sent over by Mr. Prince's office. I haven't written any additional reports since the time of Dr. Tung's record.

Q Okay. You didn't document in your reports that you reviewed those records, correct?

A I have not written any reports that stated I did.

Q And how many times have you served as an expert witness in Clark County roughly?

A I don't know, plenty. Many.
Q More than 100?
A I doubt that.
Q More than 50?
A Probably.
Q And you understand the rules for being an expert in this state and this county require that you disclose whatever materials you relied on to render your opinions, otherwise there are repercussions, correct?
MR. PRINCE: Objection. Objection. Legal -- concludes a legal opinion. Lacks foundation for this witness on the statement of the law, what the rules require.
THE COURT: I'm going to sustain it. I don't --
BY MR. KAHN:
Q You understand that you had an obligation -- sorry.
THE COURT: -- know that that is --
BY MR. KAHN:
Q You understand you had an obligation to disclose and identify any records upon which you are relying upon to form your opinions at this trial; is that correct?
MR. PRINCE: Objection. Form. Foundation as to the form requirement for a treating physician, Your Honor.
THE COURT: I'll allow the question.
THE WITNESS: I'm not a lawyer, so I can't answer these legal type issues. Here's what I'll tell you, in my experience, binders of records are sent over to me to review. Sometimes I'm asking to actually

write a report. Sometimes they're sent over, I dare say for my information only, and I'm not asked to write one, and that's of the discretion of the attorneys who are sending the records over for whatever reason that they do. I know I've seen these records before, but I was not asked to write another report on them.

So the answer is I didn't. Now, I will tell you, you never deposed me, so we never talked about it beforehand.

BY MR. KAHN:

Q What is the affect -- what can the affect be of osteophytes on a cervical spine over the long term?

A Anywhere from -- obviously, we talked about it earlier. You can have osteophytes. Just because you have nerve or compression on an MRI scan, once again does not believe that you're symptomatic from such. So the answer is it may do nothing. But again, you do have compression there, and it, by definition it's chronic, generally in patients like that, you've got to set the inflammatory cascade to become symptomatic. But the answer is anything from nothing to symptoms.

Q But Mr. Yahyavi's documented in a cervical x-ray in 2011 to have had osteophytes along his cervical spine and those same findings show up after this accident, that isn't something that this accident caused, is it?

A No. I mean, as we -- I think we said earlier, there's no question this man had pre-existing -- pretty extensive degenerative changes prior to the accident we're talking about. No question.

Q Same with the reversal of lordotic curvature. If this

gentleman is determined in an x-ray in 2011 to have had a reversal of the lordotic curvature, then that was already in place prior to this accident and this accident didn't necessarily cause that condition, right?

A It has to do with how you position patients there too, whether or not they're lying down. There's so many factors there. I don't look at that one too much. Really what I look at is the x-ray itself per say.

Q What about --

A It's -- that's too nonspecific.

THE COURT: All right. We're going to -- sorry, counsel. We're going to take a short recess.

During this recess, you're admonished do not talk or converse amongst yourselves or with anyone else on any subject connected with this trial, 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, radio or internet. Do not form or express any opinion on any subject connected with the trial until the case is finally submitted to you.

We'll take ten minutes.

THE MARSHAL: Please leave your notebooks and pencils. Rise for the jury.

[Jury out at 3:53 p.m.]

[Outside the presence of the jury.]

THE COURT: All right. We're on the record outside the presence. Steve was concerned --

THE WITNESS: Do you want me to go over there?

THE COURT: No, this isn't about you. Again, with juror number 3 who appears to be very tired.

MR. KAHN: Okay.

THE COURT: So we're taking a break. What are the likelihood that we're going to get this witness completed by tonight?

MR. PRINCE: This witness is going to be completed in 15 or 20 minutes. Mr. Arbuckle's not going to miss another day of work. He's missed four, so --

MR. KAHN: Well, I don't know, I mean, well, he's under subpoena, Judge, so he's -- if we don't get to him, he'll be here first thing in the morning to do it.

MR. PRINCE: He's missed four days of work. He's sitting out here. I'll finish this witness quickly and then Mr. Arbuckle's going to go.

MR. KAHN: Well, I'll have a little bit of redirect, but we've got a -- okay.

THE COURT: All right. We'll see what happens. Take a break. Ten minutes at the most.

[Recess at 3:55 p.m., recommencing at 4:05 p.m.]

[Outside the presence of the jury.]

THE CLERK: Mr. Prince, are you stipulating.

MR. PRINCE: Yes, I'll stipulate.

THE CLERK: Okay. So I'll admit them.

THE COURT: All right, ready? Bring them in.

THE MARSHAL: Please rise for the jury.

[Jury in at 4:06 p.m.]

[Inside the presence of the jury.]

THE COURT: Please be seated. The parties acknowledge the presence of the jury?

MR. PRINCE: Yes, Your Honor. Thank you.

MR. KAHN: Yes, Your Honor.

THE COURT: Counsel, approach.

[Sidebar begins at 4:06 p.m.]

THE COURT: I should have asked you this in the break, what does Suarez do? We've got to keep him awake. We lose him, we're down to one.

MR. KAHN: I think he's --

THE COURT: We're only -- we've got two more week.

MR. KAHN: I think he's retired.

MR. PRINCE: I think he's just -- he might not be sleeping, he might just be sitting there with his eyes closed just listening. I don't know. He usually opens them up.

MR. KAHN: Yeah, we'll keep an eye on them.

THE COURT: I don't know.

MR. KAHN: I'll keep an eye on him.

MR. PRINCE: We'll both keep an eye on him.

THE COURT: I'll try to -- okay.

MR. PRINCE: Okay.

[Sidebar ends at 4:07 p.m.]

THE COURT: Continue.

BY MR. KAHN:

Q Dr. Kaplan, I've put in front of you Exhibit FF - sorry, Exhibits FFFF. It's a two-page exhibit from Valley Hospital from the surgical records.

A Okay.

Q Are you able to take a look at them? Just let me know once you've looked at them.

A I'm there. It looks like a physician's --

Q I'm sorry. Is it four Gs? It's four Gs if you flip the tab backs.

A Yeah -- number 8, you put me there, yes.

Q Okay. And does that document not indicate that the hospital felt that Mr. Yahyavi was at moderate risk for smoking?

A I don't know where you're looking, but I can see --

Q If you look under tobacco, kind of down towards the bottom of the first page.

A It says here -- it says, "social history, smoking history, former smoker."

Q Right.

A It says, "former smoker", is what it says.

Q It says, "former smoker". So that's the opposite of what your records say, correct?

A Somehow it became in my form -- it says, "never smoker". I can flat out say I doubt I talked to him about it, but it says former smoker. It stands --

Q The question to you is, former smoker is the opposite of

what your records that say, "never smoker", correct?

A Former smoker's different than never smoker, yes, obviously.

THE CLERK: Mr. Kahn, is your microphone on?

MR. KAHN: I thought it was, but I'll try to turn to turn it on. I think it is.

BY MR. KAHN:

Q Dr. Kaplan, you've been disciplined by the Nevada State Board of Medical -- the Nevada State Medical Board, correct?

A One time, you're right.

Q And part of that discipline involved medical record keeping?

A Yeah. I mean, here's -- here's the details -- I mean, are you asking me the details?

Q No, I'm not. I'm just asking you did part of that discipline involve the medical record keeping?

A It's a little too simplistic than that, but the answer is that's -- I had an attorney involved. If you want to know the details, I will tell you, but that's what I, quote, "pled to". It was ridiculous to be truthful.

Q Do you think Plaintiff had arthritis before this accident, yes or no?

A Of course.

Q And do you think that the Plaintiff had degenerative disk disease before this accident, yes or no?

A Yes.

Q Okay. So he had arthritis; he had degenerative disk; he had osteophytes, he had all those things, correct?

A Yeah.
Q And are you blaming the autofusion of the spine on this accident alone?
A Of course not.
Q So --
A You're talking about the autofusion at C6-7, specifically?
Q Correct.
A That was preexisting.
Q Okay. So just so the jury understands, when you say as a doctor that it's preexisting, you mean that condition was in place in Mr. Yahyavi's body before this accident, correct?
A Yes, sir.
Q How do you define the word "symptomatic"?
A Symptomatic means that you're having clinical symptoms consistent with whatever pathology you're talking about.
Q So when you say something's asymptomatic, you're saying as a doctor that you haven't identified any symptoms?
A There's no symptoms.
Q And for pain, whether somebody is symptomatic or asymptomatic depends almost entirely on their representation to you as to whether they have pain or not; isn't that right?
A It's -- again, as we talked about earlier, pain is subjective, but you look for objective findings consistent with such.
Q Again, Mr. Prince asked you about this, Dr. Tung has essentially the same qualifications you do, correct?

A He's a neurosurgeon, yes, sir.
Q Do you hold any professorships right now at any medical schools or institutions?
A I'm in private practice. Dr. Tung's in academic medicine. So the answer is when you're in private practice, you know -- I did before, but no longer.
Q When did Mr. Yahyavi first come to see you? What date?
A I believe it was -- we can look at the records again, but I believe it was August of 2017.
Q So a few years ago, right?
A Exactly, yes.
Q Whatever your records reflect that's the more accurate --
A It was August, some date on August the 2017.
Q And I'm not trying to put too fine a point on it. So whenever a new patient comes into your office, they provide you with a full medical history and whatever fashion your office requests, right?
A To the best of their ability. Obviously, a patient like this is not going to be able to tell you the specifics of the injections they've had. They're not that savvy. But the answer is they will give us the history to the best of their understanding.
Q And that's standard practice in the medical field, right, to take a patient history when they first come to see you, correct?
A Of course.
Q And that's because in part to treat a new patient, you and your office want to ensure that you're completely familiar with any

earlier medical problems each of your patients may have had, right?

A Of course.

Q And when someone's treating for their neck, aside from whether they tell you they have high blood pressure or they stubbed their toe, you're going to pay particular attention to that part of their body when taking a medical history, right?

A You're right. You know, what's interesting in this case here? I never -- I looked in my first note there earlier and even before, I never asked him specifics. I really believed to be truthful, I was -- it was a shocking picture and history to me. In other words, a lot of times I'll ask if you had preexisting neck or back issues before. I'll ask the question specifically.

I look in my history of present illness at the first time I saw him, didn't even talk about it.

Q Failure of a patient to provide the proper medical history, response to request from a doctor or doctor's office could result in harm to the patient; isn't that correct?

A Potentially, based upon the specifics of course. You have to be a little bit more specific than that. That's very general.

Q Well, if someone had major head trauma when they were a child -- this is hypothetical -- and they come to you for headaches 40 or 50 years later and they don't tell you I was dropped on my head when I was kid, but they're aware of it, that would be a problem because you would have more difficulty treating them, right?

A You would, but you know, again, we have to look at every

scenario and understand patients are patients. What they perceive to be significant or insignificant may be significant to us and vice versa. Obviously something like that, you've got to imagine or hope that a reasonably intelligent individual will tell, but the answer is sometimes there's errors of omission and sometimes it's frank lies. Anywhere from errors of omission to frank lies.

And again, you try to look at each scenario, you know, in context.

Q You don't go and -- and I'm not making this specific to you, but you don't go and do any kind of detective work to find out what your patients' histories are before they come to you?

A Obviously not. I mean, the reality is patients come to us with whatever records. In other words, in this scenario here, Dr. Bahoora sent them over. So the chiropractor here in town, he would have sent some records over with -- you know, when they send a referral over, they'll send a couple records from their office and that will be the extent of likely what you will have at that time.

Q And just to be clear, I'm not accusing you of anything by not doing this, but there is no real way to -- there's no central repository records. If I -- if hypothetically, if I wanted you to check on my medical history, you'd have no way to do it unless I told you what facilities I went to, gave you HIPPA releases, and that sort of thing, right?

A That is correct.

Q So as a result, when you take a medical history from a patient, you're in essence, almost always, relying on the information provided by that patient to the exclusion of all other information unless

like you said, patient happens to bring a record a two, right?

A Yeah. I mean, we're only -- patients are only as good as the questions we ask. They're only as good as their interpretation of such, and what we believe to be important.

Q And you take the patients' information as true. That's part of your profession. You don't question the patient unless you have a reason to do so, right?

A That's fair.

Q In this case, Mr. Yahyavi told you about the accident, right?

A Yes, sir.

Q He told you that he was hit by a forklift, correct?

A Yes, sir.

Q He told you it was going 30 miles an hour, right?

A That's what that one piece of paper you showed me says.

Q He came in with complaints including aches and pains in his neck and his upper back when you first saw him, right?

A Neck and arm.

Q Neck and arm. And he told you -- sorry, pardon me -- and he said he had neck pain since this accident, correct?

A Yes, sir.

Q He never mentioned to you at any point that he had any treatment, medical visits, or x-rays taken for cervical issues in the two years before this accident; isn't that correct?

A It's not in my records.

Q So the question to you again, is Mr. Yahyavi never told you

that he had neck problems in the two years before this accident; isn't that correct?

A He never volunteered it to me.

Q Right. He didn't volunteer it with words, meaning he never told you, right?

A Yeah. And I never asked him.

Q And in fact, while you were treating him, you understood the opposite. You understood that he never had prior neck problems, right?

A I'll have to look at all the specific records there. I don't believe I ever asked him on that -- certainly the first time, did he have problems before, to be frank, I was so -- he comes to me with a significant -- seemed to be a significant injury and showed me pictures and I treated him accordingly.

Q Before you saw Dr. Tung's report -- can you look in your report records and see when you first found out from Dr. -- first saw about Dr. Tung -- can you identify -- your records have a -- that you're looking at -- have a medical chronology that -- of your review, right?

A Right.

Q So what I'm asking you is what's the date of Dr. Tung's first report that you reviewed?

A The first report. So I'm looking at my first report, which is April 12 of 2018. And let me just go through that and see if there's one in there. It's not in that first one. Then my second report of August 19 of 2018 --

Q And I'm sorry to put you on the spot. I'm doing the same

thing you're doing to try to assist.

A I'm trying to answer it for you.

Q So I'm not seeing it in your second report. I know it's in your third report, November 13, 2018.

A No, here's one. On -- I have on page 14 of 27 in my second report of 8/19/2018.

Q Got it.

A There's a report on 8/26/2016.

Q Yep.

A Says, IME 14 pages. So that's one.

Q Okay. So three years later you're referencing that you had seen Dr. Tung's, at least, first report, correct?

A That I have -- hold on please. Let me answer your question completely.

Q It's okay. You don't need to worry about it.

A And then the second, I have a third report --

Q That's okay.

A Okay.

Q It's fine. It's okay. I'll withdraw the question just to save time.

A Okay.

Q Because I have a witness in the hall. So I apologize. Before you saw Dr. Tung's report, you had never heard of this prior visit of Mr. Yahyavi to Southwest Medical Associates, correct?

A No, because if you look there's a record here. His report date

December 13, 2018 he references it.

Q Right. So that's less than a year ago though, right?

A December 13, yes, sir.

Q So before that, for -- around Christmastime this past year, you never considered the Southwest Medical Associates visits and Mr. Yahyavi, correct?

A That's right.

Q So before Christmas of 2018 all of your opinions and all of your recommendations and all of your medical decisions were based on the information you had which included a lack of any identification of prior pain symptoms or treatment or images, right?

A I was not aware of it until December 13, 2018. In the meanwhile, Mr. Prince's office sent over a binder of records.

Q And during that time you also rendered what are called causation opinions in this case. You said at certain points in your opinions in the case that this car accident alone caused Mr. Yahyavi's cervical problems, right?

A At -- yes, in my reports.

Q At those times?

A At those times.

Q And at those times you attributed all of his neck problems just to the accident and not to any preexisting degenerative problems; is that fair?

A Yeah.

Q And that's in part because you relied on what Mr. Yahyavi

told you as a patient, right?

A Well, I relied upon what he told me plus the remainder of the records that I reviewed. In other words, I have three reports over here, so it's more -- it's more complex than just whatever he tells you.

In other words, patients tell you what they tell you and then sometimes the records do not corroborate what patients talk about in general. So it's more than just what he told me, it's what the other providers tell me too.

Q You're partially his treating doctor and a surgeon; that's one role you have, correct?

A Yes, sir.

Q You're also partially now, sitting here today -- this isn't medical treatment, right? You are a paid expert being paid for your time in this case, correct?

A Yeah.

Q And you charge about $6,000 for half a day of trial time?

A About.

Q Can you estimate how much you have charged Mr. Yahyavi and/or, you know, his side to date?

A Probably -- I wrote three reports. I would say probably in the 10 to 13,000 hours prior today.

Q Okay. So adding the $6,000, you're charging $16 to $19,000 ballpark, rough number?

A Give or take.

Q And you're here to try to -- you're being paid today to try to

convince the jury that this accident caused Mr. Yahyavi's problems or --

MR. PRINCE: Objection. Argumentative. Foundation.

MR. KAHN: -- or the lion's share of them?

THE COURT: Let him get the question out at least.

MR. PRINCE: Objection. Argumentative, foundation.

THE WITNESS: I'm not here to --

THE COURT: Overruled. Go ahead.

THE WITNESS: I'm not here to convince anybody of anything. I mean, the bottom line is these are my opinions based on my interpretation of the data. I mean, it sounds pretty -- I'm not here to convince anybody of anything. They're there to determine what they believe to be correct.

MR. KAHN: Okay. Thank you, Doctor.

THE COURT: Redirect.

MR. PRINCE: Yes.

THE COURT: The jury has any questions, start writing them down.

REDIRECT EXAMINATION

BY MR. PRINCE:

Q Well, start with a couple simple ones. Dr. Kaplan, did anything that Mr. Kahn asked you in any way change or alter your opinions in any way whatsoever?

A No.

Q I want to start off with just this smoking idea for a moment. Did smoking play any role in the onset of these symptoms?

A No.

Q Did smoking play any role in the healing from these injuries or your surgery in any way?

A No, because the reality was I -- number one, I did the surgery. He had no wound healing problems, no infections. There was no complications related to smoking. Here's the issue there too, we as surgeons always worry about smoking related to the time of surgery.

In other words, what you did in the past -- I don't want to say it's a free pass -- but in a sense, we worry about what they call pseudarthrosis or failure to fuse or failure to heal, as to what you're doing from the time of the surgery on.

Q Okay.

A So the fact that you smoked 20 years ago or 10 years ago or 5 years ago or 2 years ago has no bearing on the -- no bearing at all on the responses and the healing associated with surgery, none.

Q Very good. I want to show you part of Defense Exhibit QQ. Page number 238. This is part of the intake form from August 11th, 2017 at your clinic, okay?

A Okay.

THE CLERK: Is this QQ?

MR. PRINCE: QQ, 23U.

THE CLERK: Because that one's --

MR. PRINCE: Do you have any objection to that -- us showing that? Request --

THE CLERK: That's not in here.

MR. KAHN: No, that's fine.

MR. PRINCE: Very good.

BY MR. PRINCE:

Q And the question is, do you currently smoke or chew tobacco? What was the answer?

A No.

Q Okay. Then it says -- goes down -- it says, if yes, how much do you smoke, etcetera and then it asks about quitting. Did he answer any of the questions about quitting?

A No.

Q So the statement that he never smoked, that somehow got into the typed written record, right?

A How interesting, yeah.

Q Okay. And I want to show you another record from Exhibit 106.

A So that's a mistake --

Q Page number 1039. And if we can go to the smoking part, the status. This is six months after the surgery, okay? It's dated June 1st, 2018. It says, smoking status, no, duration, quit more than two years ago; do you see that?

A That's what it says.

Q So you obviously had a discussion with him about smoking?

A He would have checked these things off. Appreciate, we do the best we can to talk to patients about all of these issues, but what happens is people fill out forms and they'll answer these questions for

us. The most important thing for me was related to surgery, he didn't smoke.

Q Understood. My point is all of this is, do you perceive Mr. Yahyavi to be a liar and you can't rely on his medical history and the information he's given you?

MR. KAHN: Your Honor, I'm going to object.

THE COURT: Sustained.

BY MR. PRINCE:

Q Based upon these statements and the questions by Mr. Kahn that he told you he was never a smoker, does this in any way affect whether -- the reliability of the information he's provided to you?

A I don't think so, no.

Q All right. Now, you have reviewed the Southwest Medical records, right?

A I have.

Q And Mr. Kahn just asked you question about those, didn't he?

A He did.

Q And on the date of the first visit, which is Exhibit Number 156, Bate number 2113 --

MR. KAHN: Your Honor, can we approach briefly?

THE COURT: Yes.

[Sidebar begins at 4:27 p.m.]

MR. KAHN: I think my questions were more in the nature of hypotheticals and letting him discuss what he talked about with Dr.

Tung, which was the Court's ruling. Now, counsel's showing him that records --

MR. PRINCE: No, you actual --

MR. KAHN: -- which I did not do.

MR. PRINCE: You actually referenced the records, asked if he reviewed the records, you talked about the findings on those records, that he complained in the Southwest Medical records that he complained of neck pain for years. You specifically talked about the degeneration findings, noted on the Southwest Medical x-rays. You asked all those questions in the listed and answered.

That's opening the door, Judge. And I'm going to now ask him about it specifically. He did on cross exam -- he did this on cross-examination.

MR. KAHN: When he said he got the records but never put them in his report, I backed away.

MR. PRINCE: No, you didn't. You asked him specific questions about the findings for --

THE COURT: I guess it was a lot of questions on the records themselves so I don't see how they're not allowable, if you will or have him -- I hate to use the open the door, but I'm going to allow the question.

MR. PRINCE: Thank you.

MR. KAHN: Thank you, Your Honor.

[Sidebar ends at 4:28 p.m.]

BY MR. PRINCE:

Q So now we're going to look at -- well, first off, we're going to look at a few records just because we're almost done here. But in looking at the records, just let's talk about, from Southwest Medical, do the records support any idea or notion, Dr. Kaplan, that Mr. Yahyavi had ongoing, symptomatic, multilevel disk problems or pain before this collision?

A No, and I'll tell you why. There's records -- there's four or five records in there. I think it's the second record that talks about neck issues. And then basically it says full range of motion, they ordered some x-rays. I think they gave him some naproxen, a little bit of non-steroidals. Then he comes back over the course of time that says he's asymptomatic and has no complaints over the course of time. And I believe the last record from Southwest Medical was a -- actually like a month or two prior to the accident and he says he has no complaints.

So if somebody is having significant neck complaints, I think like we talked about earlier, you would have had physical therapy, chiro, pain meds, MRI scans, pain management, surgical eval, all those things. I think there's one note of a -- right in the middle of like four or five where the first note says nothing about -- and actually I think the last note says no complaints at all.

Q Okay.

A So if he's got chronic problems with his neck that's significant, he's got to tell his doctor. And not only that, he had full range of motion of his neck. So the whole thing doesn't seem to make much sense to me.

Q Very good. Let's go to the one note, October 25, 2011, 2110, that's the one where he is reported complains of some kind of neck pain for several years. Let's just talk about that briefly. Just bring up the subjective through the neck exam. All right. Through the neck exam.

A So he's meds -- he's on no pain meds.

Q Well, let's -- perfect. Says subjective, sent for lab results, also complains of pain for several years, denies any history of neck surgery, no neck trauma. So we know there's no trauma, right --

A Right.

Q -- according to this? Okay. Is there any medications associated with any sort of pain or anything like that?

A No.

Q Down on the examination, it says supple with full range of motion; do you see that?

A I do.

Q If someone has multi-level discogenic pain and facet pain, are you going to have full, pain free range of motion?

A No. We talked about that before.

Q Right.

A Absolutely not.

Q Okay. Can people have neck stiffness, aches without it being associated with your disk or a facet or some kind of chronic problem?

A Ask your question one more time please.

Q Sure. Can you have neck symptoms, or you know, achiness or stiffness without it being even associated with a disk problem?

A Absolutely right.
Q Or a facet problem?
A Absolutely right.
Q Okay. Did this physician order any type of treatment directed to the neck?
A He's got no spasms there too.
Q Is that important for you?
A That's important.
Q When you saw him, did he have full range of motion?
A He did not.
Q When you reviewed the medical records in this case, did he ever have full, pain free range of motion any time after this collision?
A He did not.
Q Is that a significant clinical change from this?
A It's very different. It's night and day.
Q And more importantly, is there any arm symptoms reported in any Southwest Medical?
A No.
Q Is that an important factor for you in your analysis among others?
A That's probably the most important one, to be truthful there, because again -- you know, again, the main reason I operate, the main one -- we operate for neck pain, but it's the arm symptoms. It's the radicular symptoms. It's the discogenic problem. That's the main reason I operate on the man. And he's got no -- there's no description of

that in his record.

Q All right. Now, let's go to the November 2012 visit. That's one year after that note, okay? That's 2106. The subjective through the review systems. Okay. It says 50-year-old male.

MR. PRINCE: Get the date in line for us, if you could, Greg.

BY MR. PRINCE:

Q Fifty-year-old male -- let me highlight subjective -- presents to discuss lab results, states that he is feeling well without physical -- any physical complaints. Do you see that?

A That's what it says.

Q And if someone who had ongoing chronic, multi-level disk and facet pain would you expect them to be -- have no physical complaints at all?

A You're going to have neck complaints.

Q Did he have any -- it says current meds. There's two listed there. Do you see that?

A Yeah, hypertensive medication and it looks like some drop, some drops --

Q Was he on any pain medication of any kind?

A No.

Q Was he -- someone who's got ongoing chronic pain, do you generally see them with some type of prescription, either anti-inflammatory, muscle relaxer, some type of opioid pain medication, or a combination of all three?

A All the time.

Q Okay. And it says under the muscular skeletal -- you can just -- it says no persistent muscular pain; do you see that?

A I do.

Q Right. Was this important to -- now, even though you didn't know at the time you wrote your report, now seeing it, is that consistent with your overall analysis of this case, that he had no significant problem before this collision?

A Yeah.

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

A Yes.

Q The mere fact that he -- there's one note; does that appear to be an out layer of sorts?

A Yeah, because the reason -- the way I view it is you have one record sandwiched in between others. So if it's sandwiched, to me it doesn't sound like a significant problem.

Q Would you expect there to be recommendations for treatment if there was a significant ongoing problem?

A No question --

Q Was there any --

A -- like we talked about before.

Q Was there any recommendations for treatment made by any one of these Southwest visits?

A I think they ordered an x-ray and they gave him naproxen and I think he stopped it within a few months or six months.

Q Well, I'm showing the November 2012 and he wasn't on naproxen that day.

A Yeah, he was off it. He's --

Q Off it?

A -- on -- he's on no pain meds a year -- a little less than a year actually. It would be seven months or so --

Q Yeah.

A -- prior to the accident we were talking about.

Q Okay. Was that significant to you?

A Very significant.

Q Okay. Now, I want to kind of go to Bate number 2119, which is actually the radiology report from Southwest Medical. Okay. If you can pull me the findings.

A Say it again, sorry.

Q I'm just telling the -- my tech guy to pull it up here. Then it says here he has multi-levels of degeneration.

A No question.

Q Was there any clinical medical evidence in the 2011 to 2013 timeframe that those levels were causing symptoms or problems for Mr. Yahyavi?

A No.

Q Is that your opinion, it's a reasonable grade medical probability?

A Yes.

Q And then in the middle here, this is kind of -- it says correlate

clinically; do you see that?

A Yeah.

Q All right. Is that what we've been doing in this case?

A Of course.

Q And this radiologist, who doesn't see patients, he just looks at films, right?

A Yes.

Q Is that -- a radiologist, they just stay in a dark room, I've heard it explained, I sit in a dark room and I just look at these x-rays, MRIs or CT scans all day, right?

A Right.

Q And they say okay, I don't know what's really going on with this patient, but I'm going to leave it up to you surgeons or doctor to clinically correlate whatever findings on this exam?

A It's just like we talked about in the beginning, you have the pie chart --

Q Right.

A -- and the answer is history is the foundation, x-rays, and isolation are clinically meaningless.

Q Right.

A I mean, look, like I said earlier, if you have broken bone with two bones malaligned, it's obvious. But in situations like this, absolutely not.

Q Okay. There's a discussion about this lordotic curve, which is kind of the C -- the little curvature of the spine; is that clinically significant

to you in any way?

A No.

Q Okay. That's a relatively soft finding, don't you think?

A Big time.

Q Because there's so many things that could influence that, right?

A Right.

Q And we correlate that back to the examination, was there spasm at the time of that October 25th, 2011 evaluation?

A According to the medical doctor, no. So --

Q Right.

A -- they're saying correlate with spasm, but it doesn't exist.

Q That's why I point -- could you -- did you clinically correlate the straightening of the curve with a spasm on an exam from the exact same date?

A As we get older -- I'll give you an example. When we're young, we have a nice C-shape curve of our neck. As we get older, it tends to straighten out. That's just the nature of the beast.

Q Okay. Can spasms though influence the -- whether the curvature?

A It can.

Q Right. And in this case, since there's no spasm present, it's not influencing the curvature?

A Correct.

Q Would that be fair to say?

A Correct.

Q No clinical correlation?

A Correct.

Q Now, in my opinion -- well, strike that. In your opinion, not my opinion, you're giving the testimony here today, if this was a minor event, would the EMT personnel from the Las Vegas Fire and Rescue Department have called for a full UMC trauma activation?

A No. The person went to UMC trauma to our level 1 trauma center. This is a significant accident. There's no question.

Q Okay. And you obviously reviewed the Las Vegas Fire and Rescue records, right?

A I have.

Q I want to ask you a question about those just briefly to talk about --

MR. KAHN: Your Honor, beyond the scope.

BY MR. PRINCE:

Q We talked about the severity and the speed and so I want to talk about --

THE COURT: Counsel, approach.

[Sidebar begins at 4:38 p.m.]

THE COURT: I agree. It was never ever talked about, anything to do with the EMTs or anything.

MR. PRINCE: Well, it doesn't matter. I can -- well, I'm trying to rebut some of his argument.

THE COURT: It's beyond the scope of his cross.

MR. PRINCE: He did talk about what was happening at the hospital. He did talk about UMC trauma level. He did talk about this being -- not being a -- questioning the speed. So that is an issue. It goes back to rebut some of his questions and suggestions.

THE COURT: Well, he's not going to talk about speed other than what he was told. What does that have to do with the EMTs? This is all new stuff. And yeah, he's right. It's outside the scope of his cross.

MR. PRINCE: Okay. I'll withdraw.

[Sidebar ends at 4:39 p.m.]

THE COURT: I'm sustaining the objection.

MR. PRINCE: Okay.

BY MR. PRINCE:

Q What prior academic work have you done, Dr. Kaplan?

A I did my residency, as we talked about, my fellowship at Washington University in St. Louis. After I finished there, I went on staff at the University of Cincinnati Department of Neurosurgery for two years. I took an academic position like Dr. Tung. I decided after two years to move here to Las Vegas, as the city was growing. I think I still may have an adjunct professorship at Touro, but we're not very active in that -- me -- my group.

Q Okay.

A So for two years I was the University of Cincinnati Department of Neurosurgery. I decided to leave that realm and move here to Las Vegas. I think nearly all of my colleagues here in town do not have -- in other words, now we're going to have the University of

Nevada, you know --

Q Right.

A -- Las Vegas Medical School in the future, very -- you very well may have.

Q Well, we have -- you have medical residents at UMC, right?

A Yes.

Q Do they ever follow you, or shadow you?

A Yeah, absolutely. We have medical residents at -- you know, I've had residents shadow me from UMC. I've had residents shadow me from Valley. I have residents shadow me from Mountain View. Today I had a resident -- I was operating at Valley shadowing us.

Q And you're saying shadowing, you're actually educating them during the course of your surgeries, right?

A Of course. I -- I don't have an official title with -- you know, with -- with the University of X, but the answer is, you're involved in the teaching of residents -- and -- and again, we're don't a neurosurgery training program here in Las Vegas. There's a general surgery training program. There's neurology. A variety of others, but not neurosurgery.

Q Right. But residents follow you during the -- so they could understand the field of neurosurgery, right?

A I think it's important to say -- the reason why it's important is, I think it's important, because even if you're not a neurosurgeon, you want to understand what's important to us; what are we looking for; in other words, we talk to residents from these hospitals, and we explain to them, you know, when they evaluate somebody what's important to us,

because when they go in the -- I dare call it the real world -- it's going to be very important for the care of their patients, and they'll be interacting with colleagues like myself.

Q Okay. Very good. So you're involved with teaching, and shadowing, and mentoring other positions, not just in the field of neurosurgery, but other areas of medicine?

A Of course.

Q Okay. Very good. Now, that you have reviewed the medical record from Southwest Medical Associates, does that, in any way -- does that support your opinions?

A It doesn't change my opinion at all.

Q All right. There's no -- does it support your opinion that there's no pre-existing, on-going symptomatic problem for which Mr. Yahyavi needed medical treatment?

A Correct. I mean, again, what we just talked about a few minutes is, you have a record seven months before with no complaints. He's clinically asymptomatic, as it relates to his neck at the minute -- and other's functions, or other organs, whatever may be may, but we're here to talk about the neck, so he's clinically asymptomatic, as it relates to his neck at that time.

Q Right. Very good.

MR. PRINCE: No additional questions, Your Honor. Thank you.

THE COURT: Recross.

MR. KAHN: Your Honor, no further questions.

I'd ask to go get my witness. I'd like to get him started today if possible.

THE COURT: Well, I mean, any questions from the jury, raise your hand? No questions.

Thank you. You may step down.

THE MARSHAL: Watch your step. Remain standing. Face the clerk of the court.

THE CLERK: Please raise your right hand.

JOSHUA ARBUCKLE, PLAINTIFF'S WITNESS, SWORN

THE CLERK: Please be seated. Please state your name and spell it for the record.

THE WITNESS: My name is Joshua Arbuckle, J-O-S-H-U-A A-R-B-U-C-K-L-E.

THE CLERK: Thank you.

DIRECT EXAMINATION

BY MR. PRINCE:

Q Mr. Arbuckle, good afternoon.

A Good afternoon.

Q My name is Dennis Prince, and I represent Mr. Yahyavi, who was the driver of the black Charger involved in the collision with your forklift. We've never met before, correct?

A No, sir.

Q Well, thank you for your patience and being here today. I have a few questions for you. Before you -- were you aware that Clifford Goodrich, the safety manager for Capriati testified last Friday? Were you

aware of that?

A Yes, sir.

Q Right. And this is -- these are your team of lawyers here, right? This is who has represented you throughout -- these people here -- these gentlemen?

A They don't represent me. They represent Capriati.

Q Okay. And you were hired -- you were an employee of Capriati Construction in June of 2013, correct?

A Correct.

Q And you were hired by Capriati Construction in 1996 actually as a laborer, right?

A Correct.

Q And then as a laborer, you're primarily responsible for shoveling, sweeping, things like that?

A Correct.

Q And you were a laborer, as I understand it, for approximately five years; is that right?

A Correct.

Q And after that you became a concrete cement finisher, true?

A True.

Q And it is your understanding while working a Capriati, that Capriati did primarily large public works projects?

A Correct.

Q Right. And so in addition to laborers and cement finishers, Capriati Construction also employed operators of equipment for their job

sites, correct?

A Correct.

Q So you were a finisher and they have a title of employees who operate equipment called operators?

A Right.

Q Right. Now, prior to June 2013 you never received any sort of certification for a forklift operation, correct?

A Correct.

Q You had driven and/or operated forklifts to move material on job sites for unloading and loading trucks, pallets, those types of things, right?

A Right.

Q Right. But prior to June 2013, you had been instructed by senior management not to use a forklift; they had told you that before that day right?

A I've been told before. Yes, sir.

Q Okay. Now, in June 2013 you were doing work near Boulder Highway and --

A Glen.

Q -- Sahara Avenue, right?

A Uh-huh.

Q I'm sorry, is that a yes?

A Yes, sir.

Q Yeah. I know what you're saying, but the court reporter needs to make sure that we have everybody -- go to --

MR. PRINCE: If you can go to Demonstrative 10.

THE CLERK: What is this?

MR. PRINCE: It's a demonstrative slide.

THE CLERK: Oh, N?

MR. PRINCE: No. Demonstrative.

THE CLERK: Oh, okay. Just demonstrative.

MR. PRINCE: Yeah.

MR. KAHN: And I'm sorry, for the clerk's benefit, that was in the opening.

MR. PRINCE: It's part of the PowerPoint.

THE CLERK: Oh, okay. Thank you.

MR. PRINCE: Yep. I call it Demonstrative 10, just for my reference.

BY MR. PRINCE:

Q And so I'm showing you like a Google Earth aerial depiction of the project, yeah?

A Yes, sir.

Q Just to orientate the jury, this area right here near Glen, that's where the collision occurred, right?

A Correct.

Q And you were doing work just south of Sahara, right, where it says, "Capriati Construction", right? There's some ongoing work in that area?

A We were working all over there, not just in that park, but yes, sir.

Q Yeah. I'm only talking about you were doing work in this area -- just part of the work was there?

A Correct.

Q The whole work was -- most of the work was actually going on, on Boulder Highway down there, right?

A Right.

Q Right. But you had some -- this area was -- you were doing some roadwork in that area?

A Correct.

Q And this area where -- down here at the corner of Glen and Boulder Highway where I've said Capriati Construction Corp, that was like a storage yard where you could keep material, equipment that type of stuff?

A Right.

Q Okay. And so on June 19, 2013, you're working on the south of Sahara and Glen Avenue, right?

A Correct.

Q And as I understand it, the project is in the, kind of wrap up phases, right?

A Right.

Q And you weren't always assigned to this project, right? You did most -- a lot of your work for the Las Vegas Valley Water District --

A Right.

Q -- doing some repair and patching of work associated with some of their projects?

A Correct.
Q Okay. But that day you were also -- had another co-employee down by the name of Darian?
A Correct.
Q Okay. So you weren't working down there by yourself, correct?
A Correct.
Q And at some point, you decided you wanted to use a forklift to go to the storage over on Glen and Boulder Highway?
A Correct.
Q Right. Actually, according to your testimony that you've given, you don't even know why you were even using the forklift that day at all, correct?
A I couldn't remember.
Q Right. As you sit here today, and at your deposition, you just don't remember, why you were even on the forklift that day, right?
A I said I couldn't remember why I had gotten it, correct, sir.
Q Yeah. But you do know that Doug Goss [phonetic], the former safety manager, had told you not to operate forklifts before this?
A Before that, that's right, but not --
Q Okay.
A -- on that job.
Q And so I want to -- you agree that --
MR. PRINCE: Let's see Demonstrative 1.
BY MR. PRINCE:

Q Let me see if you agree with a few safety concepts. Okay. Do you agree that safety is the most important aspect of any construction site job?

A Correct.

Q Safety is just number one?

A Right.

Q Safety first?

A That's right.

Q And do you agree that each person should be responsible for their own safety and the safety of others around them?

A Correct.

Q Do you agree that all accidents are preventable?

A Not all accidents.

Q The vast majority are preventable?

A The majority, yes, sir.

Q If you're not trained or authorized to do something, you shouldn't do it; you agree with that, right?

A Correct.

Q Do you agree you should always follow the rules and the safety rules --

A Correct.

Q -- and the directives by your superiors?

A Yes, sir.

Q And you should use all equipment safely and in the proper way, correct?

A Correct.

Q All right. One second, sir.

MR. PRINCE: All right. If we could go to Demonstrative 15.

BY MR. PRINCE:

Q See if you agree with a few other things. Do you agree that an operator of construction equipment must take all steps necessary to avoid injury or harm to other motorists; do you agree with that?

A Yes, sir, I do.

Q Okay. And to the left there, that's the forklift that you were operating the day of this collision, correct?

A Correct.

Q And to the left of that forklift is a tractor that was there to load, like, trench plates -- those large metal plates that cover the roadway -- someone was there putting those trench plates on the trailer of that truck, right?

A Right.

Q And that truck was blocking your view of the road, wasn't it?

A Correct.

Q Right. And you agree that an operator of construction equipment must not enter the roadway, unless it's safe?

A Correct.

Q Do you agree that an operator of construction equipment must not enter the roadway when their vision is obstructed, correct?

A Correct.

Q Construction equipment, you agree, creates special safety

hazards on the road; you agree with that, right?

A Yes.

Q You agree that a forklift, while you may be able to operate it on the road, it has its own special safety hazard, because it's operate, or function like a regular automobile, right?

A Correct.

Q And it has dangerous objects on the front of it?

A Right.

Q Right. And is entering the roadway when your vision is obstructed is unsafe and can cause serious injury; do you see that?

A Yes, sir.

Q You agree with that too, right?

A Yes, sir.

Q Now, when this happened, as I understand -- let's go to a few pictures --

MR. PRINCE: You can go to 127.

BY MR. PRINCE:

Q That photograph -- you wanted to drive the forklift onto Glen Avenue and make a right turn, correct?

A Correct.

Q And when you -- you agree that Mr. Yahyavi, he was in the dedicated travel lane for travel, based upon the -- where the cones were placed, when this happened?

A And which lane would that be?

Q He was in the dedicated lane, right?

A He was in a lane.

MR. KAHN: Sorry, I'm going to object. Vague, as to which lane is being discussed.

THE COURT: I'll sustain it.

MR. PRINCE: Okay. Let's go to Exhibit Number 83A. Let's go to 2008. Okay. Fine. Let's go to Demonstrative 13.

BY MR. PRINCE:

Q So look at the photograph on the left. Do you see that?

A Yes, sir.

Q That's you in the picture talking to the police officer, isn't it?

A Correct.

Q Okay. You are standing inside the construction zone, right?

A Correct.

Q Because everything to the right of the cone is the construction zone, correct?

A Correct.

Q And you agree that before this, the entire right turn lane on Sahara was shut down by the construction equipment, and the placement of the cones, right?

A Correct.

Q So Mr. Yahyavi when he's to the left of that cone, he's in the dedicated travel lane, isn't he?

A At that position, yes.

Q Right. And well, that's where you hit him?

A But that wasn't the original position he was in when I first

saw him.

Q I'm not asking that.

A Okay.

Q I'm asking when you came into contact with him with your fork to that forklift, he was in the dedicated travel lane, correct?

A Correct.

Q You didn't see him in that dedicated travel lane, did you --

A No.

Q -- before the impact?

A No, sir.

Q I'm just asking you -- so when this impact occurred, the fork to that forklift were actually in the roadway --

A Correct.

Q -- dedicated for travel, correct?

A Correct.

Q So initially --

MR. PRINCE: Let's go back to the aerial.

BY MR. PRINCE:

Q Initially you saw Mr. Yahyavi, he was traveling on Sahara Avenue, correct?

A Correct.

Q He was going east, correct?

A Correct.

Q That obviously would have been west or to the left of Glen Avenue, correct?

A Correct.

Q You made the assumption that he was going straight, and not going to make a turn onto Glen, correct?

A Correct. I thought he was going straight.

Q Right. And so what happens is, you start to drive the forklift. You're now trying to go in front of the truck, correct?

A Correct.

Q Right. The truck wasn't the only obstruction. There's also a cement mixer, correct?

A Not correct.

MR. PRINCE: Let's look at 2008. We can look at 134.

BY MR. PRINCE:

Q You see the cement mixer in this picture?

A Yes, sir, I do.

Q Right. And that's another -- that was also another obstruction of your view, correct?

A The problem is that came after the accident.

Q Yeah. Well, Mr. Goodrich, the safety manager, was here and he said that you told him that there was two trucks there.

A I don't remember saying that.

Q All right.

MR. KAHN: I'm going to object to that, Your Honor. Lacks foundation. What somebody else said in court, unless he has a transcript.

MR. PRINCE: No, that's not the case.

THE COURT: The jury can decide. They've heard the testimony.

MR. PRINCE: Right.

BY MR. PRINCE:

Q In looking at Exhibit 64 -- excuse me -- yeah, Exhibit 64, Bates Number 136, you agree that the fork to that forklift went out into the roadway and collided with that truck, correct -- I mean, with Mr. Yahyavi's car?

A Correct.

Q Right. As you started to move, you started to elevate the forks, correct?

A Correct.

Q And while you're driving you thought that Mr. Yahyavi was going to go straight, and you never saw him obviously clear before you entered the roadway, correct?

A Correct.

Q And that truck was obstructing your view the entire time, correct -- up until the moment of this collision, correct?

A Correct.

Q Right. And in fact, at no point, before this collision were you even aware that the forks went out into the travel lane, correct?

A Correct.

Q So as you're driving and you're moving forward, you're lifting the forks up, right -- at the same time?

A Right.

Q At the same time you're moving forward, fork's coming up, you never see the forks go past the cone in front of you, right?

A Right.

Q So obviously, you're not paying attention to what's happening in front of you, right -- because you didn't see that?

A I was looking at the road waiting to see Mr. Yahyavi pass.

Q But you're obviously -- he didn't pass. You're looking at something, but you're not noticing that the forks are now going beyond the cones, correct?

A Correct.

Q Because those forks -- what are they about six-feet long?

A Six feet.

Q They almost fully went into the windshield of the car, right? Because you backed up to get to this point, on this photograph.

A Right. I backed up there.

Q Right. So those forks were almost all the -- completely in the lane at the point of impact?

A I -- I don't believe so.

Q Well, look how far -- look how far the -- look how far you backed up. You can look at the photograph with me. I mean, you backed up at least four or five feet at that point, right?

A I backed up from the tire mark that was here.

Q Yeah.

A So I wouldn't be completely in the roadway. There would be a portion of it in the roadway.

Q A significant portion was in the roadway, right?
A Correct.
Q That you didn't even know was there, right?
A Correct.
Q Right. And you agree that this accident occurred because of an error in your thinking, in your words?
A Yes.
Q It was preventable, wasn't it, by you?
A Most accidents are. Yes, sir.
Q I'm just talking about this one, respectfully. This accident was preventable by you, correct?
MR. KAHN: Objection. Hypothetical.
THE COURT: Overruled.
BY MR. PRINCE:
Q Right.
A Yes, sir.
Q Right. You didn't asked Dario [phonetic] to come out and help and make sure traffic was clear? You have a co-worker, correct?
A Correct.
Q You didn't ask the driver of that Peterbilt, hey, can you please make sure traffic is clear, I want to pull out onto Glen; you didn't do that either, correct?
A No, sir.
Q Right. And you didn't go ask the flagger, who was onsite, to come over and help you, because you wanted to drive the forklift out

onto Glen, right?

MR. KAHN: Objection. Assumes facts not in evidence. Lacks foundation.

THE COURT: Counsel approach.

[Sidebar begins at 5:00 p.m.]

MR. PRINCE: These are deposition exhibits or objections.

THE COURT: And your question -- go ahead, what was your objection?

MR. KAHN: My objection is he's asking him a leading question as a direct witness about --

MR. PRINCE: Whoa.

MR. KAHN: -- a flagger being there, and he's assuming that there was a flagger. Let him lay the foundation asking if there was one or not.

MR. PRINCE: We did on Friday.

THE COURT: Well, that was Friday. Lay a foundation.

MR. PRINCE: What's the foundation?

THE COURT: Whether or not there was a flagger.

[Sidebar ends at 5:01 p.m.]

THE COURT: I'm sustaining the objection. Go ahead.

BY MR. PRINCE:

Q The daily inspection records from Clark County indicate that there was a flagger present that day. Were you aware there was a flagger?

A No, sir.

Q Are you familiar with what a flagger is?
A Yes, sir.
Q What is a flagger?
A A flagger is somebody who slows down or stops traffic.
Q Okay. If you can look at Exhibit 13 0056. It said under the crews, there's three operators, one laborer, and one flagger. Do you see that on there?
A Yes, sir.
Q Did you call or look for the flagger to come help you?
A I don't even know how to answer that. There was no flagger there.
Q There was no flagger that day?
A There was -- that's not even correct. There's no way that that's correct. There was two people on the jobsite, no operators, one laborer, one finisher, no flaggers.
Q Well, this is what the Clark County Public Works inspector documented.
A It doesn't match what was there.
Q Okay. It doesn't match your recollection?
A No, sir.
Q Okay. So regardless, whether there was a flagger there or not a flagger there, you didn't list the help of anybody to make sure the traffic was clear, correct?
A Correct.
Q All right. Now, after this happens, you go to -- the collision

happens. That's your first sign even of Mr. Yahyavi's car again, right?

A Can you repeat that, please?

Q Sure. The collision was your first indication that Mr. Yahyavi was trying to pull onto Glen, correct?

A Correct.

Q And obviously, it was very scary to you when this happened, correct?

A Correct.

Q And you got off the forklift, correct?

A Correct.

Q Because you were worried about a severe injury or serious injury to Mr. Yahyavi, correct?

A Correct.

Q Because it was a hard impact, wasn't it?

A Yes, sir.

Q And even to you on that forklift, it appeared to be a hard or heavy impact, right?

A I didn't really feel it on the -- on the forklift. The forklift is a big piece of steel, so you wouldn't really feel it much.

Q But you -- for the Charger, it would've been a hard impact, right?

A Correct.

Q Right. And when you got to Mr. Yahyavi, he was frantic in the car, wasn't he?

A Yes, sir.

Q Those are your words; frantic. Tell us what -- tell the jury what he was doing in the car.

A From what I remember, all Mr. Yahyavi kept saying was something hit me. And I -- and I was just trying to talk to him and see if he was okay and keep him talking because I didn't -- I didn't know if he had any type of head injury. And the way he was acting, I just wanted to make sure that he wouldn't go unconscious. So I kept talking to him and making sure he was fine.

Q He didn't appear to be fine, did he?

A He was shaken up.

Q Right. He didn't appear to be fine, did he?

A I -- there was nothing visible that looked bad. But the way he was acting didn't seem normal.

Q Right. I mean, it looked like somebody who had went through a traumatic experience of some kind, right?

A Yes, sir.

Q Right. And you're there, obviously, to try to assist until emergency medical personnel get there. You're just helping out, right?

A Correct.

Q Okay. And I mean, with all due respect to you, you caused this collision, didn't you?

A Yes, sir.

Q Okay. And you caused it while you were driving a forklift owned by Capriati, correct?

A Correct.

Q Doing work for them --
A Correct.
Q -- on this jobsite, right?
A Correct.
Q And after this, you were demoted, right?
A I don't remember being demoted. I know that I had to wait for the drug test to come in before I could go back to work.
Q Right. And then you were also instructed not to use the forklift ever again, right?
A Correct.
Q Under any circumstance?
A Correct.
Q Right. And then at some point in 2014, you were later terminated by Capriati?
A Correct.
Q Right. Okay.
MR. PRINCE: All right. Nothing further, Judge. Thank you.
THE COURT: Cross?
MR. KAHN: Could we approach for a second?
THE COURT: Yes.
[Sidebar begins at 5:05 p.m.]
MR. KAHN: I probably have 10 to 20 minutes of cross because I don't want to bring him back because he doesn't work for us anymore.
THE COURT: Right.

MR. KAHN: But I don't know about your timing.

THE COURT: No, we're going.

MR. KAHN: Okay, good.

THE COURT: We're going to finish him today.

MR. KAHN: Okay. That's fine with me.

[Sidebar ends at 5:05 p.m.]

CROSS-EXAMINATION

BY MR. KAHN:

Q Hello, Mr. Arbuckle.

THE COURT: Did you have the microphone, sir?

MR. PRINCE: Oh I'm sorry.

BY MR. KAHN:

Q Hello, Mr. Arbuckle.

A Hello.

Q We've met before, correct?

A Yes, sir.

Q And you understand that my firm has acted as your attorneys at different points -- as your attorney at different points in this case?

A Yes, sir.

Q And that's because you're a former employee of Capriati's, correct?

A Correct.

Q It sounds like you've already answered this, but you take personal responsibility for having caused this accident?

A Yes, sir.

Q And when you pulled out onto the roadway, what was it that made you think you could proceed without causing an accident?

A There was an obstruction, but there was a view before the obstruction. And when I viewed Mr. Yahyavi's position, he was in a lane that was -- there was a lane between the lane that he was in. So I thought for sure he was going straight because if he was going to turn, he would've either had a blinker on, or he would've been as close to the cones to indicate that he was turning.

Q Okay.

A My original view was him with a lane in between him, so I figured he was going through.

Q Okay. So let's go over this piece by piece so the jury understands, and, kind of, unpack it a little bit. So you're pulling up in the forklift and the truck is blocking some of your vision of Sahara and/or Glen, right?

A Correct.

Q And as you pull up, are you able to see Mr. Yahyavi's car, the black Charger, off to your left past the end of the green trench plate truck?

A Yes.

Q About how far was that from where the accident occurred?

A About 350 feet.

Q So basically, about the length of a football field including the end-zones, right?

A Right.

Q And you're not saying he was speeding; he wasn't going extremely fast or anything, correct?
A Correct.
Q What about his blinker; what did you observe with his blinker at that time?
A There was no blinker.
Q Did that factor into your decision to pull onto the roadway?
A Yes.
Q So just to be clear about the lanes, there was a coned off lane with the cones where the trench plate truck was in, right?
A Correct.
Q Then there was another lane. Was Mr. Yahyavi in that lane?
A No, sir.
Q Then there was a lane past that, another eastbound lane, correct?
A Correct.
Q Was he in that lane?
A Yes, sir.
Q Okay. So when you observed him, he was not in the rightmost lane that was open? Not the one next to the cones; he was one lane away, correct?
A Correct.
Q And he wasn't signaling?
A He was not.
Q You decided to pull forward, and his car hit your forks of

your forklift, right?

A Correct.

Q And as you told Mr. Prince, you got down off the forklift. You went to check on the Plaintiff, correct?

A Correct.

Q Did you at any point touch him?

A I held his hand.

Q Okay. And why'd you do that?

A I just wanted to console him, comfort him, let him know he was okay.

Q And did you stay there until somebody came that you felt comfortable with?

A Yes, sir.

Q Who was that person?

A It was an EMT. But it wasn't the EMT that was in the ambulance. It was one that had stopped when she saw the accident.

Q Okay. A passerby stopped, told you that she had some kind of medical training?

A Correct.

Q And at that point, you left Mr. Yahyavi?

A Correct.

Q And you're sure that the white cement truck was not there when the accident happened; is that correct?

A Correct.

Q But the trench plate truck was there, right?

A Correct. I know the truck wasn't there because like he said, I'm a finisher. I would've been pouring the truck if it was there. I wouldn't -- I wouldn't have been in a forklift going to get more material. I would've been pouring that truck out.

Q You're a concrete finisher; that was a concrete truck?

A Correct.

Q So you would've been aware of it if it was coming to the jobsite; you would've had to deal with it?

A That's right.

Q How long in your -- when did you start working in your life?

A When did I first start working?

Q When did you start working? Yeah. Get a real -- when was your first job?

A That would've been Taco Bell.

Q Did you used to work for any family businesses?

A I worked for my dad.

Q What did he do?

A I did landscaping for him.

Q So, kind of, same thing; laboring, lifting. And how old were you when you started working with him?

A I think I was 15.

Q What's your current job?

A I work for Martin Harris Construction.

Q And what's your title?

A Heavy equipment operator, concrete finisher.

Q Okay. For the heavy equipment operator part, you -- do you drive forklifts?

A Yes, sir.

Q Do you drive other types of heavy equipment?

MR. PRINCE: Objection. Relevance at this point, five years later -- six years later.

THE COURT: Counsel, approach.

[Sidebar begins at 5:11 p.m.]

THE COURT: Yeah, what's the relevance now?

MR. PRINCE: Yeah, relevance.

MR. KAHN: I'm just laying a little foundation. I'm not going to bring him back.

MR. PRINCE: No.

MR. KAHN: Your Honor, if I could have two minutes.

MR. PRINCE: No. Objection. Foundation. Relevance to anything post any certifications or experience operating after. He was instructed not to use that.

THE COURT: Again, what's the relevance?

MR. KAHN: The relevance is he took a certification course. He's been asked --

THE COURT: Afterwards?

MR. KAHN: Yeah, afterwards.

THE COURT: All right.

MR. KAHN: Okay.

THE COURT: I'm sustaining.

MR. KAHN: I'll abide by the Court's rules.

[Sidebar ends at 5:11 p.m.]

THE COURT: I'm sustaining the objection.

MR. PRINCE: Thank you.

BY MR. KAHN:

Q Were there any flaggers working that day?

A No.

Q And the Daria person, the other individual working with you, there was only one other Capriati person working when the accident happened, right?

A Correct.

Q Where was that person when the accident happened?

A He was down in the manhole.

Q And how below ground is that?

A That particular one he would have been probably about 10 feet.

Q Nothing he could just kind of jump up quickly and assist; is that fair?

A Correct.

Q Do you know what signs Mr. Yahyavi would have passed that day coming into the job site?

A It would have been roadwork ahead, right lane closed ahead and a merge sign. They should have been placed 500 feet apart.

Q When the incident happened, Mr. Prince already kind of asked you this, did you see anything before the accident happened? Did