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

Electronically Filed
Aug 12 2020 01:41 p.m.
Elizabeth A. Brown
Clerk of Supreme Court

APPENDIX TO
APPELLANT'S OPENING BRIEF
VOLUME 7 of 12

Appeal from the Eighth Judicial District Court
Case No. A718689

HUTCHISON & STEFFEN, PLLC

Michael K. Wall (2098)
Peccole Professional Park
10080 Alta Drive, Suite 200
Las Vegas, Nevada 89145
Attorney for Appellant

Docket 80107 Document 2020-29756

Chronological Index

Doc No.	Description	Vol.	Bates Nos.
1	Complaint; filed 05/20/2015	1	AA000001-AA000008
2	Answer; filed 10/07/2015	1	AA000009-AA000012
3	Demand for Jury Trial; filed 10/07/2015	1	AA000013-AA000014
4	Mtn for an Order Terminating Automatic Stay; filed 10/25/2016	1	AA000015-AA000020
5	Order Granting Motion and Modifying Automatic Stay; filed 12/22/2016	1	AA000021-AA000022
6	Notice of Appearance; filed 02/21/2018	1	AA000024-AA000025
7	Notice of Refiling of Answer; filed 04/25/2018	1	AA000026-AA000027
8	Refiled Answer; filed 04/25/2018	1	AA000028-AA000031
9	Baker Initial Report; dated 07/03/2018	1	AA000032-AA000035
10	Kirkendall Initial Report; dated 07/04/2018	1	AA000036-AA000038
11	Leggett Initial Report; dated 08/20/2018	1	AA000039-AA000054
12	Kirkendall Supplemental Report; dated 08/30/2018	1	AA000055-AA000067
13	Baker Supplemental Report; dated 12/03/2018	1	AA000068-AA000092
14	Leggett Transcript 1; conducted 12/05/2018	1	AA000093-AA000095
15	Baker Transcript; conducted 12/20/2018	1	AA000096-AA000102

16	Leggett Supplemental Report; dated 01/15/2019	1	AA000103-AA000119
17	OOJ to Defendant; served 01/18/2019	1	AA000120-AA000122
18	Leggett Transcript 2; conducted 05/09/2019	1	AA000123-AA000126
19	Baker Supplemental Report; dated 06/20/2019	1	AA000127-AA000137
20	Def. Trial Exhibit A. Southwest Medical Associates, Inc. Records; dated 10/25/2011	1	AA000138-AA000139
21	De-designation of expert Leggett; filed 09/20/2019	1	AA000140-AA000141
22	Plaintiff Motion for Sanctions; filed 09/26/2019	1	AA000142-AA000189
23	Jury Instructions	1	AA000190-AA000194
24	Verdict; filed 09/27/2019	1	AA000195
25	NEO of Judgment; filed 10/22/2019	1	AA000196-AA000200
26	Plaintiff Memo of Costs; filed 10/22/2019	1, 2	AA000201-AA000481
27	Plaintiff Motion for Attorney's Fees; filed 10/22/2019	3	AA000482-AA000542
28	NEO - Decision and Order; filed 11/05/2019	3	AA000543-AA000553
29	Defendant Motion Correct Reconsider Decision; filed 11/14/2019	3	AA000554-AA000564
30	Defendant Motion for New Trial; filed 11/18/2018	3	AA000565-AA000583
31	Notice of Appeal; filed 11/19/2019	3, 4	AA000584-AA000752
32	Plaintiff Opp Motion Correct or Reconsider Decision; filed 12/16/2019	4	AA000753-AA000763

33	Defendant Reply Motion Correct Reconsider Decision; filed 12/24/2019	4	AA000764-AA000779
34	Plaintiff Opp Motion New Trial; filed 01/10/2020	4	AA000780-AA000910
35	Defendant Reply Motion New Trial; filed 01/22/2020	4	AA000911-AA000924
36	Transcript Post-Trial Motions, dated 01/28/2020	4, 5	AA000925-AA000997
37	NEO - Order Denying Def Motion for New Trial; filed 03/04/2020	5	AA000998-AA001005
38	NEO - Order Denying Def Motion to Correct or Reconsider; filed 03/04/2020	5	AA001006-AA001012
39	NEO - Order re Def Motion Re-Tax Costs; filed 03/04/2020	5	AA001013-AA001018
40	NEO - Order re Plaintiff Motion Atty Fees; filed 03/04/2020	5	AA001019-AA001026
41	Amended Notice of Appeal; filed 03/13/2020	5	AA001027-AA001029
42	Trial Transcript - Day 5 - Part 1, dated 09/13/2019	5	AA001030-AA001132
43	Trial Transcript - Day 5 - Part 2, dated 09/13/2019	5	AA001133-AA001191
44	Trial Transcript - Day 5 - Part 3; dated 09/13/2019	6	AA001192-AA001254
45	Trial Transcript - Day 6; dated 09/16/2019	6, 7	AA001255-AA001444
46	Trial Transcript - Day 7 - Part 1; dated 09/17/2019	7	AA001445-AA001510
47	Trial Transcript - Day 7 - Part 2; dated 09/17/2019	7	AA001511-AA001649
48	Trial Transcript - Day 8; dated 09/18/2019	8	AA001650-AA001792
49	Trial Transcript - Day 9; dated 09/19/2019	8, 9	AA001793-

			AA001938
50	Trial Transcript - Day 10; dated 09/20/2019	9, 10	AA001939-AA002167
51	Trial Transcript - Day 11; dated 09/23/2019	10	AA002168-AA002296
52	Trial Transcript - Day 12; dated 09/24/2019	10	AA002297-AA002357
53	Trial Transcript - Day 13 - Part 1; dated 09/25/2019	11	AA002358-AA002459
54	Trial Transcript - Day 13 - Part 2; dated 09/25/2019	11	AA002460-AA002473
55	Trial Transcript - Day 14; dated 09/26/2019	11	AA002474-AA002555
56	Trial Transcript - Day 15; dated 09/27/2019	11, 12	AA002556-AA002706

Alphabetical Index

Doc No.	Description	Vol.	Bates Nos.
41	Amended Notice of Appeal; filed 03/13/2020	5	AA001027-AA001029
2	Answer; filed 10/07/2015	1	AA000009-AA000012
9	Baker Initial Report; dated 07/03/2018	1	AA000032-AA000035
13	Baker Supplemental Report; dated 12/03/2018	1	AA000068-AA000092
19	Baker Supplemental Report; dated 06/20/2019	1	AA000127-AA000137
15	Baker Transcript; conducted 12/20/2018	1	AA000096-AA000102
1	Complaint; filed 05/20/2015	1	AA000001-AA000008

21	De-designation of expert Leggett; filed 09/20/2019	1	AA000140-AA000141
29	Defendant Motion Correct Reconsider Decision; filed 11/14/2019	3	AA000554-AA000564
30	Defendant Motion for New Trial; filed 11/18/2018	3	AA000565-AA000583
33	Defendant Reply Motion Correct Reconsider Decision; filed 12/24/2019	4	AA000764-AA000779
35	Defendant Reply Motion New Trial; filed 01/22/2020	4	AA000911-AA000924
20	Def. Trial Exhibit A. Southwest Medical Associates, Inc. Records; dated 10/25/2011	1	AA000138-AA000139
3	Demand for Jury Trial; filed 10/07/2015	1	AA000013-AA000014
23	Jury Instructions	1	AA000190-AA000194
10	Kirkendall Initial Report; dated 07/04/2018	1	AA000036-AA000038
12	Kirkendall Supplemental Report; dated 08/30/2018	1	AA000055-AA000067
11	Leggett Initial Report; dated 08/20/2018	1	AA000039-AA000054
16	Leggett Supplemental Report; dated 01/15/2019	1	AA000103-AA000119
14	Leggett Transcript 1; conducted 12/05/2018	1	AA000093-AA000095
18	Leggett Transcript 2; conducted 05/09/2019	1	AA000123-AA000126
4	Mtn for an Order Terminating Automatic Stay; filed 10/25/2016	1	AA000015-AA000020
28	NEO - Decision and Order; filed 11/05/2019	3	AA000543-AA000553
25	NEO of Judgment; filed 10/22/2019	1	AA000196-

			AA000200
37	NEO - Order Denying Def Motion for New Trial; filed 03/04/2020	5	AA000998-AA001005
38	NEO - Order Denying Def Motion to Correct or Reconsider; filed 03/04/2020	5	AA001006-AA001012
39	NEO - Order re Def Motion Re-Tax Costs; filed 03/04/2020	5	AA001013-AA001018
40	NEO - Order re Plaintiff Motion Atty Fees; filed 03/04/2020	5	AA001019-AA001026
31	Notice of Appeal; filed 11/19/2019	3, 4	AA000584-AA000752
6	Notice of Appearance; filed 02/21/2018	1	AA000024-AA000025
7	Notice of Refiling of Answer; filed 04/25/2018	1	AA000026-AA000027
17	OOJ to Defendant; served 01/18/2019	1	AA000120-AA000122
5	Order Granting Motion and Modifying Automatic Stay; filed 12/22/2016	1	AA000021-AA000022
26	Plaintiff Memo of Costs; filed 10/22/2019	1, 2	AA000201-AA000481
27	Plaintiff Motion for Attorney's Fees; filed 10/22/2019	3	AA000482-AA000542
22	Plaintiff Motion for Sanctions; filed 09/26/2019	1	AA000142-AA000189
32	Plaintiff Opp Motion Correct or Reconsider Decision; filed 12/16/2019	4	AA000753-AA000763
34	Plaintiff Opp Motion New Trial; filed 01/10/2020	4	AA000780-AA000910
8	Refiled Answer; filed 04/25/2018	1	AA000028-AA000031
36	Transcript Post-Trial Motions, dated 01/28/2020	4, 5	AA000925-AA000997

43	Trial Transcript - Day 5 - Part 2, dated 09/13/2019	5	AA001133-AA001191
44	Trial Transcript - Day 5 - Part 3; dated 09/13/2019	6	AA001192-AA001254
44	Trial Transcript - Day 5 - Part 3; dated 09/13/2019	6	AA001192-AA001254
45	Trial Transcript - Day 6; dated 09/16/2019	6, 7	AA001255-AA001444
46	Trial Transcript - Day 7 - Part 1; dated 09/17/2019	7	AA001445-AA001510
47	Trial Transcript - Day 7 - Part 2; dated 09/17/2019	7	AA001511-AA001649
48	Trial Transcript - Day 8; dated 09/18/2019	8	AA001650-AA001792
49	Trial Transcript - Day 9; dated 09/19/2019	8, 9	AA001793-AA001938
50	Trial Transcript - Day 10; dated 09/20/2019	9, 10	AA001939-AA002167
51	Trial Transcript - Day 11; dated 09/23/2019	10	AA002168-AA002296
52	Trial Transcript - Day 12; dated 09/24/2019	10	AA002297-AA002357
53	Trial Transcript - Day 13 - Part 1; dated 09/25/2019	11	AA002358-AA002459
54	Trial Transcript - Day 13 - Part 2; dated 09/25/2019	11	AA002460-AA002473
55	Trial Transcript - Day 14; dated 09/26/2019	11	AA002474-AA002555
56	Trial Transcript - Day 15; dated 09/27/2019	11, 12	AA002556-AA002706
24	Verdict; filed 09/27/2019	1	AA000195

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 7 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:

Dennis M. Prince, Esq.
PRINCE LAW GROUP
10801 West Charleston Blvd. Ste. 560
Las Vegas, NV 89135
Tel: (702) 534-7600
Fax: (702) 534-7601

Attorney for Respondent Bahram Yahyavi

DATED this 12th day of August, 2020.

/s/ Kaylee Conradi

An employee of Hutchison & Steffen, PLLC

1 you see the Plaintiff's car before you felt the impact?
2 A On the original assessment, I did. On the original -- when I
3 looked on the other side of the obstruction. From the obstruction to the
4 accident, no.
5 Q Okay. When you're looking to the left of the truck and you
6 see Mr. Yahyavi in that lane where you think he's going straight, did you
7 hear anything? Could you hear his car? Could you hear anything?
8 A When I got to the obstruction, I did hear kind of just like
9 gravel on the pavement, but --
10 Q Okay. I'm talking when the car was on the other side of the
11 truck.
12 A No, sir.
13 Q Okay. What about when the accident happened, the actual
14 collision, did you see the car before it hit or the first thing you knew was
15 it hit?
16 A First thing I knew was it hit.
17 Q And what about hearing? Did you hear anything at that
18 point?
19 A It was the same sound, like I was telling you, the gravel.
20 Hearing like, you know, how whenever the tires are turning, it's like,
21 (inaudible), kind of like that.
22 Q On the day of the accident, did anybody at Capriati tell you,
23 don't drive a forklift today?
24 A No, sir.
25 Q On the day of the accident, did anybody at Capriati tell you,

1 you're not allowed to drive a forklift at this job site on Sahara and Glen
2 and Boulder Highway?
3 A No, sir.
4 Q You have been told on other occasions at other job sites,
5 don't drive a forklift, correct?
6 A Correct.
7 Q What was the distinction in your mind, if you have one,
8 between those occasions and the occasion on the day of the incident
9 when you were driving the forklift?
10 A I wouldn't be allowed to drive something if I didn't show
11 competency first in operating a piece of equipment.
12 Q What about -- Mr. Prince asked you about operators and
13 laborers. You were designated a laborer, you weren't designated an
14 operator, correct?
15 A Correct.
16 Q So where were you going with this? You were going to the
17 storage yard across the street?
18 A Correct.
19 Q Do you know what you were going to pick up?
20 A It would have been bags of grout. Bags of cement.
21 Q And how much do those weigh?
22 A They could be there 60 or 90 pound bags.
23 Q Okay. 60 to 90 pound bags. But how many bags would you
24 have had to pick up?
25 A It would have been at least 15.

1 Q Okay. So we're talking roughly how many pounds of
2 materials you were going to get?
3 A Half a ton. Thousand pounds.
4 Q Okay, so you're going to get a thousand pounds of material.
5 Is that something you think you could have done by hand or with a
6 wheelbarrow or something like that?
7 A No, sir.
8 Q And do you believe that Capriati on that day was allowing
9 you to drive forklifts if there was a need for you to drive a forklift?
10 A Yes, sir.
11 Q What about if there was an operator present? Was that a
12 different situation?
13 A That would have been different. Yes.
14 Q Explain to the jury, please, why that would be different if
15 Capriati had an operator on site.
16 A Well, the operators there designated to use those equipment
17 and well, they make a lot more money than we do. Like they usually
18 don't want to laborer on a piece of equipment unless it's necessary.
19 Q And then what was your training to drive the forklift at
20 Capriati?
21 A Like the -- explain. What do you mean what type of training?
22 Q I mean, did you take a formal course at Capriati?
23 A I didn't take a course, no sir.
24 Q Did you have on the job training?
25 A Yes, I did.

1 Q How long before this accident had you had the on the job
2 training specifically for forklifts?
3 A It would have been at least three months.
4 Q Okay.
5 A At least three months of training prior.
6 Q When did you start driving heavy equipment for Capriati?
7 A Oh, I started probably five years prior to that.
8 Q And when did you learn about forklifts?
9 A When I first started, it would have been -- I probably would
10 have had up to that time about three years' experience messing with
11 forklifts.
12 Q And did you -- when Capriati's gave you on the job training,
13 did they let you go drive a forklift on the site immediately?
14 A No, sir.
15 Q What did they do in order to allow you to take a forklift on
16 site and drive it?
17 A I would have to drive it in the yard first and I would have to
18 show competency on it in the yard before I can do it on a site.
19 Q And is it your understanding then on the date of this accident
20 you needed some kind of license or certification or permission from the
21 government to drive a forklift on a construction site?
22 A No, sir.
23 MR. KAHN: No further questions. Thank you.
24 THE COURT: Redirect?
25 MR. PRINCE: Yeah.

1 REDIRECT EXAMINATION

2 BY MR. PRINCE:

3 Q Let me just see if we're clear. You're saying that --

4 MR. PRINCE: Pull up demonstrative number 10.

5 MR. KAHN: Hold on. I have your microphone.

6 MR. PRINCE: It might be 10 and 11.

7 BY MR. PRINCE:

8 Q So just so we're clear, you see Mr. Yahyavi almost 400 feet

9 west of Glen Avenue, right?

10 A Correct.

11 Q Right. And you think he's in -- you know that the lane, let me

12 just get to this exhibit. The construction has got the right turn lane

13 completely shut down, right?

14 A Correct.

15 Q So obviously there's going to be cars traveling on Sahara

16 and whom want to turn, they're not going to turn from the right turn lane

17 because that lane is now shut down, correct?

18 A Correct.

19 Q And you knew that that day, correct?

20 A Correct.

21 Q And so once you start to pull forward, that truck, meaning

22 the green truck, that's now an obstruction, correct?

23 A Correct.

24 Q It doesn't allow you anymore to see, as Mr. Yahyavi's would

25 say, within a couple hundred feet. It does no longer allow you to see his

1 car if it has a turn signal on or not, right? Because you're obstructed.

2 A Once you're at the obstruction. But I started way before the

3 obstruction, my view.

4 Q Yeah. My point is, is that before that, after you see him 3,

5 400 plus feet up, then you start to move forward. Then it starts to

6 become an obstruction, right?

7 A Correct.

8 Q And then as you're moving forward, it remains an

9 obstruction, correct?

10 A Correct.

11 Q So you're not saying that Mr. Yahyavi didn't turn a turn

12 signal on before he turned, you're just saying, I don't know. I didn't see

13 it when he was 400 feet away and then I had an obstruction. So I never

14 saw if he turned it on or not, right? That's really what the situation is,

15 isn't it?

16 A I'm saying I never saw one on. Yes, sir.

17 Q Doesn't mean he never turned it on, correct?

18 A Correct.

19 Q Right. And you're not here blaming him in any way for

20 causing this, are you?

21 A No, not at all.

22 Q He's not at fault, is he?

23 A I believe an accident, there's always two at fault.

24 Q Are you blaming it on him, part on him?

25 A I'm not blaming it on him.

1 Q You accept full responsibility for causing this? Can't look at
2 your lawyer.
3 A I don't even know how to answer that question, to tell you
4 the truth.
5 Q I mean, you're solely at fault here.
6 A I know that I was at fault. Yes, I was at fault, if that's what
7 you're asking.
8 Q I am asking that.
9 A Yes, sir.
10 Q So you agree your solely at fault for this?
11 MR. PRINCE: No, I'm --
12 MR. KAHN: Objection. Calls for legal conclusion. Invades
13 the province to the jury.
14 THE COURT: Overruled.
15 BY MR. PRINCE:
16 Q Go ahead.
17 A I don't believe solely. No, sir.
18 Q You think he's also at fault?
19 A I believe --
20 Q You believe Mr. Yahyavi's also at fault?
21 A When there is two parties involved. I believe fault belongs to
22 both parties.
23 Q That's what I want to make sure. So even though you're
24 saying you're accepting responsibility, you're blaming him at least
25 partially to being at fault for causing this, not just yourself, right?

1 A I'm not blaming anybody. No, sir.
2 Q Well, we're here today --
3 A I'm accepting the responsibility that belongs to me. I can't
4 do anything for him.
5 Q Respectfully, I'm not going to ask you to do anything for him.
6 I'm just saying since you were the only other person there involved,
7 other Mr. Yahyavi who's obviously in a different position today, are you
8 blaming him for saying to this jury that he is at fault in part for causing
9 this collision?
10 A Yes.
11 Q What did he do wrong?
12 A I don't know what he did wrong. I know what I did wrong.
13 Q So you're just saying just because there was two people
14 involved, both people must be at fault?
15 A That's my belief.
16 Q But it's nothing specific, any facts or information you can
17 give me, you just feel since another party was involved, that responsibly
18 should be shared, that's just your general view?
19 A Correct.
20 Q So you don't accept full responsibility then, do you?
21 A On my part, I do. Yes, sir.
22 Q But only whatever that part is?
23 A Correct.
24 Q What part? How much is it? Because if it's less than a
25 hundred percent, what part are you? 90 percent?

1 MR. KAHN: Same objection.
2 BY MR. PRINCE:
3 Q What are you?
4 A It's 100 percent of what I did. I can't -- there's a boundary
5 between me and Mr. Yahyavi. I can't own his responsibility. I can only
6 own mine.
7 Q So let's assume he puts his turn signal on, he's going at a
8 reasonable speed. Then he fulfilled his responsibility, right?
9 MR. KAHN: Hypothetically.
10 BY MR. PRINCE:
11 Q Go ahead and answer.
12 MR. PRINCE: I'm allowing a hypothetical under the
13 circumstance.
14 BY MR. PRINCE:
15 Q Go ahead.
16 THE COURT: Go on.
17 THE WITNESS: Answer?
18 BY MR. PRINCE:
19 Q Yes, answer.
20 A If that's what he did, yes. He would have been --
21 Q Then he wouldn't have done anything wrong, right?
22 A Correct.
23 Q So he's not at fault. You don't say he was speeding. You're
24 not saying that, right?
25 A No. I'm not saying that.

1 Q You didn't see him turn a turn signal on, but you're not
2 saying he didn't because you have an obstruction. You wouldn't have
3 been able to see if he did turn it on, right?
4 A Correct.
5 Q You just didn't see it when you looked, when you had the
6 ability to see it, you just didn't see it on?
7 A Correct.
8 Q So if he turned it on somewhere -- you don't even remember
9 this day that well or why you're using the forklift, right?
10 A Correct.
11 Q You told us in your deposition, you really don't recall this
12 that much, right?
13 A I didn't recall when I was picking up with the forklift. No, sir.
14 Q And you don't really recall much of the day other than this
15 collision happened, right?
16 A Correct.
17 Q Well, what you can control is you don't pull out unless it's
18 safe, right? You can control that.
19 A Yes.
20 Q You can control what you're looking out straight ahead of
21 you, correct?
22 A Correct.
23 Q And when your forks went past the orange construction
24 cone, you weren't aware of it, were you?
25 A No, sir.

1 Q That's your responsibility, correct?
2 A Correct.
3 MR. PRINCE: Thank you. No additional questions.
4 THE COURT: Anything else?
5 MR. KAHN: No questions, Your Honor.
6 THE COURT: Questions from the jury? We have some
7 questions. Write them down. Put your juror number. Steve will collect
8 them. Counsel, approach.
9 [Sidebar begins at 5:24 p.m.]
10 THE COURT: Did you turn your mic off?
11 MR. PRINCE: I did.
12 THE COURT: Okay. Interesting.
13 MR. KAHN: No objection. That's a fair question. That's a
14 fair question too.
15 THE COURT: Plaintiff, Mr. Prince, no objection?
16 MR. PRINCE: No.
17 THE COURT: Okay.
18 [Sidebar ends at 5:25 p.m.]
19 THE COURT: Sir, why were you raising the forks when
20 entering the roadway, when they should have been just above the road
21 surface?
22 THE WITNESS: Originally, that was the position I had. I had
23 them there. But I felt like if I had pulled out that way and a car would
24 come, that I would hit their tires. So I was trying to raise it above where I
25 thought it would be in a safer place.

1 THE COURT: What was the result of drug test?

2 THE WITNESS: It was clean.

3 THE COURT: Follow up from the Plaintiff on those?

4 MR. KAHN: Nothing.

5 MR. PRINCE: No, Your Honor.

6 THE COURT: Okay. Thank you. You may step down. Ladies

7 and gentlemen, I'm going to --

8 MR. KAHN: Do we have the witness released also, Your

9 Honor? I don't think I'm going to call him back. I just want to make sure

10 he's not being called back in Plaintiff's chief since he's under subpoena.

11 MR. PRINCE: He's just testified, so no.

12 THE COURT: Yeah.

13 MR. PRINCE: He's done.

14 THE COURT: He's done.

15 MR. KAHN: Thank you.

16 THE COURT: I'll have you come in -- I have the morning

17 calendar. Let's make it 10:15. I probably will hopefully get done at 10:00

18 and certainly they need to take a break. 10:15.

19 During this recess, you're once again admonished do not talk

20 or converse amongst yourselves or with anyone else on any subject

21 connected with this trial or read, watch or listen to any report of or

22 commentary on the trial or any person connected with this trial by any

23 medium of information, including without limitation, newspapers,

24 television, radio or internet. Do not form or express any opinion on any

25 subject connected with the trial until the case is finally submitted to you.

1 We're in recess.

2 THE MARSHAL: Please leave your notebooks and pens. Rise

3 for the jury.

4 [Jury out at 5:27 p.m.]

5 [Outside the presence of the jury.]

6 THE COURT: All right. Anything?

7 MR. KAHN: Not on my part.

8 THE COURT: Okay.

9 MR. PRINCE: No.

10 MR. KAHN: 10:15, Your Honor.

11 THE COURT: Yup.

12 [Proceedings concluded at 5:28 p.m.]

13

14

15

16

17

18

19

20

21 ATTEST: I do hereby certify that I have truly and correctly transcribed the audio-visual recording of the proceeding in the above entitled case to the

22 best of my ability.

23

24 Maukele Transcribers, LLC
Jessica B. Cahill, Transcriber, CER/CET-708

25

1 RTRAN
2
3
4
5 DISTRICT COURT
6 CLARK COUNTY, NEVADA
7
8

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

9
10
11
12
13
14 BEFORE THE HONORABLE RONALD J. ISRAEL
DISTRICT COURT JUDGE
TUESDAY, SEPTEMBER 17, 2019
15
16 **RECORDER'S TRANSCRIPT OF JURY TRIAL - DAY 7**
17
18 APPEARANCES:
19 For the Plaintiff: DENNIS M. PRINCE, ESQ.
KEVIN T. STRONG, ESQ.
20 For the Defendant: MARK JAMES BROWN, ESQ.
21 DAVID S. KAHN, ESQ.
MARK SEVERINO, ESQ.
22
23
24
25 RECORDED BY: JUDY CHAPPELL, COURT RECORDER

1 INDEX

2

3 Testimony 8

4

5 WITNESSES FOR THE PLAINTIFF

6 Testimony of Joseph Schifini, previously transcribed

7

8 DARIAN YAHYAVI

9 Direct Examination by Mr. Prince 8

10 Cross-Examination by Mr. Severino 34

11 Redirect Examination by Mr. Prince 59

12

13

14 INDEX OF EXHIBITS

15

16 FOR THE PLAINTIFF	MARKED	RECEIVED
17 None		

18

19

20 FOR THE DEFENDANT	MARKED	RECEIVED
21 None		

22

23

24

25

1 Las Vegas, Nevada, Tuesday, November 17, 2019
2
3 [Case called at 10:29 a.m.]
4 [Outside the presence of the jury]
5 THE CLERK: Case number A718689, Yahyavi v. Capriati
6 Construction.
7 THE COURT: Everybody here?
8 THE CLERK: Yes.
9 THE COURT: Jury's all here?
10 THE MARSHAL: I'm going out right now to check. It doesn't
11 help to check too early.
12 THE COURT: Well, it's already been -- you guys have
13 anything?
14 MR. PRINCE: Nothing, Judge.
15 MR. KAHN: No, Your Honor. Good morning.
16 THE COURT: Fine then . good morning. Who's on today?
17 MR. PRINCE: We have to start our morning, Your Honor, Dr.
18 Schifini. He will likely go through the noon hour, probably maybe -- I
19 don't know. See how we do. Maybe a little after lunch. Then I have the
20 son of Mr. Yahyavi, Darian Yahyavi. And then once we're done with
21 that, we have a deposition read of a Kevin Mackey.
22 We served him with a subpoena, but he's not available
23 because his wife is undergoing chemotherapy treatment and has to
24 attend that. So we've agreed to read his deposition. That will be the day
25 today, so we may be done a little early.

1 MR. KAHN: And both sides have agreed to portions to read,
2 so I think we're just going to have one person and counsel's worked it
3 out.
4 THE COURT: Great.
5 MR. PRINCE: And then what time --
6 THE COURT: Friday --
7 MR. PRINCE: Go ahead.
8 THE COURT: Friday, I need to leave really -- what do we
9 have on Friday?
10 MR. KAHN: Friday should be my case, Your Honor. I have
11 my doctor flying in from Southern California and my vocational expert.
12 But I don't think it would necessarily take the whole day.
13 THE COURT: Okay.
14 MR. KAHN: I think we start -- is that a 9:00 day?
15 THE COURT: I'd like -- I've got to go to a bar mitzva. So I'd
16 like to leave 4:00, 4:30 at the latest.
17 MR. KAHN: Sounds good to me. I think I can make sure that
18 happens.
19 MR. PRINCE: Yeah. I'll be done with my case on Thursday.
20 THE COURT: Okay. Steve, are they here? They're all here.
21 Bring them in.
22 THE CLERK: And tomorrow we start at 1:00.
23 MR. PRINCE: We have a 1:00 start tomorrow?
24 THE COURT: Yeah. We have criminal.
25 THE CLERK: It's criminal.

1 MR. PRINCE: Okay.
2 THE MARSHAL: rise for the jury.
3 [Jury in at 10:31 a.m.]
4 [Within the presence of the jury]
5 THE COURT: Please be seated. Good morning, ladies and
6 gentlemen.
7 GROUP RESPONSE: Good morning.
8 THE COURT: For tomorrow, again, I have my criminal which
9 usually takes longer, calendar. So that means generally 1:00. If I haven't
10 seen it yet, if we can start at 11:00, that would be great. I'll tell you after
11 lunch. Otherwise, that's pretty much it.
12 Plaintiff, call your next witness.
13 MR. PRINCE: Ladies and gentlemen, good morning. Thank
14 you for being here. Your Honor, we call next, Dr. Joseph Schifini.
15 [Testimony of Joseph Schifini previously transcribed]
16 [Sidebar begins at 3:35 p.m.]
17 THE COURT: Okay. So the second part I forgot to tell you is
18 they were pissed that they had to stay past 5:00. There's no way we're
19 going to be able to get to your client's and the depo. How long is the
20 depo?
21 MR. PRINCE: It's short, I think.
22 MR. STRONG: It's like 30 pages.
23 MR. PRINCE: 30 pages.
24 MR. STRONG: 32 pages.
25 MR. PRINCE: Probably take us --

1 MR. SEVERINO: No, they're only using 15 pages.
2 MR. STRONG: Not all of it's going to be read.
3 THE COURT: Okay. So will you --
4 MR. PRINCE: I was going to use the son, not the client.
5 THE COURT: Right. But how long is the son going to be?
6 MR. PRINCE: Oh, probably half an hour, 45 minutes. I think
7 we could do him before we go today.
8 MR. KAHN: We should be able to get the son done with
9 cross.
10 THE COURT: Okay.
11 MR. PRINCE: We'll start this on --
12 THE COURT: The son and not the depo? Okay. Let's be
13 done by 5:00 so you don't --
14 MR. KAHN: Mr. Severino is going to do the cross for this
15 one.
16 THE COURT: -- piss off the --
17 MR. PRINCE: Okay.
18 MR. KAHN: Just so you know.
19 THE COURT: Okay. Thank you.
20 [Sidebar ends at 3:36 p.m.]
21 THE COURT: Call your next witness.
22 MR. PRINCE: Your Honor, we call Darian Yahyavi.
23 THE MARSHAL: Remain standing, face the clerk of the Court.
24 THE CLERK: Please raise your right hand.
25 DARIAN YAHYAVI, PLAINTIFF'S WITNESS, SWORN

1 THE CLERK: Please be seated. Please state your name and
2 spell it for the record.
3 THE WITNESS: Darian Yahyavi. D-A-R-I-A-N Y-A-H-Y-A-V-I.
4 THE CLERK: Thank you.
5 THE COURT: Go ahead.
6 DIRECT EXAMINATION
7 BY MR. PRINCE:
8 Q Darian, how old are you?
9 A I am 28.
10 Q And how many brothers and sisters do you have?
11 A I've got one younger brother and two younger sisters.
12 Q And how old is your brother and what is his name?
13 A Casey is my brother and he is 25.
14 Q And you have a sister named Callie?
15 A Yup. Callie is 24.
16 Q Okay. And how about your other sisters?
17 A And Dominique is the youngest and she is now 21.
18 Q Where were you born?
19 A San Diego, California.
20 Q And how long did you live in San Diego?
21 A I lived there for 16 years.
22 Q Okay. And when did you move to Las Vegas?
23 A I moved here as a junior in high school in 2007.
24 Q Okay. And when you moved to Las Vegas in 2007, did you
25 live with your dad?

1 A I did.
2 Q Were your parents separated?
3 A Yes.
4 Q And your dad living here -- yeah.
5 A Yeah.
6 Q And so when you moved here, you obviously moved in with
7 your dad?
8 A Yep.
9 Q And what high school did you go to?
10 A I went to Sierra Vista High School out here.
11 Q And were you an athlete in high school?
12 A Yes.
13 Q What sports did you play?
14 A I played football, basketball, and he was a member of track
15 team.
16 Q And did you graduate from high school?
17 A I did.
18 Q And after you graduated from high school, did you attend
19 college?
20 A Yes.
21 Q Where did you go to college?
22 A I went to Murray State University.
23 Q And where is Murray State University?
24 A In Kentucky.
25 Q When you attended Murray State, did you play any sports

1 there?

2 A I did. I played football for their football team.

3 Q Okay. And is Murray State, a Division One football team?

4 A Yes.

5 Q What does it mean to be a Division One football team?

6 A It's the highest level of competition in all sports, in college.

7 And it just kind of represents a lot of the hard work and determination

8 that an athlete has to put in. And I think there's a statistic of something

9 like 1 percent of all high school athletes get to play in college. And that's

10 just college in general, so not just a Division One.

11 Q Okay. Were you a scholarship player?

12 A Yes.

13 Q Did your dad come and watch you play --

14 A He did.

15 Q -- and travel to your games?

16 A He did.

17 Q And obviously, your dad is here. Do you have a close

18 relation with your dad?

19 A I do.

20 Q Do you live together?

21 A We do.

22 Q When did you graduate from Murray State?

23 A I graduated in 2014.

24 Q And when you graduated in 2014 from Murray State, what

25 was your degree in?

1 A It was an advertising with a minor in business
2 administration.
3 Q And after you graduated college, did you go on to pursue a
4 master's degree?
5 A I did.
6 Q Did you receive a master's degree?
7 A I did, yup. I got an MBA from Liberty University.
8 Q And where's Liberty?
9 A In Lynchburg, Virginia.
10 Q How about your brother Casey, did he attend college?
11 A Casey did.
12 Q Where did he go?
13 A UNLV.
14 Q Did he graduate?
15 A He didn't graduate.
16 Q Okay.
17 A He's still in attendance.
18 Q He's still attending school?
19 A Yup.
20 Q How about your sister, Callie?
21 A Callie went to Loyola Marymount University in Los Angeles
22 and she graduated, I believe, two years ago.
23 Q Okay. How about your sister Dominique?
24 A Dominique is a senior at the University of San Francisco.
25 Q In obviously, San Francisco?

1 A Yep.
2 Q So everybody is all educated. And tell me what you do now?
3 A Right now, I'm a manager of a performance gym, so I work
4 with a bunch of athletes right now. And I also am currently in the
5 process of becoming an NFL agent.
6 Q Okay. And what are you doing in that regard?
7 A So right now, just studying. Right now the NFLPA has given
8 us source documents to study and the test is administered once a year.
9 So it'll be sometime in the spring or the summer of next year.
10 Q Okay. What do you do in your role as -- you say you manage
11 a sports facility, tell us what you do there.
12 A So on a day to day basis, I pretty much just make sure the
13 gym is run accordingly, handle accounts. I'm making sure the athletes
14 are being trained properly, overseeing program designed from all of our
15 trainers. And just making sure just day to day operations are smooth.
16 Q Obviously, you're in the health and fitness business
17 currently?
18 A Yes.
19 Q And obviously you work with athletes. I mean, health and
20 fitness is a big part of your life?
21 A Correct.
22 Q And we're here talking about your dad and the injuries that
23 he's suffered from this collision. Have you seen a significant difference
24 in the changing of your dad, you know, how he was before versus how
25 he is now?

1 A Yes.
2 Q We're going to be talking about the details of that, but do you
3 also try to help him with his health and his fitness to try to maintain his
4 strength and flexibility to help manage his problems?
5 A Of course.
6 Q How do you do that?
7 A I try to give him, I mean, within guidelines from his doctors, I
8 try to be as vanilla as I can with exercises to give him and stretches and
9 things of that nature just to kind of help him manage his day to day
10 workload around the house, just to try to make things easier.
11 Q Do you worry about him like being less active, less flexible?
12 A Yes.
13 Q Less strength and then his condition worsening?
14 A Yes.
15 Q What do you worry about?
16 A I worry about it getting to the position where he's going to
17 need me 24/7, because at some point it gets tough, especially with
18 having a full time job. Being able to, for lack of a better word, be his
19 caretaker and also have a full time job and then also have a family or a
20 social life outside of that. So that's worrisome definitely in my eyes.
21 Q Since June 2013 and through today, have you been, what
22 you called a caretaker, been there to help your dad?
23 A Yeah. So 2013 was the accident. I was still in school. I
24 moved back as soon as I was done and pretty much ever since that point,
25 I had been his right hand man in that case. Doctor's appointments,

1 injections, things of that nature. I was always the driver and pretty much
2 there through all of that kind of stuff.
3 Q As time has gone on, has your dad's condition worsened
4 with time, gotten better, stayed the same?
5 A It's gotten worse. For a second, I thought it might have been
6 getting better, but it's definitely gotten worse.
7 Q As of today, we're going to talk about some comparisons in a
8 minute. Does he have to rely, is he dependent upon you for many
9 things?
10 A Yes.
11 Q What type of things is he dependent upon you for?
12 A Daily chores, things that you and I do every day. I would say
13 he's dependent on me in the financial way as well. But definitely just
14 daily activities, helping him around the house, helping him with the
15 upkeep, maintaining everything, even necessary sometimes his own
16 personal necessary things.
17 Q You help him with personal care at times?
18 A I do.
19 Q Have you moved back in the house with your father?
20 A I have.
21 Q Why did you do that?
22 A The condition just continued to get worse and he pretty
23 much asked and at that point, I was in no position to turn him down. So
24 it was a no brainer.
25 Q How would you characterize your relationship with your dad

1 growing up?

2 A I would say he was like my best friend. I try to explain to

3 people that he's someone you would want as your neighbor. He's

4 someone you want as your friend. He's someone you can talk to every

5 day. He was always supportive of all my schooling, all my

6 extracurricular activities. So Him and I had a very good relationship

7 growing up.

8 Q Has he kept a close relationship with all your brother and

9 your sisters as well?

10 A Oh, yeah, absolutely.

11 Q And does Casey live here in Las Vegas?

12 A Casey does.

13 Q And describe for me before this, how was your dad in terms

14 of his activity level, his attitude towards life and how he approached his

15 life before this June of 2013?

16 A I would say he was pretty active. We owned a boat, so we

17 would quite frequently visit the lake. We took ski trips.

18 Q Snow skiing?

19 A Snow skiing, yes.

20 Q Okay.

21 A He would visit a lot of my football games. He would always

22 -- he was the one who introduced me to the sport, so he kind of showed

23 me the ropes and we would play together. And he was a big soccer guy,

24 so we played soccer growing up.

25 Trips to Mexico out of the country. So we were fairly active as a

1 family.

2 Q Okay.

3 A And it was just me and him as the family in general.

4 Q So all the kids?

5 A Yup.

6 Q Was he strong in education, a proponent of education for

7 you and your brother and your sisters?

8 A Oh, yeah, big time.

9 Q He himself, what is his educational --

10 A I believe he has a master's degree as well.

11 Q You talked about -- did your dad have any recall any physical

12 limitations or physical problems that held him back from doing anything

13 he wanted to do, whether it be skiing, playing soccer, going out on the

14 boat or in the lake, you know, wakeboarding or anything else that you

15 guys might do? Any physical limitations at all you recall before this

16 happened?

17 A Before the accident?

18 Q Yes.

19 A No.

20 Q Okay.

21 A No limitations.

22 Q Was he living in a happy and fulfilled life?

23 A Yeah, I would say so. From my eyes.

24 Q Nobody's like is perfect. Yeah.

25 A Right.

1 Q Yeah. Have you seen a change in his outlook and his attitude
2 and his, you know, kind of whether he's upbeat, you know, upset?
3 A Yeah, absolutely.
4 Q What have you seen? What's change have you seen, Darian?
5 A I mean, there's a multitude of things. I think the main ones
6 would be just lack of energy. As I stated before, like a lack of enjoyment
7 of things. He's more irritable. His train of thought gets lost easier. He's
8 very forgetful. But I would just say just the overall daily mood is just
9 completely different. It's a complete 180.
10 Q Can he work any longer?
11 A No.
12 Q And you think it bothers him that he can't work anymore?
13 A Absolutely. Yeah. He's very work oriented and has always
14 preached that to me and the kids in general. So I think his vulnerability
15 in this stage and him being in this state has definitely taken a toll on him
16 because in my opinion, he looks -- he believes that we look at him in a
17 weaker state and he's always been very bravado.
18 Q And do you think that makes him feel less than, like, you
19 know, I'm not the father that I'd like to be or should be?
20 A Absolutely.
21 Q And how did you first learn about this collusion, Darian?
22 A I was with my little brother. We were -- it was the offseason,
23 so we were here in Vegas. Casey was also training for his football
24 season, his senior season at Palo Verde, and we were at a workout at the
25 gym. And my brother got a call, I believe from one of my dad's co-

1 workers and pretty much told me, hey, dad's been in an accident, we got
2 to go, in the middle of a workout. So it was at that time that I found out.
3 Q Okay. So what did you and Casey do?
4 A We left immediately.
5 Q And where do you go?
6 A We went to the hospital.
7 Q Okay. UMC?
8 A Yes.
9 Q And what kind of condition do you see your dad in when you
10 get to UMC?
11 A He was just out of it. He was at a loss for words. He really
12 didn't answer any questions we had for him. We pretty much got
13 informed by -- I don't remember if it was one of the people on staff at the
14 hospital or a police officer, but -- or even one of his co-workers. But it
15 was somebody that pretty much had to let us know what happened
16 because he couldn't explain anything to us. He was not all the way
17 there.
18 Q Like he was like altered consciously? I know we've looked at
19 some records from the ambulance. They said he had an altered
20 conscious. He couldn't even provide his address and wasn't oriented to
21 even where he was.
22 A Yeah. I've never seen him like this. He just literally could not
23 answer any questions I had for him.
24 Q Is it frightening to you?
25 A Frightening. Frustrating. I was trying to get things out of

1 him. And when he wasn't responding, I was just confused.
2 Q Well, what did you learn happened from whatever source?
3 A I learned that he was transporting a car from one -- from the
4 dealership he worked at to another building that they had down the
5 street and that a forklift had come out onto the street and hit his vehicle
6 with the forks.
7 Q Okay.
8 A And at that point, I didn't get much detail after that onto what
9 exactly happened to him.
10 Q And when you were at the hospital, did he ever regain kind
11 of regain, kind of become normal and to be able to sort of answer your
12 questions and sort of piecing, you know, this stuff together for you?
13 A Not really. Towards the end, it was at least him
14 acknowledging that my brother and I were there. But there was never
15 any explanation as to what happened or how he was feeling or what was
16 going on.
17 Q How did he look? Was he able to open his eyes?
18 A Yeah. He was able to open his eyes.
19 Q Was he able to communicate normally in any way at the
20 hospital?
21 A No, not at that time. No. The look at me was like of
22 confusion. Kind of like he didn't know who I was.
23 Q How'd that make you feel?
24 A I guess frightened is the right way to say it. I just, I didn't
25 understand what was going on, so at that point, I'm just trying to figure

1 out why he's like this.

2 Q How does he get home from the hospital, do you drive him?

3 A Yes.

4 Q Where do you go from the hospital after you leave the

5 hospital that day?

6 A We take him home.

7 Q How is he doing in the hours and the few days later?

8 A I would say he got better from that mental state where at

9 least he could tell us what was happening and what went on and what

10 exactly transpired during the incident. But he was still very lethargic,

11 and I would say weary, frantic, maybe, like a little bit antsy. I noticed

12 that a little bit.

13 And to me, I didn't understand at the time the severity of the

14 issue. So in my eyes, I kind of was like, I don't understand what exactly

15 is going on or why he's frantic or why he's acting like this. So to me, it

16 was because I didn't understand the severity of the issue.

17 Q I guess we're six years later. So you would have been

18 around 22 at the time?

19 A Yes.

20 Q And after the collision and, you know, things, you know, after

21 a few days, he's now starting to go to the doctor appointments, how is

22 he doing?

23 A He's better in a sense. I think he tried to put it behind him

24 quick. And like I said earlier, he was always tough. So I think that was

25 something he tried to preach to us, and he wanted to set the example

1 and again, work oriented guy, so he didn't want to miss a ton of time.
2 So I think that he tried to show us that, hey, it didn't really matter what
3 was going on. You need to carry on and move on and get back to work.
4 Q And did he from at least your standpoint and kind of
5 consistent with his own attitude as you understood it, just try to push
6 through?
7 A Absolutely.
8 Q And even though he was going to work, was he also going to
9 his medical appointments and things of that nature?
10 A Yes.
11 Q Was he doing his best?
12 A Yes.
13 Q Even though he was working, was he back to normal ever,
14 Darian? Ever?
15 A No. No, I wouldn't say back to normal. And I use a key
16 example with my brother when we talk about these kind of things. My
17 junior year of college, which would have been the year before, he came
18 to Tallahassee to watch me play in a game against Florida State.
19 And everything was good and there was no complaints. And
20 my brother said that, you know, they had a good time together hanging
21 out. I only got to see them after the game. But they had a good time in
22 Florida together.
23 And he did come to my game my senior.
24 Q After this?
25 A After, My senior year would have been the fall of 2013.

1 Q So six months later.
2 A Six months. Yeah. Sometime after the accident, he did
3 come to that game. And I remember my brother telling me that the
4 travels were a little more tough. And this game was in Columbia,
5 Missouri. So against the University of Missouri.
6 Q Oh, Mizzou?
7 A Yeah, Mizzou. And I remember my brother telling me the
8 travels were a little more tough and my dad complaining a little bit.
9 Nothing too extraneous. But I remember at that point, kind of, are you
10 okay? Is anything wrong? And him kind of toughing it out and handling
11 it.
12 But I remember kind of a steady decline from there. I would
13 say that was like the first sense to me, like, okay. He doesn't seem right.
14 There's something going on.
15 Q Was it worrisome to you when you started seeing him like
16 towards the end of 2013, just kind of like, hey, he's not right? He's
17 declining, he's not getting better.
18 A Yeah. Yeah. I would come home and like I said, usually we
19 would take ski trips, especially in the winter and we didn't take one this
20 time. And it was just kind of very dull time.
21 And I'm only back for a couple of weeks at a time from
22 school. So usually those times are very eventful because that's the only
23 time I get to spend with the family when I'm back from school.
24 And they just weren't. And I could tell that something was --
25 something was different.

1 Q Okay.
2 A I tried not to put too much emphasis on it at the time just
3 because I was still in school, my last semester was coming up.
4 Q Yup.
5 A But I could definitely tell that something was up.
6 Q And then so now you're in the spring of 2014. Did you need
7 some water?
8 A I'm good. Yeah. I'm okay.
9 Q In the spring of 2014. Did you graduate that spring?
10 A Yes.
11 Q Okay. What do you do after you graduate? Do you move
12 back home?
13 A So at the time I was still -- I did move back home. I was
14 training to hopefully get a shot in some type of professional football
15 organization. So I moved back in with my dad and he pretty much was
16 still supporting me in that time.
17 So I didn't look for employment just yet because he told me,
18 as long as you're trying to play, I'll help you out.
19 Q But he's still working at the time?
20 A He's still working at the time.
21 Q But how's he doing? Is he back to normal, is he himself, as
22 you knew him before this collision by the summer of 2014?
23 A No. No, it was different. I wouldn't say it was a whole ton
24 different, but I would say there was definitely a difference.
25 Q And he's going for treatment during that time?

1 A Yup. Still going for treatment. I'd go with him often.
2 Q And would you attend some of the sessions with him?
3 A Uh-huh.
4 Q I've looked at some of the records from the injection facility
5 for the surgical centers. And almost every time it said, who is your ride,
6 who's there to drive you? It said, Darian.
7 A Yeah.
8 Q Did you take him and drive him home virtually every one of
9 those injections?
10 A Yeah. I would say something like 90 percent of the time it
11 was me that he would ask.
12 Q And over time, you said in 2014, you notice a change. Did
13 you notice the decline over time?
14 A Yes.
15 Q What did you notice most?
16 A Like I said, I think that the big thing was just day to day
17 activity and overall mood. Just gradually there was just a decline in how
18 he was and how enjoyable he was to be around. Because beforehand,
19 like I said, he was somebody you would consider a great friend. And he
20 was always -- it was always good conversation and always positive
21 talking to him. And I think at this time it started to change in the sense
22 that he started to become a little more sad, for lack of better words. And
23 then speaking to him wasn't always the most enjoyable thing ever. Not
24 because he was rude, but just because there wasn't a ton of positivity.
25 Q Right. As we move into late 2014, now we're into 2015, was

1 his work starting to be affected by his injuries and his physical
2 problems?
3 A Yeah, definitely. So there would be times I would go to work
4 and I'd see him with the ice pack on the neck --
5 Q At work you mean?
6 A At work, yeah.
7 Q Tell us about that.
8 A So there'd be times where he would -- for whatever reason,
9 we'd go visit him at work or to bring lunch or whatever the case was and
10 I'd walk in and ask for him and they would say, oh, your dad's upstairs.
11 And go upstairs and he's kind of propped up on the couch with the
12 icepack.
13 Q Kind of like he is now?
14 A Yeah, kind of like that. Propped up on the couch with his
15 head back with ice pack on his neck. And it was weird to me because I
16 hadn't seen him like this, and I didn't know -- I still at this time didn't
17 understand the severity of the issue and I didn't understand what was
18 going on.
19 So I'm like, hey, what's going on? Get up. You got to go
20 back to work. And he's like, I just got to be up here for a little bit. I come
21 up here frequently. Take little breaks and go back down. So at that
22 point, I kind of -- that became regular at that point.
23 Q Okay. And as you kind of move into 2015 and now we're into
24 2016, how does his condition continue after that? Is he staying the
25 same? Is he getting worse?

1 A Yeah, it's getting worse at this point. I would say I saw that
2 more often. Even at the house. Now at the house, he's not doing much.
3 He's propped up at the house similar to how he is now and gradually just
4 got worse and worse.
5 Q At some point, did he ultimately have to stop working?
6 A Yes.
7 Q Why did he have to stop working?
8 A I think it got to the point where it was just unbearable and
9 there was a lack of production. And I think it frustrated him and that he
10 couldn't be productive or be what he once was because he was always
11 used to being one of the best employees at his job, so I think that the fact
12 that his production had fallen off drastically took a toll on him and
13 eventually it was physically, mentally unbearable.
14 Q And did your dad enjoy, do you recall, working in the
15 automobile business and the auto sales business?
16 A Yeah. Whenever I'd bring friends over or when I would ask
17 about it and they would ask about how you get into cars and this and
18 that, he would explain and that was his passion. And ever since he was
19 16, 17 years old, he always had -- been fond of cars and whatever
20 fashion.
21 And he was good at it. He loved it. He taught my brother
22 how to work with cars and he'd always talk about it. Knew the newest
23 cars, knew the newest models, new engines, knew things of that nature.
24 So you could tell he was he was -- it's something that enjoyed him.
25 Q Did he spend his whole career working in the auto sales

1 business?

2 A Yes.

3 Q His entirety of his whole professional life?

4 A Yeah. From everything that I remember, he's always in the

5 car business.

6 Q And how did you, after your dad stopped -- let me step back

7 a second. I know you went to a lot of these -- you said about 90 percent

8 of the injections. You take him to the surgical center --

9 A Right.

10 Q -- and obviously drive him home because it wouldn't be safe

11 for him to do it. Did they really help him much?

12 A Overall, I'd say no. There were some times where he would

13 say that he felt relief for a day or two on some of the occasions. There

14 was sometimes where I would ask him and he'd be like, this doesn't help

15 me at all. And there'd be sometimes that he'd come back and would be

16 in more pain.

17 And at that point, I remember asking him, are you just going

18 to -- is there anything else that we can do or are we going to keep doing

19 these? At what point do we stop this because it's not helping?

20 Q Okay. And your dad stops working in 2016, ultimately

21 decides to go see another surgeon in 2017 before surgery. What do you

22 recall prompted that, Darian? Were you involved in that at all? We need

23 to do something about this.

24 A Yeah, I remember that -- I think me bringing up those

25 questions may have had something to do with his decision making in

1 that case. But I think that it just finally got to a point where he was in
2 aggreeance [sic] with me and was like, yeah, this this isn't helping and
3 it's unbearable. And I've got to figure out a way to try to fix it.
4 So I remember him bringing the idea up to me and I was
5 apprehensive about it. But I think that with my trust in the medical
6 system, I gave him kind of my green light to go do it.
7 Q And he ultimately had the surgery. How'd he do after the
8 surgery, Darian? Did it help him much?
9 A After the surgery, immediately after, I would say for about
10 four weeks it was rough. That was the worst I'd ever seen him. To the
11 point where he couldn't walk without pain. I'd have to help him with
12 pretty much everything.
13 His mood was at an all-time low. Depression, in my opinion,
14 was at an all-time high. And I think that that definitely was in the worst
15 shape that I'd seen him. That month to six weeks after surgery was not a
16 good time.
17 Q Once we get kind of past the initial post-operative phase,
18 kind of after the first few weeks of surgery, you see him at an all-time
19 low. I mean, one of the things that Doctor Thalgott talked about
20 yesterday was, he developed a nerve problem in his arm. He couldn't
21 move his arm very well. Couldn't move it up. What do you remember
22 about that?
23 A I remember any specific movement or any kind of movement
24 at all would trigger it. He would have numbness in his arm. He would
25 tell me at times, especially immediately after the surgery in those month

1 to six weeks after that he would feel a tugging pain on his shoulder and
2 his arm, shortness of breath.
3 So still many complaints and in my eyes, I'm wondering
4 what exactly happened again. Are we just going in a big circle here?
5 Q After the surgery, I mean, did it provide any lasting relief for
6 your dad after the major surgery?
7 A No.
8 Q And did he stay about the same or do you think he's
9 continued to decline after the surgery?
10 A I would say he's continued to decline.
11 Q In what way?
12 A At least beforehand, he was still able to do things himself.
13 He was still able to manage the house and keep up with the upkeep and
14 daily activities.
15 Now, it's pretty much, he tries, he'll try. He definitely will try
16 things that he probably shouldn't be doing. But it's definitely much
17 more of a burden for him. And he knows that he needs my help in
18 majority of the activities.
19 Q How about his social life?
20 A I would say non-existent.
21 Q Is he a personable guy?
22 A Absolutely.
23 Q Is he charismatic?
24 A Yup.
25 Q Is it hard to watch him kind of decline and be kind of not as

1 engaging and outgoing as he once was?

2 A Yeah, absolutely. I mean, I try to make up for it in ways by

3 spending as much time with them as possible, bringing home pizza or

4 whatever the case is to try to make his mood a little better, because I

5 know there's not a lot of things that he can do to live normally or enjoy

6 normal experiences.

7 And with our two sisters being out of the state and Casey

8 living with his girlfriend, who he's been with for four or five years, who's

9 got pretty much his own life, it's difficult for him by himself.

10 Q Yeah. I mean, I guess I knew you because I've known you all

11 these years now. But I can't remember a time you didn't come with your

12 dad when he'd come to the office, we had to deal with something.

13 A Right.

14 Q Were you that way with the medical appointments, too?

15 A Yeah, absolutely.

16 Q And watching kind of. I mean, these are emotional issues at

17 times. I mean, watching your dad decline and being now dependent on

18 you and he's only in his mid-50s. How does that make you feel?

19 A Worries me. It does.

20 Q In what way?

21 A I worry for him and I also worry for kind of the direction of

22 my life and what exactly that entails for me with his physical condition. I

23 wonder how it's going to dictate or how I need to tailor my life to make

24 sure that he's accommodated as well, because at the end of the day he's

25 my dad and I have to make sure that he's doing fine, too.

1 So it worries me that it's almost an extra person I've got to
2 bring on board.
3 Q I'm sure you do it with love and affection --
4 A Of course.
5 Q -- as much as you can, but in terms of like watching your dad,
6 did you think about that when you get married or when Casey does or
7 when the girls do and there's grandchildren, he's not going to be able to
8 participate in the way that you would have known your dad to participate
9 in his life?
10 A Right. Yeah, that kind of stuff worries me. I mean, especially
11 if when it comes to travel and things of that nature. Can't really go
12 anywhere, sitting in a car. You're going to have to take multiple frequent
13 stops.
14 Flying on a plane is pretty much out of the picture just
15 because he can't sit for longer than an hour or so.
16 Q Yes. He's been in Court, you know, because this is his case
17 and --
18 A Uh-huh.
19 Q -- he's been here as much as he can. Tell us what it looks like
20 when he comes home for the next day or two after he's been here for a
21 few hours?
22 A Oh, yeah, he's pretty much just in the bed, and he doesn't get
23 up much.
24 Q Pretty much he's down for a few days?
25 A Yeah. He's out of commission I would say.

1 Q And do you see him try, though, to like do his best?
2 A Yeah.
3 Q Physically?
4 A Absolutely, yeah. Like I said, he's not much of a -- he's not
5 much of a quitter at all. So if anything, he's so stubborn and so proud
6 that he tries to do things that he knows he can't do, like I said. And he'll
7 try to do things that he doesn't want to ask for my help with.
8 Q Does he do the exercises that you and the physical therapist
9 have given instruction? Does he do those at home?
10 A Yeah.
11 Q Do you guys have that little place at home where you guys
12 go to work out and can stretch or, you know, train?
13 A Yeah. Yeah, we have like a little home gym area.
14 Q Does he try to do those things every day?
15 A Yeah.
16 Q What have you noticed with his left arm function, his
17 shoulder and everything?
18 A From a trainer standpoint, there's just a ton of atrophy and I
19 think that's just because of lack of use. He's not able to use it very often,
20 very minimally. So obviously he favors his right hand. So the majority
21 of the things that he does on a day to day basis is with his right hand.
22 And he'll tell me about numbness and pain in the arm.
23 Q Do you guys -- going on a ski trip would be obviously out of
24 the question at this point?
25 A Right.

1 Q I mean, do you do -- do any of the same things you did
2 before -- strike that. Is the picture of your dad's life look anything now,
3 like it did before this happened?
4 A No.
5 Q Dramatically different?
6 A Yeah, I would say it dramatically different.
7 Q Do you worry about his overall mental well-being if you're
8 not around?
9 A Yes. Yup, I do.
10 Q I mean, and I represent clients sometimes who have these
11 chronic pain issues. Sometimes friends stop calling because they'll
12 invite you to go somewhere and then you're in pain, you can't.
13 A Right.
14 Q So people then, they kind of withdraw and they just don't
15 participate. Has that happened to your dad?
16 A Absolutely. Yeah. That's kind of why he's at home all day
17 and that's he's always calling me even when I'm at work and just wanted
18 to talk or hang out or text. But I get it. I understand. So I try to be as
19 accommodating as possible. But, yeah, I've absolutely seen the decline
20 in friends.
21 Q Has your siblings, Casey and the girls, have they also seen
22 the same things you've talked about?
23 A Yes.
24 Q Sounds like you're the closest to it because you live --
25 A Right. Yeah. I'm also very close with all three of my siblings

1 and we talk about it all the time.

2 Q Do you all worry about your dad?

3 A Yeah.

4 Q What do you think it affects your dad the most?

5 A In my opinion, I think that the fact that he can't provide or do

6 things on a day to day basis affects him the most. He's always looked at

7 himself as a strong and tough person. And I think that the fact that he

8 has to rely on me for a lot of things, eats at him. And I think that him not

9 being able to provide and him not being able to give the kids or give

10 anybody what they need is something that he's so used to doing his

11 whole life, that now all of a sudden, it's gone. It makes him feel

12 inadequate.

13 Q What else would you like to share that we haven't talked

14 about?

15 A I think we pretty much covered everything.

16 Q Okay. Thank you, Darian.

17 A Yeah. No problem.

18 THE COURT: Cross?

19 MR. SEVERINO: Mr. Prince, the microphone?

20 MR. PRINCE: Oh, I'm sorry.

21 CROSS-EXAMINATION

22 BY MR. SEVERINO:

23 Q Mr. Yahyavi, my name is Mark Severino. I'm one of the

24 attorneys that's been retained by the Defendant in this case. I just have a

25 few questions for you. I probably shouldn't be too long.

1 A Sure.

2 Q But I want to go over some of the stuff you talked about and

3 probably some different stuff, okay?

4 A Okay.

5 Q The first thing is you said your father asked you to move in

6 with him; is that correct?

7 A Yes.

8 Q When was that?

9 A So this was -- when I moved back, I was with my father until

10 about 2000 and I believe 16. And then at that point, I moved out for I

11 would say a little under a year. So maybe in the 2017 range, I would say.

12 Q And you've been with him since then?

13 A Yes.

14 Q And the reason I'm you asking you that is just the witness

15 before you and you were here for that witness, they put up a medical

16 record, it was from the psychologist. And part of that record stated that,

17 you being Mr. Yahyavi.

18 A Uh-huh.

19 Q Darian. I don't want to insult you.

20 THE MARSHAL: Counsel, I'm sorry to interrupt you. The

21 recorder can't hear you.

22 MR. PRINCE: Is the mic on?

23 THE COURT: Is it on?

24 THE MARSHAL: Can you put it a little higher up on your tie?

25 Give us a test.

1 THE COURT: Say test.

2 MR. SEVERINO: Test.

3 THE CLERK: It's not on.

4 THE COURT: No, it's not on.

5 MR. SEVERINO: Test.

6 THE MARSHAL: Now you're on.

7 BY MR. SEVERINO:

8 Q The record that we saw, and it was up on the board, it said,

9 you --

10 A Uh-huh.

11 Q -- currently -- I'm sorry. Mr. Yahyavi currently lives with his

12 son, you, temporarily as his son is in between moves. Is that inaccurate?

13 A In between moves?

14 Q That's what the record said, yeah.

15 A In what sense does in between moves mean?

16 Q Well, my impression from the records was that you were in-

17 between your own places and were living with your father at that time,

18 because you were in-between places. Is that not accurate?

19 A I would say that's an accurate just because I don't know what

20 places I would be in between. There was one house that I lived in with a

21 couple of roommates, a couple buddies of mine.

22 Q And that would be 2016?

23 A Yes. Where I moved out, wanted my own independence and

24 then realized that his condition continued to get worse. He asked me to

25 move back in. And since that point is kind of when I've been back.

1 Q So that's just what I'm trying to clarify.
2 A Yeah.
3 Q If the record says it was only because you're in between
4 moves, that's, not right?
5 A Gotcha.
6 Q And you've been there since?
7 A Correct.
8 Q And so what I've all said is, right, the record's inaccurate?
9 A Yes.
10 Q Now I'll go over some of your other testimony. You said you
11 oversee athletic programs at the gym you work at. What's the gym you
12 work at?
13 A Phase 1 Sports.
14 Q Where's that?
15 A Well, there's two locations. The one I work at mainly is on
16 Summerlin Parkway and Rampart.
17 Q What type of training do they do there?
18 A Athletic performance training.
19 Q And it's specifically for athletes?
20 A Mainly for athletes, but there's different programs. We offer
21 classes for general population, one on one training for general
22 population. So there's different types of things.
23 Q How do you oversee the program? Are you a certified
24 trainer?
25 A Yes.

1 Q And what certifications do you have?
2 A NASAM.
3 Q N-A-S-A-M?
4 A N-A-S-A-M. Yeah.
5 Q How long have you had NASAM?
6 A I got it in 2016.
7 Q Kept it up since then?
8 A Yeah.
9 Q When you say you assist your dad with stretches and
10 movements and things like that, can you tell us exactly what you do?
11 What programs do you give your father?
12 A They're just minimal exercises. I wouldn't say exact
13 programs. So we'll do some stretching for his hamstring and his glutes
14 to kind of loosen up his lower back. We'll do minimal exercises just to
15 kind of shoulder range of motion to try to help to see if we can get the
16 arm moving a little bit. A lot of bodyweight stuff.
17 Q What type of body weight stuff?
18 A I would say we try some squats. He can't do -- we'll do push-
19 ups, but hands against the wall so there's not a ton of load.
20 Q Let's break it down for a second.
21 A Sure.
22 Q So you do some squats?
23 A Minimally, yes.
24 Q With own weight?
25 A Yes.

1 Q Do you ever add weight to him?

2 A No.

3 Q You never add weight to him, but he can do pushes against
4 the wall as well?

5 A Minimally.

6 Q Minimally. At what angle?

7 A I would say about that. Yeah. Just to try to get some range
8 of motion with the shoulder to see if we can build up any kind of
9 strength.

10 Q Have you been able to do that?

11 A Have I been able to do that?

12 Q Build up his strength and movement?

13 A I would say, no. I would say it stayed the same or gotten
14 worse. But strength, we haven't really been able to get much. This is
15 just an attempt.

16 Q When did you start this training with your father?

17 A I would say we've been doing it for quite a while. I mean,
18 ever since the accident, I had been trying to give him things to do. And I
19 know that therapists have been trying to give him things to do.

20 Q What has a therapist given him to do?

21 A I don't recall exactly. But very similar things. Stretches, very
22 light activity.

23 Q So we covered squats, push-up against the wall, stretches.
24 Anything else you do with your father for his training?

25 A Nothing off the top of my head. I mean, there may be other

1 things.

2 Q Any banded exercises?

3 A No. We don't have any bands.

4 Q Any other bodyweight exercises?

5 A Nope. Not that I can think of.

6 Q How often are you doing this?

7 A I'll check in on him every once in a while, just to make sure

8 that he's doing stuff. We'll do stretches a couple times a week. But the

9 other things I kind of just ask if he can do it and if he is doing it, it'll either

10 be a, yeah, I did it already or things of that nature. It's not necessarily a

11 regular routine that we have or we're on schedule.

12 Q So you do your stretches with him a couple times a week

13 yourself, right?

14 A Uh-huh.

15 Q And then he does independent training that you check up on,

16 right?

17 A Correct.

18 Q How often is he doing independent training?

19 A I'm not sure. That's a question you got to ask him.

20 Q Fair enough. How often do you expect him to?

21 A I would say the same. Maybe a couple times a week.

22 Q So in total, you're hoping he gets in about four -- I'm going to

23 call them workouts, I know it's not probably the workout --

24 A Okay.

25 Q -- me or you are used to, but workouts a week?

1 A Yeah. I would hope.
2 Q You would hope?
3 A Right.
4 Q Do you believe he is getting in roughly four a week?
5 A Yeah. If he tells me he does them, then yeah, I believe him.
6 Q I'm not saying otherwise.
7 A Right. Yeah.
8 Q So he's reporting to you he does about two exercises a week
9 by himself and does two with you, so roughly four times a week he's
10 doing some sort of physical activity?
11 A Well, you're making it sound like it's very scheduled. It's just
12 sporadic. It's if he does it or if I do ask him. But I mean if I was to give
13 you a number somewhere around there.
14 Q That's fair enough. But I'm not trying to make it sound
15 scheduled or --
16 A Yeah, no worries.
17 Q -- anything like that. Just it is about four times a week,
18 you're able to -- not you get him, but you're able to get him to do some
19 stuff?
20 A Gotcha. Yup.
21 Q Yes? Correct?
22 A Yes.
23 Q And then you said you do things for him around the house,
24 right?
25 A Uh-huh.

1 Q What exactly do you do for him around the house?
2 A So I'll do a lot of the yard work. So he'll pretty much be like
3 the project manager and I'll help him with reseeding the grass.
4 Q When you say help with reseeding, what work is he doing?
5 A He's more just --
6 Q Watching?
7 A Yeah, pretty much just directing us. He'll be out there with
8 the hose and spraying the grass. Cleaning the pool is other activity.
9 Q That you do?
10 A Yes. Just daily cleaning the house, daily chores. We've got a
11 dog, so sheds a lot so cleaning the hair. Make sure the house stays
12 somewhat clean.
13 Q What type of dog?
14 A He's a husky.
15 Q Good dog. How old's the Husky?
16 A He is three.
17 Q When did you get him?
18 A I got him in 2016.
19 Q And he moved back in with your father with you?
20 A Yep.
21 Q Does your father take care of the dog at all?
22 A Yeah. He loves the dog.
23 Q What does your father do with the dog?
24 A I would say that's his daily companion. So they just hang
25 around the house with him. I do all the feeding with the dog and all the

1 activity for the most part.

2 Q Walk him?

3 A Yeah, I do all that.

4 Q All walks, are you?

5 A Yes.

6 Q Does he use, for lack of a better term, use the backyard for

7 his business?

8 A The dog?

9 Q Yes.

10 A Yes.

11 Q Who cleans that up?

12 A I do.

13 Q Is there anything you do for your father that we have not

14 discussed?

15 A Yes. Tons of things.

16 Q Let's hear it.

17 A Just more yard work. I would say more yard work, more

18 upkeep on the house. Groceries. Can't carry a bunch of groceries, so I'm

19 always doing that with him. Just off the top of my head the other day

20 when bought gallons of water and I've got to carry all of those because

21 he can't.

22 Q You go to store with your father, right?

23 A Uh-huh.

24 Q Do you drive him?

25 A Sometimes.

1 Q Does your father own a car?
2 A He does.
3 Q Is able to drive?
4 A Yep.
5 Q We've been in here several times for court, I haven't seen
6 you other than they're in trial.
7 A Uh-huh.
8 Q So he's able to get here from your house, correct?
9 A Yes.
10 Q On his own?
11 A Yep.
12 Q Right?
13 A Yep.
14 Q And how far is that drive, about 30 minutes?
15 A I would say a little less.
16 Q 20, 30 minutes.
17 A Yeah, maybe 20 minutes. We don't live too far.
18 Q Where's the house located?
19 A It's in -- right by Sunset Park.
20 Q At what crossroads?
21 A Warm Springs and Pecos. Yes. Warm Springs and Pecos.
22 Q Where else does your father drive that you know of?
23 A To his appointments, if I can't take him.
24 Q Doctor's appointments?
25 A Uh-huh. Doctors, dermatologists, things of that nature.

1 Q Where are those located?

2 A I'm not sure. I've been to so many. I've been ones that are

3 over here on Charleston. I've been the ones in Henderson. So they're

4 kind of all over.

5 Q And we could agree -- or would you agree with me that your

6 father can drive 20, 30 minutes? I know where some of those doctors

7 are --

8 A Right.

9 Q -- and [indiscernible] from your house, right?

10 A Right.

11 Q So he can do that by yourself?

12 A Yeah. Sometimes, yeah. He could definitely do that by

13 himself.

14 Q He doesn't really have an issue with driving, right?

15 A Well, the big issue -- I think he does, and he tries to say he

16 doesn't. He can't turn his neck to look. So there's been a couple times

17 where we've had close calls that he's not able to look for oncoming

18 traffic. I think one way he's okay, but the other way doesn't do very well.

19 Q What type of car does your father drive?

20 A Right now it's an Isuzu Trooper.

21 Q That's a small SUV type thing; is that right?

22 A Yeah. Yeah.

23 Q Like a short little SUV?

24 A Yes. Yes. Yeah. Exactly.

25 Q Give me one second. I'm going through some notes.

1 A No problem.
2 Q What hours do you work?
3 A They vary. It depends. When we have some of our NFL
4 clientele in town, I may work 8:00 a.m., all the way until -- usually I work
5 until 7:00 or 8:00 p.m. every day, Monday through Friday, excuse me.
6 Q So you're working roughly 12 hours a day, 11, 12 hours a
7 day, five days a week?
8 A Well, that's just only if the NFL clientele is in town. Usually I
9 would say about 12:00 to 7:00 or 12:00 to 8:00 every day, Monday
10 through Friday.
11 Q Break that down for me.
12 A That's eight hours. 8 times five-forty. Right around --
13 Q Forty -- roughly 40 hours?
14 A Yeah. I would say like 35 to 45 hours a week.
15 Q And while you're gone, your father does not have a caretaker
16 come in the house, does he?
17 A Correct.
18 Q And while you are gone working 40 hours a week, fulltime,
19 right?
20 A Uh-huh.
21 Q He's able to take care of himself through his daily activities,
22 right?
23 A For what he can, yeah.
24 Q Does his self-care by himself, right?
25 A Meaning like showering, things of that nature?

1 Q Showering, general everyday self-care activities, he's able to
2 keep himself up?
3 A Yes. Yeah. He can shower and feed himself and go to
4 bathroom. He can do those things.
5 Q He does feed himself, right?
6 A For the most part, yeah.
7 Q Cooks for himself?
8 A Yeah. If you want to call it cooking. Yeah.
9 Q He provides for his food?
10 A Yes. He can. Yup.
11 Q He's able to walk around the grocery store with you when he
12 has to go to the grocery store?
13 A Yeah.
14 Q And you said he can sit for roughly an hour you said about?
15 A Give or take. Sometimes it can be an hour and 15 minutes,
16 sometimes it's like 30 minutes and he's got to go. That's why sometimes
17 the driving, he'll ask me to drive if he's not feeling properly, feeling well.
18 Q We could say 30 minutes to an hour you think he can sit?
19 A Yeah. I would say that's a fair range.
20 Q And I believe you testified that after that, just sitting roughly
21 for an hour or whatever, he might have some pain for a few days after
22 that, right?
23 A Right. Yeah.
24 Q So we've been in here in court several days in a row now.
25 A Uh-huh.

1 Q We've seen your father here and he's been sitting and able to
2 be here, right?
3 A Right.
4 Q He's able to come back the next day, right?
5 A Uh-huh.
6 Q So he can continue to do these activities day after day? I'm
7 not saying he's not in pay, he can do them?
8 A Yes. Yep. I would say he can do them. Activities like sitting?
9 Q Yes,
10 A Yeah. He can sit. It's just going to be painful, but yeah, he
11 can sit.
12 Q Does your father own a computer?
13 A Yeah.
14 Q Does he use the computer?
15 A No.
16 Q He owns it, doesn't use it at all?
17 A No.
18 Q Do you use the computer?
19 A I have my own laptop that I use personally, yes.
20 Q What is your understanding of why your father has a
21 computer if he doesn't use one?
22 A I think he used to. We have one of those standalones --
23 something like this, but a MacBook. Excuse me, but a Mac.
24 Q Sure. Those ones that doesn't have a tower or something
25 like that, correct?

1 A Exactly. Yup. We've had it for a while. Five years maybe.
2 So I think at some point found a lack of use for it and I think his phone
3 kind of took over for that.
4 Q Okay. So he uses his phone to surf the Internet and things
5 like that?
6 A Yes.
7 Q Email?
8 A Yes.
9 Q Text messages?
10 A Yes.
11 Q Phone calls?
12 A Yep.
13 Q Do you know if your father uses his phone to still research
14 cars, things like that?
15 A Yeah, I'm sure he does.
16 Q Cars are a passion of mine. So I spend --
17 A Right.
18 Q -- a considerable amount of time looking at cars, reading
19 cars --
20 A Right.
21 Q -- shopping for cars.
22 A Right.
23 Q Does your father still do that?
24 A I'm not sure that he does that exactly, but I don't see why he
25 couldn't.

1 Q So you would agree with me, he could use his phone to shop
2 for vehicles if he wanted to?
3 A Yeah.
4 Q Amazon?
5 A Yup.
6 Q Things like that?
7 A Yeah.
8 Q There's nothing stopping him?
9 A Right. Yeah.
10 Q And while he's home all day, while you're working 40 hours
11 a week --
12 A Uh-huh.
13 Q -- what else does he do?
14 A Not a whole ton. He watches -- I know he's a big fan of the
15 news. He's always got the news on.
16 Q So TV?
17 A TV.
18 Q Movies?
19 A Not so much movies. Not a big movies guy. Well, I gave
20 him my Netflix password, so he'll use that every once in a while. I'm
21 able to see what he watches.
22 Q Keep an eye on him?
23 A Yeah. But yeah, there's not a whole ton.
24 Q Okay, so if we break it down, his typical day is news, TV,
25 phone for computer type things. Anything else?

1 A He'll sleep a lot because he doesn't sleep all the way through
2 the night. So I know he sleeps a lot during the day as well.
3 Q When he uses his phone, how is he positioned? Is he in bed,
4 is he in a chair, is he on a couch?
5 A For the most part he's in kind of like a recliner sofa chair that
6 we have.
7 Q Like a La-Z-Boy type thing?
8 A Yeah. And he'll kind of be propped up kind of like the
9 position that he's in where he's got something behind his neck or in is
10 back that's pressing on the part that's bugging him. So he just finds that
11 comfortable point.
12 Q How long can he sit in that position for in the chair at home?
13 [Indiscernible] careful.
14 A I would probably say the same amount of time. He's got to
15 get up and kind of walk around and do his little round around the house
16 and can come back and sit down.
17 Q And prior to the accident, prior to the incident we're going to
18 talk about, you've discussed some of the activities your father did. I
19 want to ask you about some of those.
20 A Sure.
21 Q You play football with him, right?
22 A Yeah. We throw the football around.
23 Q How heavy of contact did you guys get into?
24 A We didn't get into contact.
25 Q Just throwing around?

1 A Yeah, just throwing it around.
2 Q Okay. And you said soccer also, right?
3 A Soccer. Yup. He's a big soccer guy.
4 Q Did you play soccer with your father?
5 A Yes, I would play with him.
6 Q And that can be fairly physical as well, right?
7 A Yeah. I was always afraid to get too physical with him
8 because him being older, I didn't want to hurt him, but yeah, I mean,
9 normal boy roughhousing.
10 Q You'd agree with me that prior to the accident your father
11 was very physically active?
12 A Yes.
13 Q Was he fit? Again, not like we might say fit.
14 A Yeah, he was fine.
15 Q Okay. For his age type thing?
16 A Right. Exactly. He was okay for his age.
17 Q Did you ever see the neck problems we discussed?
18 A The neck problems?
19 Q Yeah. The years of neck pain.
20 A Did I see the years of neck pain?
21 Q Yeah.
22 A Yeah.
23 Q You did?
24 A The years of neck pain.
25 Q Prior to the accident?

1 A Oh. Prior that accident. No.
2 Q You never saw neck pain prior to the accident?
3 A No, I didn't.
4 Q Ever hear him complain about neck pain prior to the
5 accident?
6 A No.
7 Q Any other physical activity you used to do with your father
8 prior to the accident?
9 A I mean, just normal father, son, shooting the basketball.
10 Q Basketball, skiing --
11 A Yeah.
12 Q -- boating?
13 A Yeah.
14 Q Anything else?
15 A No.
16 Q Working out, running, anything like that?
17 A No. We didn't really do that.
18 Q You said your father after the accident went back to work.
19 When was it he went back to work after the accident?
20 A You mean how soon after the accident?
21 Q Correct.
22 A I don't remember exactly when. I don't recall.
23 Q If I jog your memory and say a couple weeks, does that
24 sound about right?
25 A Maybe.

1 Q Somewhere a couple of weeks, maybe a month, something
2 like that?
3 A Yeah, I would say right around there.
4 Q And he was able to work, right?
5 A Yeah. At the time.
6 Q He was earning an income, right?
7 A Yes.
8 Q And he was earning a good income, wasn't he?
9 A Yeah.
10 Q After the accident, right?
11 A Uh-huh.
12 Q And he continued to work for several more years. Now you
13 talked about some pain, but he was able to work for several more years,
14 right?
15 A Right.
16 Q And along throughout that time, for the most part, he was
17 still earning a good income, right?
18 A Right.
19 Q Still providing for the family?
20 A Yeah.
21 Q Still taking care of you and your siblings and --
22 A Right.
23 Q -- providing for the house and --
24 A Right.
25 Q -- college and all, et cetera, yes?

1 A Right.
2 Q You said he came to one of your games six months after the
3 accident; is that correct?
4 A Yes.
5 Q And that was where? Tennessee you said?
6 A No. That was in Columbia.
7 Q Columbia.
8 A Missouri.
9 Q Missouri.
10 A Yeah.
11 Q How long is that flight from here?
12 A From here?
13 Q Yeah.
14 A I'm not sure. Yeah, I don't know. I flew from school, so I
15 don't know exactly.
16 Q Fair enough. My understanding is about 3, 3 1/2 hours.
17 Somewhere in there.
18 A Okay.
19 Q So you would agree with me your father's able to do that
20 after the accident, right?
21 A Right.
22 Q And he was able to then fly back home, right?
23 A Yep.
24 Q He didn't receive medical care while he was there, right?
25 A While he was where?

1 Q In Missouri, watching your game.

2 A Received medical care?

3 Q Correct. He did not that you know of?

4 A No. I don't know about any medical care in Missouri.

5 Q So he was able to attend the game, right?

6 A Yes.

7 Q And you saw him afterwards?

8 A I did.

9 Q What'd you do afterwards?

10 A We just talked. I don't get much time after the game because
11 we got to get back on the bus and get back on the plane. But just kind of
12 talked about the game and talked about how he was feeling and how
13 he's doing, how everything was going. Just a quick catch up.

14 Q Where was that?

15 A Right outside the stadium.

16 Q Did you see him again after that before he went back?

17 A No.

18 Q Do you know when he went back? Day later, that night?

19 A That I don't remember. I believe it was that same night, but I
20 don't remember.

21 Q I think you said your dad is at home all day because no one
22 calls him to hang out for lack of a better way of saying it; is that right?

23 A Yeah.

24 Q What would he be able to do if people were to call him to go
25 out?

1 A He would be normal for a little. I'm sure he could go out and
2 socialize for a little bit. I just think that the whole idea of him being in a
3 place where he's not able to rest for an extended period of time gets
4 tough for him.
5 Q Your opinion, though, is physically, if he wanted to go out
6 and socialize for at least a time, he could, right?
7 A Sure.
8 Q What type of social activities does your father like to do?
9 A I would say he was always like a big football guy. He liked
10 football games, liked --
11 Q Go to games?
12 A -- going to the games, going to restaurants or bars to watch
13 the games.
14 Q Where would he go watch football games? Your high school
15 games or college, things like that?
16 A Yeah, he would watch my -- he came to all my high school
17 games. He'd watch my football games on TV when he didn't come.
18 Q Darian, I apologize. I'm just going through some of my notes
19 to make sure I've got stuff covered.
20 A Sure.
21 Q Do you have any plans to move out of your father's house?
22 A Say that again.
23 Q Any plans to move out of your father's house currently?
24 A Currently, no plans. Eventually, I'd like to.
25 Q You'd like to?

1 A Yeah.
2 Q And what timeframe were you thinking?
3 A I don't really have a timeframe right now.
4 Q Coming in and out of court, we've seen your father. He can
5 walk and I've seen him climbing stairs. You agree with me he can climb
6 stairs?
7 A I would say he's able to climb some stairs. Yeah.
8 Q Seen at least a couple of flights, you think that's possible?
9 A He doesn't really go upstairs in our house, so I don't see him
10 climb stairs very often. We take elevator here. But I would say a flight of
11 stairs is fine. Not an issue for him.
12 Q Your father used to ride horseback?
13 A I wouldn't say used to as in all the time, but I know he has
14 before, yes.
15 Q Did he do that within the year or two years prior to the
16 accident?
17 A No. The last time I remember was 2010.
18 Q So that's nine years ago, three years before the accident?
19 A Yup, I remember.
20 Q Do you know if he had any plans to continue riding horses?
21 A I don't know if he had any plans, but I know it was always
22 something that intrigued him as well.
23 Q Do you know if your dad had any skiing accidents before the
24 car accident?
25 A Skiing accidents?

1 Q Yes, sir.

2 A Not to my knowledge.

3 Q Thank you.

4 A No problem.

5 THE COURT: Redirect?

6 REDIRECT EXAMINATION

7 BY MR. PRINCE:

8 Q Darian, I know your dad, he can sit here, obviously.

9 A Uh-huh.

10 Q But when he gets up, what kind of pain is he in after he's

11 sitting for a long period of time?

12 A A pretty good amount of pain.

13 Q And when the pain sets in, do you ever see him like wince in

14 pain or kind of like jerk? Do you ever see his body kind of like

15 involuntarily jerk like that?

16 A Yeah. Yeah.

17 Q It's pretty alarming, isn't it?

18 A Yeah. He'll definitely have that point where kind of like his

19 wind gets taken out or he needs to readjust to make sure he's able to

20 find that point of comfortability.

21 Q You and I have had meetings where it almost like -- all of a

22 sudden there's this lightning bolt that jerks in him.

23 A Yeah. Right.

24 Q It's frightening to see, isn't it?

25 A Yeah.

1 Q How often do you see that?
2 A Often.
3 Q Have you ever seen that before June of 2013, before this
4 forklift crashed into him?
5 A No.
6 Q It's unsettling when that happens, isn't it?
7 A Yup.
8 Q Is he exhausted?
9 A Yes, that's a good word to describe him.
10 Q Does he sleep well?
11 A No.
12 Q How does that affect him during the day?
13 A He sleeps a lot during the day. He's got a very weird sleep
14 schedule. Yeah, I'll hear him in the middle of the night, so I know he's
15 up.
16 Q Does he get woken up a lot in the night?
17 A Yeah. Just because I hear him. I'll hear him coming into the
18 kitchen or -- my room's very close. So I hear him in the kitchen, or I hear
19 him --
20 Q You think he's fatigued?
21 A Yup.
22 Q You think that affects his concentration level?
23 A Yes.
24 Q If something happened to his right hand, what kind of shape
25 would he be in?

1 MR. SEVERINO: Objection, calls for hypothetical.
2 MR. PRINCE: No. It's just an observation.
3 THE COURT: Counsel, approach.
4 [Sidebar begins at 4:33 p.m.]
5 THE COURT: Yeah, what's the foundation?
6 MR. PRINCE: Because his problem -- he has a permanent
7 injury to his left. And so if he hurt his right hand, he would even have
8 more limitations. So we're talking -- he's talking about being critical of
9 him for not doing certain things, and so he overdoes it. Then that's
10 going to be a problem because his right hand would be at risk and his
11 right arm would be at risk.
12 MR. SEVERINO: Not only does it ask for a hypothetical, but
13 it's vague and ambiguous because he hurts his right hand. You can hurt
14 your right hand in a million different ways. Being that it's vague and
15 ambiguous does not change the fact though that it is still a hypothetical .
16 MR. PRINCE: That's a deposition objection. It's not even a
17 trial objection. It's not a relevancy objection. It's not a hearsay
18 objection. It's not a foundational objection. It's nothing.
19 MR. SEVERINO: He is [indiscernible].
20 MR. PRINCE: He doesn't have any basis --
21 MR. SEVERINO: It's also a foundational objection.
22 THE COURT: Yeah, how's he qualified to testify?
23 MR. SEVERINO: He's not a medical expert.
24 THE COURT: He's just a regular person.
25 MR. PRINCE: That's right. Lay people are allowed to provide

AA001504

1 opinion testimony on --

2 MR. SEVERINO: No, that --

3 THE COURT: Only certain opinion testimony.

4 MR. PRINCE: No, hang on.

5 MR. SEVERINO: Your Honor, that's expert -- that's expert --

6 MR. PRINCE: No.

7 MR. SEVERINO: -- medical opinion.

8 THE COURT: For instance if he is driving a car, he can

9 estimate speed because he's a licensed driver, but what background

10 does he has to testify regarding this?

11 MR. PRINCE: Lay opinion is what he can physically observe.

12 THE COURT: It's something you can argue --

13 MR. SEVERINO: He does --

14 THE COURT: -- to the jury, but --

15 MR. SEVERINO: -- he lives with them. He sees them every

16 day.

17 THE COURT: I'm sustained the objection.

18 MR. PRINCE: Okay.

19 [Sidebar ends at 4:34 p.m.]

20 THE COURT: The objection's sustained.

21 BY MR. PRINCE:

22 Q Does your dad have very good function of his left arm or

23 hand?

24 A No.

25 Q What limitations does he have in his left arm and his hand?

1 A I would say a good amount. There's tons of daily activities I
2 see him struggle to do with his left hand. Sometimes I'll see him catch
3 himself, he'll reach to go do something or whatever and switch.
4 Q Does he guard?
5 A Yes.
6 Q Always?
7 A Pretty much. Always. Yeah.
8 Q And do you ever see even simple tasks at times like he's
9 doing something or moving cause pain or kind of that obvious sign of
10 like a jolting pain?
11 A Yes.
12 Q What happens when that happens to him, when he has that
13 kind of jarring pain that kind of just grips him?
14 A Like I said, he kind of has to find that point of comfortability
15 and he kind of just needs like that moment to reset. So it takes about 30
16 seconds, 20 seconds to kind of maneuver himself to find that point
17 where he feels comfortable and to regulate his breathing again and
18 come back to like a normal state.
19 Q Is that kind of his normal and is that his new normal --
20 A Yeah.
21 Q -- living like that?
22 A Yes.
23 Q Thank you, Darian.
24 THE COURT: Cross?
25 MR. SEVERINO: No further questions, Judge.

1 THE COURT: Questions from the jury, raise your hand.
2 Anybody have a question? No questions. Thank you. You may step
3 down. Counsel approach.
4 [Sidebar begins at 4:36 p.m.]
5 THE COURT: I'm inclined to let them go --
6 MR. SEVERINO: Oh, of course.
7 THE COURT: -- so we don't go over.
8 THE COURT: All right.
9 MR. PRINCE: Yeah, yeah. Your call, Your Honor.
10 THE COURT: I don't know with those 15 minutes --
11 MR. PRINCE: Yeah. No, no. Let's do it. We'll pick up --
12 THE COURT: Okay.
13 MR. PRINCE: -- another one.
14 THE COURT: We'll see you tomorrow.
15 [Sidebar ends at 4:36 p.m.]
16 THE COURT: Ladies and gentlemen, we're done for the day.
17 We'll see you back here at 1:00.
18 During this recess, you're once again admonished. Do not
19 talk or converse amongst yourselves or with anyone else on any subject
20 connected with this trial or read, watch or listen to any report of or
21 commentary on the trial or any person connected with this trial by any
22 medium of information, including without limitation, newspapers,
23 television, radio or Internet.
24 Do not form or express any opinion on any subject
25 connected with the trial until the case is finally submitted to you.

1 We're in recess.
2 THE MARSHAL: Please leave your notebooks and your pens,
3 grab all your personal items. Please remember to get your parking
4 validated. Tomorrow, 1:00.
5 [Jury out at 4:37 p.m.]
6 [Outside the presence of the jury]
7 THE COURT: Okay. What's on for tomorrow?
8 MR. PRINCE: I have Dr. Oliveri and Ira Spector for tomorrow.
9 And then if we have time, the depo read.
10 THE COURT: Not likely. Oliveri and Spector?
11 MR. PRINCE: Yes.
12 MR. SEVERINO: Well, Oliveri's half done.
13 MR. PRINCE: Yeah. I mean, I think now I've covered Kaplan
14 and Schifini, that covers a good amount of topics I was going to do. So
15 we'll see how it goes.
16 THE COURT: Okay.
17 MR. PRINCE: You're such a cynic, Judge.
18 THE COURT: I am a cynic. Yes. Because I've been through I
19 don't know how many dozens and dozens, and civil attorneys generally
20 take much longer than they think. And criminal attorneys actually
21 generally are less time than they think.
22 In any event, so when are we going to start, at least with jury
23 instructions? I want a copy of the agreed to and --
24 MR. PRINCE: We've already provided all that to you.
25 MR. KAHN: Yeah. I think we were under orders to do that at

1 the day the trial started.

2 MR. PRINCE: Yeah. We've logged --

3 THE COURT: All right. I have some. I didn't know -- okay.

4 MR. PRINCE: If you want us to redeliver --

5 THE COURT: So those are agreed to.

6 MR. PRINCE: Oh, we delivered both. If you'd like us to bring

7 copies tomorrow just so you have them, we can.

8 THE COURT: No. I think they're up here. All right. Yeah,

9 bring me in a copy.

10 MR. PRINCE: Well, anyway, I think the case is going -- I think

11 I'll be done with my case on Thursday. The Defense has got a couple

12 people on Friday. We're going to have an argument on whether they

13 can even call the biomechanical expert, Baker. We filed a brief on that,

14 so we're going to need argument time on that, and we potentially have a

15 Hallmark hearing.

16 MR. KAHN: But we're not planning to call him until next

17 week anyway. So we have --

18 MR. PRINCE: I think the case is done by next Tuesday. I

19 think we're arguing by Wednesday latest.

20 MR. KAHN: Yeah, I have the biomechanical -- I mean, I

21 basically just have experts since he called my client. So I'll probably call

22 Goodrich, the biomechanical, the economist, our medical expert's Friday,

23 our vocational is Friday and that's most of it.

24 We may have tagged one other witness with a subpoena, but

25 I'm not certain we're going to use him anyway at this point. So we'll

1 have to see.

2 THE COURT: All right. The sooner you could tell -- they're

3 willing to give up their lunch to get this done quicker.

4 MR. KAHN: What?

5 THE COURT: They were willing to give us their lunch to get it

6 done quicker.

7 MR. PRINCE: Well, I think you could tell the jury tomorrow

8 we're right on -- maybe Steve can. We're right on track. We're going to

9 be done actually earlier than estimated.

10 THE COURT: That's great. Okay.

11 MR. PRINCE: So I think we're doing fine.

12 THE COURT: All right. See you tomorrow.

13 [Proceedings concluded at 4:40 p.m.]

14

15

16

17

18

19

20

21 ATTEST: I do hereby certify that I have truly and correctly transcribed the audio-visual recording of the proceeding in the above entitled case to the

22 best of my ability.

23

24 Maukele Transcribers, LLC
Jessica B. Cahill, Transcriber, CER/CET-708

25

1 RTRAN
2
3
4
5 DISTRICT COURT
6 CLARK COUNTY, NEVADA
7
8 BAHRAM YAHYAVI,) CASE#: A-15-718689-C
9 Plaintiff,) DEPT. XXVIII
10 vs.)
11 CAPRIATI CONSTRUCTION CORP INC.)
12 Defendant.)
13
14 BEFORE THE HONORABLE RONALD J. ISRAEL
DISTRICT COURT JUDGE
TUESDAY, SEPTEMBER 17, 2019
15
16 **RECORDER'S PARTIAL TRANSCRIPT OF JURY TRIAL - DAY 7**
TESTIMONY OF JOSEPH SCHIFINI
17
18 APPEARANCES:
19 For the Plaintiff: DENNIS M. PRINCE, ESQ.
KEVIN T. STRONG, ESQ.
20
21 For the Defendant: MARK JAMES BROWN, ESQ.
DAVID S. KAHN, ESQ.
22
23
24
25 RECORDED BY: JUDY CHAPPELL, COURT RECORDER

INDEX

Testimony 3

WITNESSES FOR THE PLAINTIFF

JOSEPH SCHIFINI

Direct Examination by Mr. Prince 3

Cross-Examination by Mr. Kahn 86

Redirect Examination by Mr. Prince 123

INDEX OF EXHIBITS

FOR THE PLAINTIFF	MARKED	RECEIVED
None		

FOR THE DEFENDANT	MARKED	RECEIVED
None		

1 Las Vegas, Nevada, September 17, 2019
2
3 [Designated testimony begins at 10:33 a.m.]
4 [Inside the presence of the jury.]
5 THE COURT: Plaintiff, call your next witness.
6 MR. PRINCE: All right. Ladies and gentlemen, good
7 morning. Thank you for being here.
8 Your Honor, we call next Dr. Joseph Schifini.
9 THE COURT: The parties acknowledge the presence of the
10 jury?
11 MR. PRINCE: We do.
12 MR. KAHN: We do.
13 THE COURT: Thank you.
14 THE MARSHAL: Watch your step, sir. You can remain
15 standing. Face the Clerk of the Court.
16 JOSEPH SCHIFINI, PLAINTIFF'S WITNESS, SWORN
17 THE CLERK: Please be seated. Please state your name and
18 spell it for the record.
19 THE WITNESS: My name is Dr. Joseph Schifini,
20 S-C-H-I-F-I-N-I.
21 THE CLERK: Thank you.
22 DIRECT EXAMINATION
23 BY MR. PRINCE:
24 Q Dr. Schifini, good morning.
25 A Good morning.

1 Q What is your area of medical specialty?
2 A I'm an anesthesiologist specializing in pain medicine.
3 Q Okay. And were you involved in Mr. Bahram Yahyavi's care
4 after his June 19th, 2013 crash involving the forklift?
5 A I was, and I continue to be involved in his care.
6 Q Okay. So not only were you involved in 2013, you're
7 involved even in the summer of 2019?
8 A That's correct.
9 Q Okay. So you have an ongoing patient/physician relationship
10 with Mr. Yahyavi?
11 A I do.
12 Q At this point, would it be fair to say over the period of -- over
13 six years now or close to six years, that you're very familiar with his
14 nature of his injury, his course of his care, and his current medical
15 status?
16 A I think I am very well versed in his injury, his prognosis, his
17 status, the course of his treatment, and his current options for future
18 treatment.
19 Q Very good. Doctor, we've heard from Dr. Oliveri so far, who
20 is a physical medicine and rehabilitation specialist. We heard from Dr.
21 Kaplan yesterday, who is a neurosurgeon. Please describe for us your
22 area of medical specialty pain management?
23 A Sure. Pain management has different definitions as far as
24 the medical specialty, depending on who you talk to, but my definition of
25 it, as I've kind of been involved in being a pain management physician

1 since 1997, kind of has evolved, as well, but I think just to summarize it
2 and to kind of keep it sort of simple, my role as a physician in the pain
3 management or pain medicine is related to the accurate diagnosis and
4 treatment of painful conditions. Many times, those involve various areas
5 of the spine, but it can also involve other areas of the body, such as
6 headaches, shoulder pain, knee pain, ankle pain, foot pain. You name it,
7 but I would say probably well over 80 percent of my time is spent
8 dealing with spinal conditions, whether it be the neck or the cervical
9 spine, the middle part of your spine, which is your thoracic spine, or your
10 lumbar spine, or your low back.
11 Q And in your area of medical specialty and pain management,
12 do you also help patients who suffer from chronic pain to manage those
13 complaints either through some treatment form, medications, therapy,
14 or otherwise?
15 A Of course. So sometimes, the treatment that we offer
16 patients or the diagnosis that we offer them doesn't really have a specific
17 treatment plan, and so often times, I'm tasked with the role of managing
18 these patients over years. Sometimes, and currently, decades for some
19 of my patients. You're kind of helping them figure out the options that
20 they have, and the risks associated with choosing those options, the
21 potential benefits of those options, and then alternatives, and there are a
22 lot of alternatives for certain situations and unfortunately, other
23 situations, there are very limited choices as far as alternatives based on
24 the circumstances that you're presented with.
25 Q Okay. And tell us about your medical education, Dr. Schifini.

1 A So I grew up here in Las Vegas. I graduated from Valley High
2 School, and I got a scholarship to UNLV. While at UNLV, I majored in
3 biology, and I got a minor in chemistry, was accepted to medical school
4 at University of Nevada School of Medicine, which is up in Reno, and
5 graduated there after four years. I got accepted to two residency
6 programs. One where I did my internship, which is the first year of
7 residency. I did that here at UMC, right down the street, and then -- that
8 was in internal medicine, and then following that, I did three years of
9 anesthesia residency at the University of California Irvine in
10 anesthesiology where I served as chief resident before returning back to
11 Las Vegas in July of 1997, to start my private practice in pain
12 management.
13 Q Have you been in private practice in Las Vegas since 1997?
14 A I have, and you know, in addition to my private practice, I'm
15 also involved in teaching medical students and residents from the three
16 medical schools here in Nevada. The one in Henderson, which is an
17 osteopathic medical school called Touro, the one I graduated from,
18 which is now called UNR School of Medicine, because it's kind of in
19 competition with the other one that I'm involved with, which is UNLV
20 School of Medicine. So I'm on their clinical staff, so I deal with rotating
21 medical students and residents from them, in addition to my duties as a
22 private practice physician in pain management.
23 Q Okay. And are you board certified?
24 A I am.
25 Q In what areas are you board certified?

1 A I'm board certified in anesthesiology, and I have two
2 additional certifications in pain management through the American
3 Board of Pain Medicine and the American Academy of Pain
4 Management.
5 Q Okay. And can you describe the nature of your practice as a
6 -- well, let me step back a second. Often times, we know that, you know,
7 anesthesiologists will give like a -- before labor, if someone gives birth,
8 they'll give them an epidural injection to help make a mother -- expecting
9 mother, more comfortable during the delivery process. Did you do stuff
10 like that as an anesthesiologist?
11 A Of course. So as part of your anesthesia residency, you do
12 specific rotations in obstetrics and gynecology, where you provide labor
13 epidurals for women who are having pain during the -- you know, during
14 the birthing process. But it's also part of the residency. When you're on
15 call, you may get called to the OB suite to provide anesthesia for a
16 patient who needs an epidural or perhaps an emergency c-section. So
17 that process goes on throughout the entire residency, but most
18 concentrated during your rotation in that particular specialty, which is
19 where you gain a lot of your experience in placing needles properly.
20 The other areas that we use for, you know, for pain relief and
21 placing needles in various places are for pain relief following surgery. If
22 somebody has, you know, a shoulder surgery, we can place needles and
23 do kind of what we call blocks, which are just kind of infiltration of local
24 anesthetic into various areas where bundles or nerves are following a
25 shoulder surgery or a knee surgery, to make the process -- the post-

1 operative or the after surgery process a much more comfortable
2 experience for those patients who are undergoing those types of
3 treatments.
4 Q And as part of -- why is it that anesthesiology, or people like
5 you who have anesthesiology training, fit well into the area of pain
6 management, or go on to be kind of board certified in pain management
7 like you are?
8 A Well --
9 Q What is it about that particular training?
10 A Well, I think it starts with just -- the word anesthesia involves
11 pain relief. It's a Latin word, kind of implying pain relief, so that specialty
12 -- because we're often tasked to do things that would be difficult to do, if
13 you weren't trained to do it, as to other specialties -- even other
14 specialties that are involved in spinal surgery perhaps, you would
15 assume that they'd be able to place a needle, but often times, they
16 involve folks like an anesthesiologist specialized in pain management to
17 do that for them, to assist them.
18 So it's kind of a team effort when it comes to those things, but
19 because we have so much experience in placing needles in different
20 places of the body, it's a natural progression to go from being an
21 anesthesiologist to being a pain management physician.
22 Q In fact, anesthesia is one of the very few medical
23 subspecialties that can even qualify you to become board certified in
24 pain management; isn't that true?
25 A Yeah, it is true; yes.

1 Q Okay. And we're going to be talking about, you know,
2 injections and the interventional procedures with Mr. Yahyavi
3 specifically, but describe the nature of your private clinical practice, and
4 the types of patients that you see, and the conditions that you treat
5 during the course of your day.
6 A Sure. So my clinical practice, meaning seeing patients in the
7 office, the typical type of patient that I see is different than most pain
8 management physicians in the City of Las Vegas and perhaps, most of
9 the country. The primary focus of my practice is industrial medicine,
10 worker's compensation patients. I see those patients, probably I would
11 say, you know, if you kind of look at it as a month or a week or
12 something, that probably makes up about two-thirds, maybe three-
13 quarters of the patients that I see on a regular basis.
14 So I'm very familiar with not only dealing with the worker's
15 compensation system, which is somewhat cumbersome to deal with at
16 times, but also dealing with patients who have been involved in various
17 different accidents, whether, you know, they lifted something, they fell
18 downstairs, you know, they got crushed by, you know, a structure that
19 fell on them while they were working at the convention center, a car
20 accident.
21 So I've seen and experienced a lot of different types of patients,
22 different types of injuries, different types of body parts involved, but my
23 role in that setting is to really evaluate the patient, kind of evaluate the
24 likelihood of their injury to come up with a prognosis for them to come
25 up with a treatment plan for them, and then to kind of follow through

1 with that along the way. And often times, in assistance with other
2 physicians that are involved, that may not be in my own specialty, but
3 maybe surgeons, or physiatrists, or physical medicine and rehab
4 doctors, psychologists. There's a wide variety of different doctors I have
5 to interact with on a regular basis because in worker's compensation, to
6 get a patient back to be as functional as they can, really is the goal. And
7 often times, that takes a team effort to be able to do that, and I'm part of
8 that team that does that.
9 So that is the great majority of my practice. The remainder of it is
10 patients who have, you know, private health insurance of various sorts,
11 or cash pay. Sometimes, people who are involved in accidents that are
12 not work-related.
13 Q Okay. So a primary focus of your practice, is it fair to say, Dr.
14 Schifini, is treating people who have been involved in some traumatic
15 event and suffered some kind of injury?
16 A I think that's a fair statement, yes.
17 Q All right. And that would be really part of your overall
18 specialization and treatment of people who have been injured in a
19 variety of different contexts?
20 A Absolutely.
21 Q Okay. And in addition to your work as a pain management
22 physician, do you also do work as an expert witness, or make yourself
23 available to people in the community as an expert witness?
24 A I do. I call that my medical/legal work, and that's the -- kind
25 of distinguished in my mind from the clinical practice. Sometimes there

1 is overlap, like this particular case, but most of the time, it's kind of a
2 separate sort of a service I provide, I suppose, and I would say that
3 probably represents about 20 to 40 percent of my time that I spend doing
4 that, is interacting with patients, reviewing records, preparing reports,
5 showing up at depositions or in trial like this.
6 Q Okay. And have you testified as an expert in the area of pain
7 management here in Clark County before?
8 A Multiple times, yes.
9 Q Very good. And just so we're clear, in terms of your expert
10 witness where you actually get hired by a law firm to either review
11 records and reach certain conclusions or opinions, what percentage of
12 your time would you say is for the Defense, as opposed to say the
13 Plaintiff side?
14 A I would say, if you look at my overall practice in the
15 circumstances where I'm asked to review records, and I'm kind of
16 retained for that purpose, probably 75 to 80 percent of it has to do with
17 defense work, and the other 20 to 25 percent has to do with plaintiff
18 work.
19 Q Okay. And just so you -- and you and I have known each
20 other probably more than 20 years at this point, right?
21 A Yes.
22 Q Have you ever testified in a case for me where I represented
23 an injured plaintiff before in a trial?
24 A I have not.
25 Q All right. And in fact, most of the time -- in fact just a few

1 weeks ago, we were on opposing sides, weren't we?
2 A We were.
3 Q Right. And in fact, the vast majority of times, we're on
4 opposite sides?
5 A I would say that's a fair statement; yes.
6 Q Very good. Now, the first time you saw Mr. Yahyavi,
7 according to the records, was November 25th, 2013. Does that sound
8 accurate?
9 A It does.
10 Q In front of you, Doctor, I have the -- took the liberty of
11 opening up Exhibit Number 92, which has been admitted into evidence.
12 That's your chart note.
13 A Okay.
14 Q Okay? Exhibit 93 is the Las Vegas Surgical Center records, in
15 case you need to refer to a hard copy.
16 A Okay.
17 Q Any time I reference a document, I'm going to put it on the
18 monitor so we all can follow along, okay?
19 A I think that's helpful for everyone. Thank you.
20 Q Very good. And I want to start with Bates number 313 of
21 Exhibit 92. That's going to be your -- I believe it's the intake form. And
22 we only want the top piece of it, like down to referred by and the date.
23 MR. PRINCE: You see that, Greg? There we go. Okay.
24 BY MR. PRINCE:
25 Q And so you first see Mr. Yahyavi November 25, 2013,

1 according to your notes?

2 A That's correct, yes.

3 Q Now, obviously, is there any lawyers involved in this at all?

4 Were you hired by a lawyer or selected by a lawyer?

5 A No, absolutely not.

6 Q Who referred Mr. Yahyavi to you?

7 A So a spine surgeon -- an orthopedic spine surgeon by the

8 name of Dr. Archie Perry referred the patient to me under the worker's

9 compensation system for a date of injury of June 19th, 2013.

10 Q Okay. And to the right of your date, it says, accepted body

11 part, cervical. What does it mean in your vernacular or your -- the

12 worker's compensation vernacular, to mean an accepted body part?

13 A So worker's compensation is a system that, you know, is

14 there to protect patients and employers from not being able to receive

15 medical care as a result of an injury that may have happened at their

16 work, or in the course of their employment, and when worker's

17 compensation injuries occur, they have to be evaluated by an adjuster.

18 Often times, there's a medical director involved that is unrelated to

19 the patient, meaning they're not treating the patient. More likely than

20 not, they've never even met the patient. They're just evaluating the

21 facts, and what they end up accepting or denying are various body parts

22 that are injured. So unfortunately -- and this is very much -- not very

23 personalized to the patient, but they kind of break down a person into a

24 body parts when they look at various injuries.

25 And so what happens when a claim gets accepted is they look at

1 the body part that was injured. In this case, it's the cervical spine. Once
2 they've accepted a body part, like the cervical spine or the neck, they
3 also assign a case number, and you can see that -- or a claim number.
4 You can see that by the number sign, and there's a 16 digit number
5 beyond that. And then there's something called the DOI, which is the
6 date of injury.
7 So as opposed to a lot of situations that I get involved in when
8 there's a legal case, we call it a date of loss, because nobody wants to
9 admit that there's an injury involved, the worker's compensation, by
10 accepting the claim for a particular body part, not only assigns it a claim
11 number, but they assign it a date of injury rather than date of loss,
12 meaning we've all agreed that there is an injury to the cervical spine as a
13 result of the events that happened on June 19th, 2013.
14 Q Okay. And inf act, the cervical spine, that has been not only
15 an accepted body part going back to June 19th, 2013, it's still an
16 accepted body part today for which you're treating Mr. Yahyavi, would
17 that be fair?
18 A It is fair. The same body part has been involved. Various
19 different treatment modalities have been instituted since this original
20 record was documented, but it's still the same body part that's involved.
21 It's still claim number, and it's still the same date of injury.
22 Q Well, you're here today, and you're an expert in the field of
23 pain management. No one hired you as an expert witness in this case.
24 You're here as a treating physician, and as an expert in the field of pain
25 management; is that fair to say?

1 A It is; yes.

2 Q I am paying you for your time to be here, away from your

3 office and seeing your patients today?

4 A You are. I still have seven staff members that are at the

5 office doing work, but I'm not there generating any money, so --

6 Q Okay. And I want to talk about, you know, have you formed

7 an opinion whether Mr. Yahyavi suffered a cervical spine structural

8 injury caused by the June 19th, 2013, motor vehicle collision?

9 A Yes. It is my opinion that he suffered a structural injury to

10 his cervical spine, which prompted a variety of different treatment, which

11 is still ongoing.

12 Q Okay. Does that include surgery?

13 A It does.

14 Q Does it include the need for spinal cord stimulation?

15 A It does.

16 Q Okay. Do you have an opinion whether or not that is a

17 permanent and life-altering injury suffered by Mr. Yahyavi as a result of

18 the June 19th, 2013 motor vehicle collision?

19 A Well, Mr. Yahyavi's injury, in my opinion, is permanent. His

20 prognosis in reference to kind of how well I predict he would be doing in

21 the future is poor. Based on the injury that he had, based on the failure

22 of some of the treatment that he's had to date, it is very likely that he is

23 going to have to live with pain, which most currently, he's rating it as a 7

24 to 8 out of 10 on a pain scale, which places him in, what I would call, the

25 severe area of pain.

1 And unfortunately, I don't expect that pain to improve over time.
2 In fact, as he gets older, it will likely worsen. So it is definitely a
3 permanent injury which has affected his life and the ability to particular
4 in what we call activities of daily living, things that you would have to do
5 during the day, including some of his -- well, some of his, all of his
6 occupational responsibilities.
7 He is, in my opinion, permanently and totally disabled, based on
8 my interactions with him and my familiarity with the opinions that have
9 been provided by other doctors in this case.
10 Q Okay. And we're going to now -- I want to talk about that. As
11 part of reaching your opinions in this case, did you use clinical
12 correlation as part of your -- not only in your treatment of Mr. Yahyavi,
13 but also your analysis of the permanency of his injuries?
14 A Of course. So clinical correlation really is just a kind of taking
15 a patient's symptoms and kind of looking at it from, how did this happen,
16 what we call the mechanism of injury, and the likelihood of injury, and all
17 of the testing that has been done, which we call objective testing, which
18 shows various different findings. So his symptoms correlated with the
19 objective testing that had been done. It also correlated with the way that
20 he was injured in this particular case.
21 Q Okay. And I've kind of shown this diagram to the jury. Is
22 that representative of the various components of the clinical correlation
23 including history, exam findings, response to treatment, diagnostic
24 imaging, such as x-ray, MRI, and other testing like what you've done in
25 the form of site specific injections?

1 A Yes. I think this summarizes it just as well as I could have.
2 Q Okay. And did you use clinical correlation in reaching your
3 opinions in this case regarding what the cause of his injuries was?
4 A Of course.
5 Q Okay. Are all the opinions you're expressing here today to a
6 reasonable degree of medical probability, meaning more likely true than
7 not?
8 A Yes.
9 Q And beyond that, are you certain, given the years of
10 involvement in his care?
11 A I am.
12 Q Very good. All right. Let's look at your first note of -- we're
13 going to look at Bates number 336. This is your dictation from
14 November 25, 2013.
15 A Okay.
16 Q And if you could just read just the date and the chief
17 complaint? Actually, I want the whole first part from consultation
18 performed, requested by, date of injury, all the way through chief
19 complaint.
20 A Okay.
21 Q Why did Dr. Perry refer Mr. Yahyavi to you?
22 A Well, Dr. Perry is an orthopedic spine surgeon, and he does
23 not perform injections. Dr. Perry was concerned about the potential
24 sources of Mr. Yahyavi's pain, and so he sent him to me with a variety of
25 different symptoms and asked me or tasked me with the job of trying to

1 identify a particular pain generator or pain generators, something that's
2 causing Mr. Yahyavi's pain for the complaints that he had, which are
3 listed down here under what we call chief complaints. So the chief
4 complaint is the reason the patient came to see you.
5 So it's just a quick summary of why are you here. Mr. Yahyavi on
6 that particular date talked about neck pain with occasional headaches
7 and numbness in both of his hands and arms, left greater than right,
8 meaning the left side was affected more than the right side, and it
9 affected all of his fingers of both hands.
10 Q All right. And as part of the history -- well, in terms of the
11 quality of the symptoms, if you could go down to the history.
12 A Sure.
13 Q How did he describe his symptoms to you in terms of their
14 severity?
15 A So the -- these words that are here where we talk about, you
16 know, Mr. Yahyavi complaining of constant daily aching, shooting, and
17 numbing type pain, are words that we use and give patients on a -- on an
18 intake form to choose from. And those words to me, and doctors who
19 do this type of work, are indicative of pain affecting muscles, nerves,
20 discs, joints.
21 So there -- you're starting to formulate a picture, or, kind of, an
22 idea in your mind of what's going on with the patient based on pieces of
23 information, kind of like you saw in that pie chart -- the very colorful pie
24 chart a few minutes ago. And this is -- this helps with the clinical
25 correlation. Basically, you're putting all the pieces of the puzzle together

1 is really what that -- that reflects.

2 Q Was it significant to you that not only did he describe, you

3 know, the severity of the neck pain, but he also had -- 80 percent of the

4 pain was in his left arm?

5 A It was significant in the sense that when we're talking about

6 how people are dividing up their pain is that -- that the pain itself, people

7 are trying to reflect what is, you know, your number one pain, your

8 number two pain. And that's trying -- seeing what we're -- you know,

9 what we're trying to get at here. And that's a very significant source of

10 pain for him, in addition to the -- you know, the head, the neck, and the --

11 and the upper back areas for him.

12 Q And with regard to the neck pain and arm pain, the fact that

13 he not only has severe neck pain, but also has pain, and numbness, and

14 tingling into the left arm, is that significant that a disc may be causing

15 some type of nerve root irritation?

16 A It is significant for a disc or discs. At this point we don't

17 know --

18 Q Okay.

19 A -- how many discs are involved. It might be one; it might be

20 more than one. But those symptoms are leading me to believe that there

21 are at least one disc involved that's pinching a nerve that is causing the

22 arm symptoms.

23 Q Okay. Did Mr. Yahyavi tell you when these symptoms began

24 as part of the history that you took from him on November 25th, 2013?

25 A He did. He --

1 Q What did he tell you?
2 A He indicated that they began following the motor vehicle
3 accident that he was involved in on June 19th, 2013.
4 Q Okay. With the forklift?
5 A With the forklift, yes.
6 Q Was your understanding that -- whether or not he was taken
7 by ambulance to UMC?
8 A Yes, he was.
9 Q Okay. And you -- part of your care and treatment includes
10 your review of some other records that are -- would be included in your
11 chart, right?
12 A Yes.
13 Q To have an understanding about the other treatment that he
14 may have received from other providers?
15 A Yes. So in this particular case, I was provided with other
16 records in my course of treatment of Mr. Yahyavi from other providers,
17 including Dr. Archie Perry, who is the orthopedic spine surgeon. There
18 were some records that I have reviewed related to the hospital
19 admission, the ambulance ride. Records from, kind of, a primary care
20 provider, an industrial medicine doctor named Dr. Klausner. Those were
21 the records, and as well as the imaging studies that were taken, the CT
22 scans, the MRIs, the x-rays, that have been taken on Mr. Yahyavi up to
23 this point. And I have been provided with other records beyond that.
24 Q Okay. What was significant to you when you reviewed the
25 Las Vegas Fire and Rescue records? What was significant -- stood out to

1 you? The date -- I mean, shortly after this collision occurred.

2 A Well, first of all, they were consistent with the history that

3 Mr. Yahyavi provided to me. So his histories to various different doctors

4 -- he's a good historian, meaning that he provides accurate histories. So

5 his representations or recollections of the events are consistent with

6 what I found independently in records from other providers closer to the

7 time of the accident, because remember, I'm seeing him about five

8 months after this accident has occurred.

9 So the histories that were provided to me early on were similar to

10 the histories that were provided. So it made me confident that the

11 history that was being provided to me was accurate.

12 The things that stuck out in that particular note from the fire and

13 rescue was that Mr. Yahyavi described striking his head on something,

14 he didn't know what it was. And the reason why he didn't know what it

15 was was he confused at the time of this particular event. He had a

16 decreased level of consciousness.

17 He was unable to provide a tremendous amount of information to

18 the Las Vegas Fire and Rescue, and basically the emergency medical

19 services at that particular time, which led to them -- there's a thing called

20 a Glasgow Coma Scale, which is a quick assessment of a person that's

21 involved in a trauma. The high number is 15. He got a 13 because of the

22 decreased level of consciousness that he was displaying. And he was

23 transported by ambulance based on those facts, plus the amount of

24 damage to his vehicle -- the intrusion to his vehicle from the forklift.

25 Those facts led him to be transported as a -- what we call a level

1 one trauma, which is -- level one is the highest level of trauma, meaning
2 we need to get him there fast to assess him to the hospital in a very
3 urgent way.
4 Q Now, do they -- if it's a minor traffic event, do they typically
5 have a level one trauma activation at UMC based upon your knowledge
6 and experience in this area?
7 A Absolutely not. Level one traumas are -- there's very specific
8 criteria that need to be met because when you -- when you call a level
9 one trauma -- I worked in a -- in a trauma unit when I was in residency,
10 and as a medical student here at UMC. But when you're involved in a
11 level one trauma center, an activation of that trauma not only involves
12 emergency room personnel to be dedicated to a room waiting the arrival
13 of a patient, but you're also there with a surgeon who might need -- be
14 deemed to be necessary.
15 So everyone gets involved. An anesthesiologist is involved, x-ray
16 people are involved. So there's a whole bunch of costs and, kind of,
17 coordination that's required.
18 So just the fact that someone is calling a level one trauma is
19 probably 30 to $40,000 just before the patient has even arrived just to get
20 everything in place awaiting the arrival of that particular patient. So it's
21 a pretty serious designation. It's not taken lightly. And you have to meet
22 specific criteria. The two pieces of information that caused this level one
23 trauma to be called were most likely his decreased level of
24 consciousness, the mechanism of injury, the contact of the forklift forks
25 with the car, which caused significant damage, and the amount of

1 intrusion to the vehicle that occurred as a result of the forceful nature
2 that the forks contacted the vehicle that Mr. Yahyavi was operating.
3 Q Okay. And at the time of your evaluation, November 25,
4 2013, did you have an understanding of whether Mr. Yahyavi's neck or
5 cervical complaints had been continuous and ongoing from the date of
6 the collision up through the time when you first saw him?
7 A Yes, that was my understanding based on the history that he
8 provided to me, which as I -- as I stated, has been accurate throughout all
9 of the records I've reviewed to date.
10 Q Okay. And what sort of treatment had he received prior to
11 coming to see you on November 25th, 2013?
12 A So prior to seeing me, he had been evaluated by ambulance
13 services, emergency medical personnel. I believe he was evaluated
14 initially at Concentra Medical Center, which is an industrial medicine
15 clinic; they have a few of them around town. He had been evaluated by
16 a Dr. Victor Klausner, who's an occupational medicine doctor. He had
17 undergone physical therapy, trials of medications, some chiropractic
18 care. He had imaging studies, including x-rays and MRI studies. He's
19 also been evaluated at that point by an orthopedic spine surgeon, and
20 perhaps other people that I'm forgetting at this moment.
21 Q Okay. And had he had any significant relief by the time he
22 comes to see you in November of 2013?
23 A No. He didn't. The symptoms were ongoing.
24 Q Right. Generally, let's talk about a soft-tissue injury claim.
25 One of the Defense told this jury that this really -- he only had a soft-

1 tissue injury claim as a result of this collision. Generally speaking, a soft-
2 tissue injury to the neck, or you know, the muscles and the ligaments,
3 how long does it take for that to resolve, Dr. Schifini?
4 A Well, if it was limited to that, those types of injuries typically
5 resolve in four to twelve weeks from the time of the injury with fairly
6 simple care. If this was just limited to a soft-tissue injury, we would not
7 have proceeded with all the treatment that I just described to you. We
8 also wouldn't have performed spinal injections, and surgery, and things
9 of that nature.
10 So although there may have been some soft tissue component to
11 this, I don't doubt that, that likely had resolved within, you know, weeks
12 of the accident. It probably would've resolved without any treatment.
13 But the -- there was clear evidence that there was a need for treatment --
14 a higher level of treatment; something more than soft-tissue based on
15 my review of all the records.
16 Q Is it common when you have an injury like this, you know,
17 the motor -- a significant motor vehicle collision, to have not only a soft-
18 tissue injury, but also an underlying structural injury to the spine? Can
19 you have them both at the same time?
20 A Of course. And so I don't disagree with the fact that he had a
21 soft-tissue injury.
22 Q Right.
23 A I accept that as to -- as true. But I -- in -- based on what I
24 know, I don't think -- and to -- this is to a reasonable degree of medical
25 certainty, that it was limited to that based on my familiarity with the --

1 the records that I have come to know.
2 Q And with regard to your treatment, if using the workers'
3 compensation system, as you discussed it, would there had ever been
4 even a referral to a pain management specialist to do injections in his
5 spine if it was simply a soft-tissue injury?
6 A No. That would have been inappropriate. And occasionally,
7 I do get inappropriate referrals where someone's not paying attention
8 and they refer the patient to me. And when I see them, I'll evaluate them
9 and I'll say you don't need me, you don't need to have needles poked in
10 your spine, or any other higher level of treatment, we need to send you
11 back to the chiropractor or to the -- to the physical therapist.
12 When I evaluated Mr. Yahyavi, that was not the conclusion I had
13 reached, and it was certainly not the conclusion that the doctors who
14 were involved in his care up to that point had reached, otherwise, the
15 referrals that were made to the orthopedic spine surgeon to discuss
16 surgery, and the orthopedic spine surgeon determining that he didn't
17 have enough information at that time to recommend surgery, he needed
18 to gather more information and made the referral to me.
19 So although I don't disagree with the fact that there were soft-
20 tissue injuries, there were certainly way -- there was certainly way more
21 evidence to indicate that the injury was much more severe, and it
22 continues to be so to this date, even when we're talking about back in
23 November of 2013.
24 Q Okay. Did you also review the MRI imaging from --
25 A I did.

1 Q -- that? Okay.
2 A Yes.
3 Q And I want to talk -- did you also perform an examination?
4 A I did.
5 Q All right. And then I want to talk now about your impression
6 from November 25th, 2013. That's Bates number 337. Okay. All right.
7 Let's talk about the impression. I want to -- if you can first show me that.
8 A Okay.
9 Q I want to first start off with you -- when you read the -- and
10 reviewed the imaging, meaning the MRI and x-rays of Mr. Yahyavi's
11 cervical spine, did you see evidence of degeneration?
12 A Of course I did. And I wasn't surprised based on his age at
13 the time we saw him, which was 51.
14 Q Okay. And the mere fact that some -- did he have -- would
15 you characterize those as age-related changes?
16 A Yes. Expected age-related --
17 Q Okay.
18 A -- preexisting changes.
19 Q Okay. So those age-related changes would've pre-dated this
20 motor vehicle collision, correct?
21 A Yes.
22 Q Just because someone has age-related changes, does that
23 mean they have multilevel sources of pain coming from multiple levels
24 of the disc or facet in the spine?
25 A No, because these age-related changes are expected.

1 Otherwise, everyone of a certain age would have pain associated with
2 them. So oftentimes these are things we see that are not associated with
3 pain. We don't even notice them, or we're not even aware that they're
4 there in a patient until we take an imaging study. But the fact that
5 they're there is not equivalent to pain.
6 The way that I counsel my patients on these when I -- when I
7 discuss this, because oftentimes especially in the workers'
8 compensation, patients are suspicious that they're not going to get the
9 proper care, they're not going to get what they think they need as far as
10 treatment, or their treatment's going to be limited or cut off. So when I
11 discuss age-related changes that we see in patients, I say to them, look,
12 your -- your symptoms that you're having are related to these because
13 they have been aggravated, or they've been permanently worsened as a
14 result of the injury that you had.
15 But the changes themselves were likely there before this accident.
16 And I can't prove that to them because we don't have an imaging study
17 directly before the accident -- the day before to, kind of, compare.
18 But what I explained to them is these findings are, kind of, like gray
19 hair and records. As you get older, we expect that you're going to get
20 these things. So everybody has them, but most people who have them
21 have zero pain associated with them. The only reason we notice them is
22 because we take imaging studies.
23 So the difference between having these and then -- and being
24 asymptomatic, meaning I don't have any symptoms, I'm pain free,
25 versus being -- having these and being symptomatic as a result of them

1 is typically the result of a trauma or some sort of event that happened.
2 And we certainly have an event. That event caused symptoms that are
3 documented in the records from the emergency medical service
4 personnel, which have been persistent to this date.
5 So although I recognize that -- that they're symptoms --
6 degenerative changes that are expected to be there, I don't -- I have -- I
7 did not for one minute think that those were the sources of his -- of his
8 current symptoms. It was the accident that was the source of his
9 symptoms.
10 Q When someone has degeneration, based upon your training
11 and experience, particularly dealing with people who have been injured
12 at work or otherwise, can yet aggravate multiple levels of the spine to
13 become symptomatic on a permanent basis?
14 A Yeah. So I would agree with that statement. In the workers'
15 compensation realm, we oftentimes use the term aggravated to mean
16 something different than exacerbated. And they may sound similar. But
17 if I -- if I believe that a motor -- motor vehicle accident, you fell down the
18 stairs, whatever kind of accident that you're involved in caused a
19 temporary worsening of a condition, which is expected to resolve on its
20 own in a short period of time, then I will use the word exacerbated to --
21 to describe that, meaning it's a temporary worsening. As opposed to the
22 word aggravated, which when I -- when I use that term, which I've used
23 today with you, it -- it's meant to imply that there's a permanent
24 worsening of the condition.
25 So when we look at these types of situations where there's clear

1 pre-existing conditions affecting in this case the cervical spine or the
2 neck, what -- what I typically will discuss with the adjuster when I'm
3 counseling them on these particular cases, is I'll say there was an
4 aggravation of a previously asymptomatic condition, meaning person
5 had a problem before. The condition that they had before was
6 aggravated in a permanent fashion by the injury that they had, in this
7 case, June 19th, 2013.

8 Q Is that what we have in this case? Do you have -- do we have
9 a permanent aggravation of an asymptomatic condition in Mr. Yahyavi's
10 cervical spine?

11 A Yes.

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

14 A It is.

15 Q Is that what was in fact accepted by the worker's
16 compensation carrier even up through today?

17 A Yes.

18 Q Very good. Now let's go to your fourth impression, which is
19 on page 338 -- or Bates number 338 of Exhibit 92. I want to look at
20 number four.

21 A Okay.

22 Q What do you mean that he -- by November 2013, he's failed
23 conservative care?

24 A So for the five months that Mr. Yahyavi sought treatment
25 before he saw me, he tried what I'll call simpler things, and I'll define that

1 as not involving needles or scalpels. He tried simpler things like the
2 medications, rest, chiropractic, physical therapy, other doctor
3 evaluations. And all of that in the -- in the five months or so before I saw
4 him, did not assist him in reaching a pain free state. It didn't get him
5 back to where he was before, which was pain free.
6 So to me, he had done all the things -- he had checked all the
7 boxes of things that you would normally -- you would expect for
8 someone to get better in that timeframe. And based on what I know
9 about him, the information that I had at that point, I felt that he had failed
10 to receive adequate benefit from those more conservative measures, and
11 therefore additional care was needed involving -- I'll call it a higher level
12 of care with, you know, needles and/or scalpels, meaning spinal
13 injections and potential surgery if those failed to relieve his symptoms to
14 a reasonable -- in a reasonable fashion, which is what prompted the
15 plan, which is in the next session.
16 Q All right. Okay. And let's go back for a second on the
17 degeneration. Number one, would work comp even accept a claim for
18 cervical degeneration without a traumatic onset of symptoms?
19 A No. They often times will deny something, if it's just purely
20 degenerative and there's no symptoms associated with it, which fit with
21 that. So if it was just purely degenerative and there was no traumatic
22 event which caused those degenerative symptoms to become
23 aggravated in a permanent fashion.
24 Q If somebody like Mr. Yahyavi, who has these age-related
25 degenerative changes, is he more susceptible or prone to an aggravation

1 on a permanent basis than someone who didn't have those things?
2 A That is the thought process, that he kind of had a head start
3 to having a more permanent injury, because of the degenerative
4 changes that were present in his spine. I can't prove that to you, but
5 that's kind of -- that makes sense to me.
6 Q In fact, that's your opinion, correct?
7 A It is, yes.
8 Q Okay. Now, is the timing of the onset of the symptoms and
9 with -- you know, and the duration and quality of the symptoms, was
10 that also important to you in reaching your opinions and formulating
11 your treatment plan in this case?
12 A Absolutely, that's part of that clinical correlation that we
13 talked about it.
14 Q Okay. Now, under your plan, if we look at item number 1 on
15 your plan, Bate number 338 --
16 A Yes.
17 Q -- it says performed stage C7-T1, followed by possibly C6-7
18 and possibly C5-6 transforaminal selective epidural steroid injections.
19 Number one, what role does pain management -- interventional pain
20 management play to determine the source of a patient's pain? Just first.
21 A Sure. So these injections that were just mentioned are
22 particular injections that you would do in the spine and when I was
23 asked to do these by Dr. Archie Perry, first of all, I have to agree. He's
24 asking me to do them. I'm evaluating the patient on my own
25 independent of Dr. Perry. I'm aware of what he's asking for and I have to

1 determine whether or not they're reasonable. So the method in which I
2 chose to undertake these were helpful and designed to identify how
3 many levels were involved.
4 Because as we've discussed, there were multiple levels involved,
5 not just one. And so in order to do and identify where the patient's pain
6 is coming from, you have to first of all understanding that the patient has
7 100 percent of pain, okay? So whatever you define and whatever makes
8 up that 100 percent. So the fashion that we try to do these in what we
9 call a staged fashion, which means do one, bring the patient back, ten
10 minutes later do another one, bring the patient back ten minutes later
11 and do another one.
12 We're trying to figure out is 100 percent of the patient's pain
13 coming from you know, the first injection? Because if so, they don't
14 need the other two. If 100 percent of the patient's pain is coming from
15 the second injection, they don't need injection number three. So we're
16 trying to kind of figure out how that pain is defined and how much pain
17 is coming from one level versus another level versus another level. The
18 simpler way to do this or the more efficient way to do this was -- would
19 be to have injected all three levels at the same time.
20 The problem with that is although that's easier and way more
21 efficient for me and probably more efficient for the patient receiving the
22 injections, if you have three needles in a patient's neck in this particular
23 case, it'll be placed under x-ray guidance, so we know where they are.
24 But if you inject three times for the same time and the patient says I feel
25 wonderful, what was wrong with me, there's about six different

1 combinations of things that could be wrong with him.
2 It could be all three are involved. It could be the first one and the
3 third one. It could be the second one and the first one. It could be the
4 second one and third one. I mean, could be just multiple different
5 combinations that you can imagine associated with that. So I chose to
6 do this in a way that made more sense, that we were going to be able to
7 identify one level versus another level versus a third level, although that
8 was more cumbersome for me and unfortunately for Mr. Yahyavi, it was
9 the best way to get a clear answer for Dr. Perry, who was considering
10 surgery on him at that point.
11 Q Right. So you're kind of wearing a detective hat in kind of
12 investigating where the pain is coming from. Would that be a fair way to
13 describe what you just said?
14 A I think that's fair, yes.
15 Q All right. And so how does a surgeon use this type of
16 information?
17 A So a surgeon is looking at something they can fix, so they're
18 looking at structural things or anatomic structures. They're looking at
19 the spine, like is front of you here from a how can I fix that? So they're
20 kind of the carpenter, okay? And I'm the guy drawing up the plan, if you
21 kind of think of it from that fashion. I'm giving them the information.
22 They can then put that information together with what they knew about
23 the structure of the spine and then kind of make up a plan as to go well
24 gee, obviously there's more than one level involved, so I may have to
25 change my way of thinking about this.

1 There were, as we discussed, multiple levels involved, so this
2 information was not only important to me, Mr. Yahyavi understood that
3 this was going to take longer for him to have this type of thing. But he
4 felt it was important and I knew it was going to be important to Dr. Perry,
5 because it's -- again, he's now also doing the same thing that I'm doing
6 is clinically correlating the symptoms that Mr. Yahyavi's experiencing
7 and the results of testing, which is now going to include results of spinal
8 injections.
9 The way that the spinal injections help to identify something is by
10 using local anesthesia, okay. So you use numbing medicine, like the
11 dentists do on your teeth. The reason why we picked the things to
12 identify or target in the order in which we pick them is we start with the
13 bottom one, because I'm a big believer in gravity and I'm sure you all
14 are, too. You're not hovering above the chairs, so gravity is important.
15 So you want to start with the bottom one, because if you inject there, if
16 anything, the medicine is going to go down and effect a level you're not
17 concerned about.
18 So you want to start with the bottom one and work your way up,
19 rather than starting with the top one, which potentially will spoil the
20 diagnostic value, the usefulness to figure out something when it comes
21 to these cases. So we're using these injections to identify something
22 and figure out how much percentage of a pain is attributable to one
23 particular level versus another.
24 Q Very good. Now, I -- according to the records, part of Exhibit
25 93, Bate number 404, your first procedure -- or the series of injections

1 was performed on December the 9th, 2013.

2 A Yes.

3 Q Okay. And I want to -- if we can -- number one, just tell us

4 what you did. What is a transforaminal epidural steroid? And I have a

5 demonstrative maybe that we could -- we can use. That's Number 41.

6 Or maybe you could step down and use the spine model and a pen and

7 you could identify where. So Demonstrative 41 and I'm going to have

8 the doctor step down.

9 THE WITNESS: Is that okay?

10 THE COURT: Go ahead.

11 THE WITNESS: All right.

12 BY MR. PRINCE:

13 Q And tell us what you did on December 9th, 2013.

14 A So first of all, like we talked about --

15 Q I have a little image there, so --

16 A Oh.

17 Q -- maybe you could maybe start there and then --

18 THE MARSHAL: And use the microphone.

19 MR. PRINCE: Yeah. Sorry.

20 THE WITNESS: All right. I'll hold this while I do this. So first

21 of all, as we talked about with these -- any information that I'm providing

22 to the work comp, I have to request authorization approval to have this

23 done. Just because Dr. Perry has asked me to do these things doesn't

24 mean I just have a -- you know, an open checkbook and just start doing

25 random things on patients. I have to now send these notes that we just

1 went over to the work comp people and often times talk to adjusters to
2 be able to get that approved. So these injections we're going to talk
3 about had to be signed off by someone else other than me or Dr. Perry.
4 So there's other people involved in the whole process.
5 But when you look at the spine -- so if you look at it from the
6 front, the disks are in the front of the spine. So you have these white
7 things here, which are the bones or the vertebrae. These rubbery pieces
8 in between, those are the discs. As we kind of turn the spine to the side,
9 you'll see these yellow things that are coming out. Those are the nerves.
10 And then if you turn it from the back, all you see is a bunch of bones. So
11 this is kind of a cartoon image of what we're talking about, so I'm going
12 to start with what I'll call normal anatomy.
13 So this right here would be the disk. These white structures
14 here or kind of tan structures are going to be the vertebraes. So the
15 disks are kind of rubbery, kind of the consistency of maybe a pencil
16 eraser. They form like a shock absorber or a bushing. And so they are
17 there between the bones to prevent the bones from touching, because
18 you can imagine if the bones touch, that would hurt. The disks also are
19 important to determine the size of this hole back here.
20 Now, that hole is in the bone, and it's kind of a clamshell
21 arrangement. You have the top part of the hole, which is made by the
22 top bone and the bottom part of the hole, which is make by the bottom
23 bone. So this bottom part is made by this bone. This top part of the
24 hole is made by the bone on the top here. That allows a nerve to exit.
25 Behind that, you see this other stuff back here. That's the spinal cord.

1 That's protected by these bones. It's something that as a pain doctor,
2 you don't want to deal with, you don't want to touch.
3 So when we deal with these injections, we're dealing with
4 the nerve structure and we're dealing with the hole that the nerve comes
5 out. So this is different than a labor epidural for a pregnant woman,
6 which is done down here in the low back and it's done in the middle.
7 Because a pregnant woman, what you're trying to do is get her numb
8 from about here down so when the baby comes out, there's not a lot of
9 pain and perhaps you can trick her into having a second one. But when
10 we do these injections, we're trying to target a very specific nerve.
11 We're not trying to get everything from here down numb,
12 because then you can't figure out anything. It's the reason why I didn't
13 want to do the injections all three of them at the same time as well. But
14 let's say we were interested in these three nerves here. So you see this
15 one here. You see the one that's red to show that it's enflamed and we
16 do this one here and those are the three that I'm intending to target.
17 So if I was going to do this, I would have a needle, but I
18 would have targeted this one first, because if put medicine in here, in
19 this hole where the nerve comes out, what's going to happen is the
20 medicine would potentially drip down to a level I don't really care about,
21 I'm not concerned about.
22 So if it affects this level, which I don't think is going to be
23 painful for a patient, it really isn't going to screw up my diagnostic
24 results or spoil them in any way. But when we do these injections, the
25 idea is to isolate one thing at a time. And I don't mean to refer to Mr.

1 Yahyavi or any patient as a number, but just to kind of get you to
2 understand what a staged injection is. So Mr. Yahyavi was scheduled for
3 three injections on the same day. I put him on my schedule as let's say
4 patient number 1, patient number 3 and patient number 5, meaning
5 there was a patient number 2 and 4 in between.
6 So if I do him here as patient number 1, then I now let him go
7 sit out in the recovery room, move his head around, move his neck
8 around and see if his pain is any better while I'm doing an injection of
9 patient number 2. I then go out and I assess him and determine if he's
10 pain free. If he's not pain free at that point, I then bring him back and I
11 add the second one. Well, this is one is still numb, because the numbing
12 medicine lasts for maybe two hours. I'm now going to go do this one.
13 I'll take him out to the recovery room.
14 We'll bring patient number 4 back and I will then reassess
15 Mr. Yahyavi after I've done patient number 4. Are you pain free at this
16 point? No, I'm not pain free. Then we will add the third one, the last one
17 for him in that particular session. But the idea is we're trying to figure
18 out is this causing 20 percent. This one, now when I had both of those,
19 now it's 50 percent better and I have the third one. It's now 100 percent
20 better. Unfortunately, he didn't ever get pain free with those three,
21 which indicated to me that there was even more levels involved than just
22 these three.
23 But in either case, when we do these injections, this needle is
24 showing up on a big TV like this. So we can see where the needle is
25 being placed. We don't just kind of randomly go I want to just poke the

1 needle here. We can see this anatomy under x-ray. The patient is
2 usually face up, so the disks are kind of displayed this way. The reason
3 why we do it that way, rather than poking a needle from the back is we
4 don't want to touch their spinal cord. So if we have them up like this, we
5 have an x-ray, that's a live x-ray.
6 We can look at them straight on. We can then rotate it to the
7 side or the other side and identify the particular nerve and do this
8 injection in a safer fashion. Because again, these injections are risky.
9 There's nerve damage that's involved. You can be paralyzed, if you
10 touch the spinal cord. You can cause an infection in this area. There's --
11 what's not shown here is a big blood vessel that sits in there. A patient
12 can have a seizure or a stroke during these injections.
13 So these are not things that you want to do just because.
14 You want to do them for a particular purpose and your -- this purpose
15 was important to identify things, because have risks. So does surgery.
16 And when you want to give that information to a surgeon like Dr. Perry
17 or another surgeon, that information is going to be extremely important
18 for them to do future treatment planning.
19 BY MR. PRINCE:
20 Q Okay. And so on the first day, you did -- I think we're good.
21 Thank you. On the first day of these injections -- I'll wait until you get
22 back on. You talked about doing them in a staged fashion. Did you
23 actually do three different injections on the same day?
24 A We did, yes. So --
25 Q Okay. Which levels?

1 A So we did C7-T1, which is kind of where your neck transitions
2 into your chest. The C numbers are for cervical and the T numbers are
3 for thoracic. So we did C7-T1 first. The next level above that is C6-7 and
4 then the next level above that is C5-6 and he ended up going through all
5 three of those on the same day.
6 Q So he actually had three series of injections on the same
7 day?
8 A Yes.
9 Q And following those injections, did he receive any relief of
10 symptoms?
11 A So when we did those injections on the first level -- and I'll
12 have to refer to my notes, because I haven't memorized this. So on
13 December 9th, 2013 when we did these -- so we started off with the
14 lowest level. He -- pre-procedure, meaning before the procedure, rated
15 his pain on that pain scale that you guys have become very familiar with
16 as a 6 out of 10. So we then anesthetized the disk and the nerve
17 associated with that. His pain went from a 6 to a 5 when I evaluated him
18 in the recovery room, meaning the area away from the procedure room,
19 where we do these.
20 We're hopeful that he'll have gone from a 6 to a zero with the
21 numbing medicine, which would indicate that he doesn't need to be
22 patient number 3 or 5. But he only went from a 6 to a 5, which is about a
23 15, 16 percent reduction in his overall pain. So we have identified that
24 lowest level as a part of the problem. He then goes back to the
25 procedure room. He then is a 5 out of 10, okay? And he has his second

1 procedure, which brings him down to a 2 out of 10. So he went from a 5
2 to a 2.
3 So now we're getting closer to the zero, which is really the goal.
4 And that was at C6-7. We then bring him back to do the third procedure
5 and we're hoping to get him from a 2 to a zero and unfortunately, he
6 stayed at a 2, meaning the third level, the C5-6 level didn't really add
7 much to the whole process. But if you look at it from a different point of
8 view, if we would have done all of those together, we would have went
9 from a 6 to a 2, okay, because that's where he started and that's where
10 he ended up, but now we have much more specific information.
11 We know that at least two of those levels and perhaps the third one
12 are involved in his process, but at least two of those levels are involved.
13 Maybe the third one isn't involved at that point is kind of the though
14 process. And so we then ended up doing more testing.
15 Q Okay. Did you -- after December of 2013, did you repeat
16 injections again?
17 A We did.
18 Q The same type -- the transforaminal epidural steroid
19 injections?
20 A Yes, that's correct.
21 Q And according to my notes, you did that on 415, Bate
22 number 415?
23 A Yes.
24 Q January 2nd, 2014?
25 A That's correct.

1 Q What did you do? Just the procedure performed.
2 A So on that day, we did bilateral, meaning both sides. So
3 instead of just the left side, like we did on this first one, I was requested
4 by Dr. Perry to focus on the C6-7 level, which was the level that gave Mr.
5 Yahyavi the most relief with the first set of injections. So we did bilateral
6 C6-7 injections of the same type, so left and right at one level.
7 Q Okay. And what was the response to that?
8 A He started off at an 8 to 9 out of 10 and went down to about a
9 6 out of 10 following that injection, but never he got to zero.
10 Q Okay.
11 A So we didn't identify everything.
12 Q Okay. So did that reflect a component of the pain?
13 A It did, yes.
14 Q Very good. And the pain would be coming from the disc and
15 or nerve?
16 A Yes.
17 Q Okay. And it looks like you repeated another set of injections
18 on the right side at C3-4. Now another level above on April the 7th,
19 2014?
20 A Yes.
21 Q And what information did that provide to you concerning
22 whether that was a source of the pain?
23 A Well, that particular level indicated that he didn't have any
24 change in his pain immediately, despite the fact that there was some
25 numbing medicine in there, which may indicate C3-4 was not a

1 significant pain generator for him.

2 Q Okay. Now, you did a left and a right on April the 7th, 2014?

3 A Yes.

4 Q Was it the same results for both?

5 A Same results for both, yes.

6 Q Okay. Very good. Now, are you reporting this information

7 back to Dr. Perry?

8 A Not only to Dr. Perry, but to the work comp provider, yes.

9 Q Right. And this is still part of the accepted work

10 compensation claim, right?

11 A Yes.

12 Q Okay. Now, you again did injections on July 10th, 2014,

13 which would be a year later?

14 A Yes.

15 Q Okay. Now -- by now, he's now -- this is his -- even though

16 you did them in like three stages, this is probably his eighth injection,

17 right, eighth procedure?

18 A It may even be more than that, yes.

19 Q More than that. And what were the results of the July 10,

20 2014 procedure?

21 A So on that date, we focused on the disc and the nerves

22 between the C-5 and the C-6 bone, so C5-6 segment. His pain went from

23 a 6 out of 10 to a 4 out of 10 immediately following that procedure,

24 which again identified a component of his suspected pain generator.

25 Q Okay. And now, did you obviously communicate that back to

1 Dr. Perry?
2 A I did.
3 Q Now, based upon -- let's just focus on just the epidural
4 steroid injections. Did you have an impression as of July 2014 whether
5 there was multiple sources of discogenic pain coming from Mr.
6 Yahyavi's cervical spine?
7 A Not only discogenic, but neurogenic, meaning nerve-related
8 pain.
9 Q Okay. Tell me -- tell us what neurogenic pain is.
10 A So, when a disc bulges back, herniates, protrudes, extrudes,
11 there's a lot of different words that all kind of indicate something is
12 sticking out from the disc, something is pushing out and potentially
13 pinching a nerve. In that particular case, based on the information that I
14 had to review, I was unable to identify any one source of pain and that's
15 simply because I identified multiple potential sources of pain for Mr.
16 Yahyavi.
17 So it wasn't as clean or clear as identifying the one source. And I
18 was -- I would have been very surprised to identify just one source in
19 him based on the appearance of his imaging studies.
20 Q Okay. Now, that informa -- you sent that back to Dr. Perry,
21 the surgeon?
22 A Yes.
23 Q Was it your understanding from working with Dr. Perry that
24 he had in fact recommended a multilevel cervical spine fusion surgery to
25 Mr. Yahyavi?

1 A He did.
2 Q Okay. And did you also perform injection to determine it's
3 not only something coming from a disc and a neurogenic pain, but also
4 coming from a structure known as the facet joint?
5 A Yes, I did. The facet joint is a joint that's on the back of the
6 spine.
7 Q I'm going to hand you the model and then we're --
8 MR. PRINCE: Let's put up Demonstrative 42.
9 BY MR. PRINCE:
10 Q What I've shown is -- I call it an irritated facet on the little
11 illustration, but if you can --
12 A Okay.
13 Q That shows what the facet is and how they become injured in
14 a traumatic event, such as this motor vehicle collision.
15 A All right. So the -- in order to understand what a facet is,
16 you're going to kind of thinking of cracking your knuckle. Those knuckle
17 cracks that you make and the noise that your knuckles make are the
18 same noise facet joints make. It's the joints that chiropractors move
19 around. It's just way more dramatic when a chiropractor does it,
20 because there's multiple things being cracked at the same time. Those
21 joints allow you to move.
22 If I'm sitting talking to you all and now somebody calls my name
23 from behind me, I can turn around and address them and say hold on a
24 second. I'm busy. And I'm still facing you and I could only do that if I
25 had these facets. These facets allow your body to move and twist. So

1 Dr. Perry, when he asked me to address the facet joints, asked me to
2 address the things that move in someone's spine. So he asked me to
3 move the -- or I'm sorry, address the discs. So when you move the
4 spine, the discs move.
5 Well, when you move the spine, there's little joints that are paired
6 joints. You have left sided and right sided joints that are kind of made up
7 by bones above and below, kind of like the discs are. And they're kind of
8 in a way a shock absorber, but they allow you to twist back here. So
9 these little slits that you see back here on the sides of the spine is what
10 you see here. So you see these areas here that are kind of curved. You
11 can kind of see a blue area to that and it's that to -- meant to kind of
12 indicate that there's some sort of cartilage involved.
13 There's also a capsule that's not shown on here that's also
14 involved, because there's some fluid in there to lubricate the actual joint.
15 When a joint becomes enflamed, it can become painful and it can also
16 become a source of the pain. Sometimes it's hard to identify, because
17 when you move your neck, you're moving these structures in the front,
18 which are discs. You're also moving those structures in the back. So
19 often times, I'm asked before a doctor wants to do a major surgery to see
20 are those involved.
21 Because if those are the major sources of the pain, there's different
22 treatment options for the joints, which are on the backside of spine as
23 compared to the discs and perhaps you can avoid a major surgery. So I
24 was being asked to see, is this the only source of pain? Because if so, we
25 may be able to avoid a major surgery in the front. And when we did

1 these injections, what we're trying to do is isolate the nerves that supply
2 those joints. So each joint is made up by two bones. If you follow this
3 bone back, it's here. It gives this component to the facet joint. If you
4 follow this bone back, you see that there's a component of a facet joint
5 that comes up.
6 So they kind of fit together. So you have one bone coming up and
7 another bone coming down. It's the way that the back of the spine fits
8 together. And you can see those by looking at these little spaces in
9 between here on the sides. If I pull them apart, the spaces become a
10 little bit clearer in here. And those are the facet joints that we're talking
11 about. And the -- again, those joints glide and slide and allow you to
12 twist your head and move your head. Everybody's heard cracking and
13 popping in their neck. Those facet joints, by moving them, can create
14 that sound that you hear and those can also become a major source of
15 pain when they're enflamed.
16 Q Okay. Now did you --
17 MR. PRINCE: Go to demonstrative 43. You can go back to
18 the stand. Thank you.
19 BY MR. PRINCE:
20 Q Did you perform a facet joint injection? I know we talked
21 about it in this case.
22 A We did on October 23rd, 2014.
23 Q Okay. And what were the results of the facet joint injection?
24 A So on that particular occasion, we addressed four different
25 nerves --

1 MR. PRINCE: Go to 426.

2 THE WITNESS: -- that were supplying three facet joints -- the

3 bottom three in the neck, C5-6, C-6-7 and C7-T1.

4 BY MR. PRINCE:

5 Q Okay. And kind of like before, how you described how you

6 injected that, did you inject both a numbing medication and a steroid

7 into the joint itself --

8 A Yes.

9 Q -- at those levels?

10 A Well, it wasn't -- in this particular case, it was more into the

11 nerves surrounding the joints.

12 Q The medial branch.

13 A The medial branch nerves, but yes.

14 Q Okay. Well -- fair point. The medial branch. Is that the nerve

15 supply in the facet joint itself?

16 A Yes.

17 Q But can a medial nerve become -- a medial branch nerve

18 become painful in response to trauma?

19 A Of course, because those medial branch nerves are really

20 tiny nerves that supply the capsule. So if the joint is enflamed, the

21 capsule is swollen, it stretches those nerves and every time you move

22 something, it fires up those nerves, so those often times are the source

23 of the pain related to the facet joints in the neck, as a result of the facet

24 joint being enflamed itself. So it's kind of hard to separate those two,

25 but the facet joints and/or the nerves are enflamed. The nerves are way

1 more specific and that's what we're looking for is a specific answer to
2 what's causing Mr. Yahyavi's pain, so we chose to take this --
3 Q Okay.
4 A -- point of view.
5 Q And what was the result of the facet injection -- or excuse
6 me -- the medial branch blocks that you performed to either rule in or
7 rule out whether the facets were a source of pain at those three levels?
8 A Based on what we determined, his pain went from a 6 out of
9 10 to a 4 out of 10 following those injections, which also indicated that
10 the facet joints were a source of his pain. So his problem -- I kind of
11 understood it when I first met him and reviewed all of his information
12 that I had at that time that this was going to be a more complex kind of
13 an issue going on and it became even more complex when you added
14 the facet joints, meaning that those were likely involved and were pain
15 generators as well.
16 Q So based upon the injections you performed up through
17 October 2014, did you have an opinion at that time whether he suffered
18 multilevel disc pain caused by the trauma of June 19, 2013?
19 A Yes.
20 Q Okay. And also, did you make a determination whether he
21 also had suffered a second source of pain coming from multiple levels of
22 the facet joints as of October 23rd, 2014 caused by the trauma of this
23 motor vehicle collision?
24 A Not only did I determine that the facet joints were sources of
25 pain in addition to the discs, I also determined that the nerves were likely

1 sources of his pain as well, so there were three sources at multiple levels
2 in his cervical spine at that point, based on what I knew about Mr.
3 Yahyavi.
4 Q Right. Assuming somebody had multiple sources of pain in
5 their spine, you know, both coming from the disc and the facet and
6 nerve, would you expect someone to have pain-free full range of
7 motion?
8 A No.
9 Q Would you expect someone to be undergoing treatment,
10 whether physical therapy, chiropractic care, medications, consultation
11 with a pain physician as well as a surgeon?
12 A I would expect those things to be present, if these structures
13 were ever painful before that accident, after the accident they became
14 painful and I expect him to have medications and seek medical attention,
15 including pain management and surgical consultations.
16 Q In your opinion as of the last date that you saw him, October
17 2014, did you have an opinion whether he was a surgical candidate at
18 multiple levels of his spine, based upon your impression?
19 A Although I'm not a surgeon, I'm often times tasked with
20 assisting surgeons, as I explained, in making those decisions and in my
21 opinion, he was a candidate for multilevel surgery, which was an opinion
22 that Dr. Perry had previously expressed even before we had performed
23 these. I felt even more confident with that conclusion after I performed
24 these injections.
25 Q Okay. Now I want to kind of fast forward in time a little bit,

1 okay?

2 A Okay.

3 Q And after these -- in 2014, when did Mr. Yahyavi come back

4 to see you as part of his care?

5 A So Mr. Yahyavi returned to my care, it looks like, on June

6 3rd, 2019.

7 Q Okay. And who referred him to you?

8 A This time it was a different spine surgeon and that surgeon

9 was Dr. John Thalgott --

10 Q Okay.

11 A -- who's another orthopedic spine doctor.

12 Q Okay. And did Dr. Thalgott also forward to you some of his

13 chart note entries from his evaluation of Mr. Yahyavi from 2019?

14 A He did. He not only sent me his notes, but updated imaging

15 studies and some records from other physicians involved, including a

16 psychologist, Dr. Staci Ross.

17 Q Okay. Were those records that were supplied to you,

18 whether from Dr. Thalgott, who's a -- also -- he's fellowship trained

19 orthopedic spine, right?

20 A He is.

21 Q And also you reviewed records from a I think a Chiropractic

22 Care, correct?

23 A Yes.

24 Q Did you review the surgical records from -- for Dr. Kaplan for

25 the surgery he performed?

1 A I have that, yes.

2 Q And did you also look at updated imaging studies as well as
3 neurological testing?

4 A I did.

5 Q Okay. Was all that relevant and helpful to you in formulating
6 your opinions and plan of care for Mr. Yahyavi in the course of your
7 care?

8 A It was, because since the last time I saw him in October 2014,
9 now we're fast forwarding about five years, he had had a surgery in
10 between. I wasn't surprised that he had had a major surgery extending
11 from C-3 all the way down to T-1 in reference to the care that had been
12 provided to him. So that -- I was basically being provided with records
13 to update me as to the timeframe that I hadn't been actively involved in
14 his care.

15 Q Okay. And with regard to that surgery, did you -- based on
16 the records that you had, the history that you've taken, your examination
17 and findings, your testing results, did you form an opinion of what was
18 the cause of the need for that five level cervical spine surgery?

19 A It remained my opinion that the need for that surgery was
20 the June 13th, 2019 -- or excuse me. I'm sorry. June 19th, 2013 motor
21 vehicle accident involving a forklift.

22 Q Right. And isn't it true that worker's compensation, they
23 actually referred Mr. Yahyavi to Dr. Thalgott for a second opinion?

24 A Yes. He was --

25 Q Okay.

1 A -- sent there for what I believe what they call an independent
2 medical evaluation, so that Dr. Thalgott had the opportunity to review all
3 the pertinent records associated with Mr. Yahyavi and come up with a
4 treatment plan from that point forward.
5 Q And based upon your review of the records that were
6 supplied to you as part of your care and treatment of Mr. Yahyavi, did
7 you note that Dr. Thalgott, the spine surgeon, also related the need to
8 the -- for the cervical spine surgery performed by Dr. Kaplan to this
9 motor vehicle crash with a forklift?
10 A He did, yes.
11 Q Okay. So his opinion was consistent with your own?
12 A Yes.
13 Q And consistent with Dr. Perry?
14 A Yes.
15 Q And consistent with Dr. Kaplan?
16 A Yes.
17 Q Very good. Now, I want to talk about -- well, let me ask you
18 another -- just kind of a housekeeping question. Do you believe, in your
19 opinion, based upon your overall participation in the care of Mr. Yahyavi,
20 review of these records and your understanding of his current condition,
21 that Dr. Kaplan's surgery was reasonable and appropriate for the
22 condition he present with?
23 A Absolutely, yes.
24 Q Okay. And related to this motor vehicle collision?
25 A Yes.

1 Q To a reasonable degree of medical probability?

2 A Yes.

3 Q What was the reason that Dr. Thalgott sent Mr. Yahyavi back
4 to you?

5 A Well, Mr. Yahyavi, following the surgery, which was
6 necessitated by the accident in June of 2013, had ongoing pain
7 complaints, neck pain and left arm symptoms. At that point, there was
8 no more surgical intervention that could be done in the sense of fixing
9 the spine. You were no longer able to fix anything. That had already
10 been addressed and unfortunately, based on the circumstances that
11 were there, Mr. Yahyavi continued have significant pain complaints,
12 which to this date, he continues to rate at about a 7 to 8 out of 10.

13 So Dr. Thalgott wanted to send him to me for consideration of
14 something called a spinal cord stimulator placement, which is a device
15 that essentially takes a patient's pain level and tries to cover it up,
16 because we can no longer fix it. You don't want to cover up something
17 that can be fixed. We've kind of given up on fixing it. We're now in the
18 process of doing the best to cover it up and that was one of the options.
19 Dr. Thalgott referred Mr. Yahyavi to me as an expert in spinal cord
20 stimulator placements to discuss that option with him, to explain it to
21 him from perhaps a different point of view and to proceed with my
22 recommendations regarding that placement of that procedure.

23 Q Okay. And it's in connection with that evaluation that you
24 reviewed a bunch of additional records from the time you left your care
25 up through the time he came back to your care in 2019?

1 A Yes.

2 Q Okay. Your -- one of your impressions was a cervical post-
3 fusion syndrome. Why are you calling this a cervical post-fusion
4 syndrome? What does that mean?

5 A Well, unfortunately when you do surgery, there's no
6 guarantees. All the surgeon can guarantee you is two things. One is
7 you're going to have a scar. The second thing they can guarantee is that
8 you're not going to be the same. The hope is that you're going to be
9 better and not worse.

10 Q So Mr. Yahyavi had undergone a very big surgery and he
11 ended up having pain associated with that surgery, which again, was
12 necessitated by the accident that had preceded that by, you know, a few
13 years. So as a result of that surgery, he didn't do well. And so that
14 diagnosis and that diagnosis code is specifically to reflect that a patient
15 has undergone a surgical procedure and continues to have symptoms
16 afterwards. It doesn't reflect the severity of their symptoms.

17 It just reflects the fact that they continued to have symptoms
18 following a surgery. So it's also commonly referred to as failed back
19 surgery symptoms, although this is his neck and not his back and that
20 designation can also fit.

21 Q Right. Was this also necessitated, including the
22 complications and additional problems he developed following the
23 surgery, all caused by this trauma of June 19, 2013?

24 A Yes.

25 Q And was this also this -- these ongoing symptoms also

1 accepted by the worker's compensation administrator as well?

2 A Yes. That was who referred me the patient. Dr. Thalgott saw

3 the patient for the evaluation. He had to then request an authorization to

4 come see me through the work comp system, so they were still

5 accepting the cervical spine as an included body part for the date of

6 injury, June 19th, 2013.

7 Q Right. And prior to seeing you in June of 2019, did Dr.

8 Thalgott request that Mr. Yahyavi undergo a psychological evaluation in

9 connection with the spinal cord stimulator placement?

10 A Yes. So he did --

11 Q Well number one, why do they? Why do surgeons request

12 someone undergo a psychological evaluation before they do one of

13 these placements?

14 A So a psychological evaluation is useful for patients to

15 determine their candidacy of the procedure. Doctors, physicians have

16 already kind of determined that medically it's a reasonable procedure to

17 look at, but we're not psychologists. And you know, although we deal

18 with some psychological issues associated with treatment that we

19 provide to patients and certainly patients who are in chronic pain often

20 times have symptoms of depression and some other things that are

21 involved with that.

22 We're not experts in that. We don't spend a great deal of time

23 evaluating the patients for that. So in my opinion, the value of the

24 psychological sort of consultation beforehand kind evaluates the

25 patient's mental candidacy for this. We're looking at it from a physical

1 standpoint. Yes, you have pain. You have a place to put this and we
2 think it's going to help you. The psychologist is looking at it from a
3 different point of view as how has this affected your life, what are you
4 expecting from this?
5 Do you have unrealistic expectations from placement of this? Do
6 you think it's somehow going to make you better or a better person, a
7 happier person? Things of that nature. So they're looking at it from a
8 whole different point of view. And often times, it is recommended
9 before either a trial or a test drive of a stimulator or a permanent
10 stimulator that a psychological clearance has to be obtained, because
11 your -- you want to make sure that the patient has realistic expectations,
12 that they're not expecting that they're going to have magical powers
13 after you put in this electrical device in them, something of that nature.
14 So you're looking for a different point of view to assess the patient.
15 I find them very, very helpful. Dr. Ross actually performed a way more
16 thorough evaluation than I've ever seen in a patient in the sense that she
17 reviewed almost every record that was available and summarized each
18 and every one of them. Most of these evaluations I see are one or two
19 pages basically. It appears to have kind of some sort of rubberstamp on
20 it saying yeah, the patient's fine. They're not crazy. They can go ahead
21 and have a stimulator.
22 She did a very, very thorough evaluation, something that I very
23 rarely see, and she came to the conclusion, like I did and like Dr. Thalgott
24 did that the spinal cord stimulate is an appropriate source of potential
25 relief of Mr. Yahyavi's pain and that he was an appropriate candidate to

1 undergo such a surgery.

2 Q Okay. Now, a patient who suffers from severe chronic pain

3 can -- that can have psychological effects, right?

4 A Absolutely and that's another reason, because patients who

5 have a need potentially for a spinal cord stimulator often time have

6 psychological overlay and you want to make sure that's not

7 overwhelming their medical condition, because -- not that that patient's

8 an inappropriate candidate, but sometimes you have to deal with some

9 of the psychological issues before they become a candidate for a spinal

10 cord stimulator. And in this case, there were no barriers to proceeding

11 with the medical treatment based on Dr. Ross' recommendations as well

12 as my own opinion of Mr. Yahyavi and Dr. Thalgott's opinion, Dr.

13 Kaplan's opinion.

14 So we all agreed that Mr. Yahyavi was an appropriate candidate.

15 She sealed the deal by basically saying and he's psychological

16 appropriate for this procedure. We were all looking at it from a medical

17 point of view. She was looking at it from a whole different point of view

18 and also agreed with us.

19 Q Okay.

20 THE COURT: We're going to take a break. During this rec --

21 we'll have you come back at 1:15. During this recess, you're

22 admonished do not talk or converse amongst yourselves or with anyone

23 else on any subject connected with this trial or read, watch or listen to

24 any report of or commentary on the trial or any person connected with

25 this trial by any medium of information, including without limitation,

1 newspapers, television, radio or internet. Do not form or express any
2 opinion on any subject connected with the trial until the case is finally
3 submitted to you. 1:15. Have a good lunch.
4 THE MARSHAL: Please leave your notebooks and pens.
5 Don't forget to get your parking validated. Grab all your personal items.
6 Rise for the jury.
7 [Jury out at 12:01 p.m.]
8 [Recess at 12:02 p.m., recommencing at 1:21 p.m.]
9 THE COURT: Are we ready to go?
10 MR. PRINCE: Yes.
11 MR. KAHN: Yes.
12 THE COURT: Okay. Bring them in.
13 THE MARSHAL: Please rise for the jury.
14 [Jury in at 1:22 p.m.]
15 [Inside the presence of the jury.]
16 THE COURT: Please be seated. Good afternoon.
17 JURORS: Good afternoon.
18 THE COURT: So we're going to stick with 1:00. I have a lot
19 of matters tomorrow morning. At best, probably 11:30, but that's
20 ridiculous because then you'd go to lunch, so come in at 1:00.
21 Doctor, you're still under oath.
22 THE WITNESS: Yes. Thank you.
23 THE COURT: You may continue.
24 MR. PRINCE: Very good.
25 MR. KAHN: Parties stipulate to the presence of the jury, Your

1 Honor.

2 THE COURT: Thank you.

3 MR. PRINCE: Your Honor, just for the record, also present is

4 Darian Yahyavi, along with Mr. Yahyavi. And Darian is going to be our

5 next witness by agreement. He's been allowed -- well, I asked if he could

6 sit in the courtroom while Dr. Schifini finishes.

7 THE COURT: All right.

8 MR. KAHN: Defendant stipulates and has no objection to

9 these circumstances.

10 THE COURT: Okay.

11 MR. PRINCE: Very good. Thank you.

12 BY MR. PRINCE:

13 Q Dr. Schifini, before we left on our lunch break we were

14 talking about kind of the psychological effects of chronic pain, and how it

15 affects someone's life.

16 A Yes.

17 Q You told us that part of the spinal cord stimulator process

18 that he actually went to a psychologist by the name of Stacy Ross; do

19 you recall that?

20 A Yes.

21 Q All right. And you have Dr. Ross's evaluation as part of your

22 chart that was sent to you?

23 A I do, yes.

24 Q All right. Let's look at page 346 of Exhibit 92.

25 MR. PRINCE: We're just going to set the date and time. So

1 just give me the top psychological evaluation, along with the identifier.
2 Okay.
3 BY MR. PRINCE:
4 Q And with a -- I've often seen it's not only for actual spinal
5 cord stimulators, but sometimes some surgeons will send someone for a
6 psychological evaluation even before a surgery to determine if they're an
7 appropriate candidate for the surgery or not?
8 A Yes, that's also an appropriate use of this psychological
9 evaluation.
10 Q It's kind of clearing, if you will -- kind of a clearance process
11 to make sure it's appropriate, not only from a physical medicine
12 standpoint, but also from a psychological perspective?
13 A I would agree with that, yes.
14 Q Okay. And so in this case, here, it says, the referral is by Dr.
15 Thalgott. Would you consider Dr. Thalgott a well-trained competent,
16 orthopedic spine surgeon?
17 A Absolutely. Dr. Thalgott in -- in my opinion, is probably
18 invented some of the things that are commonly used today in orthopedic
19 spine surgery, so he's -- I would consider him, sort of, a pioneer.
20 Q Okay. And so we talked about that Dr. Thalgott thought the
21 surgery was necessary, and now an appropriate thing to do would the
22 placement of a spinal cord stimulator?
23 A Yes. That was the purpose of this evaluation that he
24 requested with Dr. Ross.
25 Q Right. And the date of Dr. Ross's evaluation was April 30,

1 2019?

2 A That's correct.

3 Q All right. And among other things, did you note that she did

4 a very comprehensive review -- detailed review of all of the various

5 medical records of Mr. Yahyavi from, you know, the time of the collision

6 all the way up and through 2019?

7 A Yes. This -- as I stated earlier, this is very unusual in its

8 comprehensive nature. I was pleased to see this. Most of the time when

9 I get these psychological evaluations on a patient it's a two-page report.

10 This is probably a 15 or 20-page report, you know, when I look at it, I

11 mean, so there's quite a bit of information that she used to process, not

12 just information she gathered from Mr. Yahyavi, but information that she

13 gathered from other sources to put together her opinions.

14 Q Okay. And I want to talk about the psychological effects this

15 injury and his ongoing pain -- the chronic pain that, you know, Mr.

16 Yahyavi has experienced.

17 MR. PRINCE: I want to go to page 347 of Dr. Ross's report

18 and talk about -- it's the very first paragraph, Greg.

19 BY MR. PRINCE:

20 Q Let's read it together. It says, "Psychologically he reports

21 increased irritability. He has feelings of sadness, depression, anemia."

22 What is that? Anhedonia, what is that?

23 A It means loss of enjoyment of life.

24 Q Okay. "Low motivation times, and a loss of confidence level,

25 as he is unable to work." Are those feelings of sadness, depressions,

1 loss of enjoyment of life, low motivation, and lack of confidence, because
2 of the inability to work, is that something that you would commonly see
3 in someone who suffers from a chronic pain syndrome like my client
4 does?
5 A Yes. Those are -- those are features of chronic pain. The
6 longer that you have it, the more likely it is that you will have these and
7 even other features of -- of psychological overlay, in addition to the
8 medical problems that are -- are present and prevalent.
9 Q So we're clear: Are you saying, Dr. Schifini, that there's a
10 physical component to the pain, but also a psychological or emotional
11 component as well?
12 A Yes. And -- and sometimes it's hard to separate those two,
13 because they're most commonly found together, rather than one or the
14 other. They're very commonly -- especially in a patient who has had
15 chronic pain for -- I don't know -- by this time probably six years it's very
16 common to see these and other features.
17 Q It says, "He feels stressed secondary to his financial situation
18 and reduced ability to provide for his family." Does people who are
19 vocationally now displaced, meaning they can't work, that financial
20 stress and -- you know, that they can't provide for them self in the way
21 they would like to, does that increase or have a negative effect on the
22 chronic pain, and the ability to cope with it?
23 A It does have a negative effect, because it -- when you have a
24 career, and you're out in the workforce, you're making money. You have
25 a purpose in life. Following this -- this accident, he attempted to work

1 and then he was unable to continue that, based on what went on, so
2 he -- he loses one of the parts of himself that, sort of, define him, and
3 that part of him will never come back, and this is what he's expressing.
4 So these types of feelings that he's expressing to Dr. Ross, he's also
5 expressed to me, and are present in some of the documentation in my
6 own chart, so I wasn't surprised when I read this information that Dr.
7 Ross had supplied from information that she had gathered directly from
8 Mr. Yahyavi, as well as review of his own records.
9 Q Then it goes on to say, "He has anxiety and concerns on a
10 regular basis." Do you see that?
11 A Yes.
12 Q And I learned this from one of my clients actually, somebody
13 who had a low-back problem, with chronic pain, and he told me -- and it
14 made sense to me and tell me if you agree. He says, depression is like
15 looking back at what has happened and anxiety is more looking forward
16 about hey, what's the future going to bring, what's the future going to
17 hold, am I ever going to get better, am I going to return to my normal
18 function; does that make sense to you?
19 A Well, I've now learned something, because I -- I would say
20 that that's a fair way to kind of look at things depression is you're
21 concerned about something that has happened in the past that you may
22 or may not be able to change, and anxiety is usually you related to
23 something that you may experience. Commonly patients describe it to
24 me when they get anxious about something is prior to an injury or
25 chronic pain syndrome being present, they describe not having to think

1 about things that they do, and oftentimes now they're having to think
2 about things and they become anxious because if they are having a good
3 day, they're concerned that they may do a little bit more, because they're
4 motivated to do so, but they may end up paying for it three days later,
5 and they're concerned about even participating in a simple activity
6 because they may pay for it later, in the sense of increasing their
7 symptoms that they may experience. So this all makes sense to me,
8 based on, not on Mr. Yahyavi, but all the patients I deal with who have
9 chronic pain complaints.
10 Q And so are those reported -- well, he also says, "He feels
11 fearful in construction zones, in which he is very cautious, and has
12 flashbacks to this situation." Have you had experience in treating
13 patients in your practice who had suffered a traumatic injury, such as like
14 a collision like this, which is pretty dramatic having being hit by a forklift,
15 that they have these kind of flashbacks, and kind of these recurrence of
16 memory?
17 A Right. Right. So most commonly, this is discussed as kind of
18 in the category of post-traumatic stress disorder, or PTSD. You're
19 involved in a traumatic event in your life that became a bigger event, as
20 time went on, and you're constantly remembering that; wishing that it
21 wouldn't have happened, all sorts of feelings come into play.
22 Q Okay.
23 MR. PRINCE: And if we go down, Greg, to the second to the
24 last paragraph of 347 under background information. And it says, kind
25 of, where he currently reports limited social, just go to the bottom third

AA001575

1 of that. Just bring it down just to focus on that. That's fine.
2 BY MR. PRINCE:
3 Q It says, "He currently reports limited social activities."
4 Patients with chronic pain, like my client, is it common for them to
5 experience -- to start to withdraw and not participate in the social aspects
6 of our life? Is that a common thing that you see in your practice?
7 A It is because you have to explain a lot, why you can't do
8 something, because -- and what I've learned from one of my patients is
9 that people judge you based on what you can't do. They expect that you
10 can do things and they oftentimes want an explanation. The problem
11 with Mr. Yahyavi and a lot of patients, who have chronic pain, is that
12 they may look normal to you when you just view them or look at them,
13 but you have no idea really what's going on, on the inside of them.
14 And so it's very common for people to be judged for discussing
15 things that might make them disabled or discussing their pain. And
16 oftentimes they kind of learn that people don't want to hear it anymore.
17 They're -- they're -- you know, they -- or they don't want to burden
18 someone else with that, so there's -- there's lot of factors that make
19 people withdraw from a lot of social interactions with -- with others,
20 because of symptoms that they may have; conditions that they may have
21 that prompts all of these types of feelings and behaviors, that weren't
22 there before, because if you read the next few lines, he talked about
23 what he used to like to do, and he's no longer able to participate in these,
24 and -- and he's describing that he feels bad about this, and he just avoids
25 those situations.

1 Maybe because if he sees somebody else participating in an
2 activity that -- that he used to enjoy, or be involved in, and he's no longer
3 to be able to be able to do that, it may make him even feel worse, so
4 avoidance of this type of social interaction is very, very common.
5 Q Okay. And let's look at -- well, you just note in your review of
6 Dr. Ross's report that she also read Dr. Oliveri's comprehensive
7 evaluations?
8 A She did, as part of her report, and -- she read Dr. Oliveri's
9 evaluations, all of my evaluations pre-dating them, and every other one,
10 but specifically, Dr. Oliveri's.
11 Q And --
12 MR. KAHN: Your Honor, I'll object to this line on foundation
13 and double hearsay.
14 THE COURT: Counsel, approach.
15 [Sidebar begins at 1:34 p.m.]
16 THE COURT: Did you that on?
17 You're getting in -- this is way hearsay.
18 MR. PRINCE: How?
19 THE COURT: And is he an expert on psychology?
20 MR. PRINCE: We're talking about -- it's in his report, and part
21 of --
22 THE COURT: It's not in his report --
23 MR. PRINCE: It's in his chart.
24 THE COURT: -- it's in her report.
25 MR. PRINCE: No, be he had to use that information to make

1 a recommendation for the spinal cord stimulator. He did use it.

2 THE COURT: He relied on it.

3 MR. PRINCE: Correct.

4 THE COURT: But he can't sit there and testify oh, this is what

5 she interpreted, and why, whatever. I'm sustaining that objection.

6 MR. PRINCE: No, no, no, Judge.

7 THE COURT: Sustained.

8 MR. PRINCE: Judge, well, hang on a second. Well, I'm not

9 done. Well, I'm going to --

10 THE COURT: Then make your record. Counsel --

11 MR. PRINCE: No, that's fine. But I'm going to get ready to

12 ask him a question, because this in evidence so that's fine.

13 MR. KAHN: Sir.

14 MR. PRINCE: I'm just going to show it in evidence. What I'm

15 going to show is next is in evidence. I'm fine. We're good.

16 [Sidebar ends at 1:35 p.m.]

17 THE COURT: I'm going to sustain the objection.

18 MR. PRINCE: I want to show the last paragraph on Bate

19 number 354.

20 BY MR. PRINCE:

21 Q It says, "According to Dr. Oliveri's comprehensive medical

22 evaluation subsequent visit, and third supplemental report dated

23 November 8th, 2018, further record were reviewed. Based on re-

24 evaluation, the static nature of his presentation, it is indicated that

25 physical abilities are sub-sedentary, and he is permanently and totally

1 disabled as a result of the subject accident."
2 Do you see that?
3 A I do.
4 Q And before you even participated in the recommendation for
5 the placement of the spinal cord stimulator, you read this record of Dr.
6 Ross, correct?
7 A That's correct.
8 Q And you relied upon it, correct?
9 A I did.
10 Q Was it part of your -- did it help you formulate in your
11 impressions and your opinions in this case, in terms of formulating your
12 care plan?
13 A I don't know that it helped me formulate my care plan. It -- it
14 solidified the opinions that I had already formulated independently.
15 Q Got it. Do you agree with Dr. Oliveri's opinion, as reported
16 here, that he is permanently and totally disabled, as a result of the
17 subject collision?
18 A Yes.
19 Q Okay. Is that your opinion to a reasonable degree of medical
20 probability?
21 A It is.
22 Q All right. Why do you -- what's the basis for your opinion,
23 Doctor, why is he -- why do you agree with Dr. Oliveri that he's
24 permanently vocationally disabled from working?
25 A Well, both Dr. Oliveri, and I are very familiar with the

1 workers' compensation system, and as part of that, we do assessments
2 to determine the safe return-to-work capabilities of patients. So not only
3 are we determining what disabilities may prevent them from returning to
4 work, we also are looking at whether or not it is safe for them to return to
5 work. And in this particular case -- and Dr. Oliveri determined that Mr.
6 Yahyavi was in a sub-sedentary category.
7 So when you look at job descriptions, they kind of fall into different
8 categories, as defined by the U.S. Department of Labor. There's
9 sedentary, which is a sitting job, kind of a secretarial type job, where
10 the heaviest thing you might lift is, you know, a bundle of copy paper to
11 fill up the copy machine. So there's that type of job where you're
12 answering phones, and not doing a lot of physical work.
13 Then there's the light-duty jobs, and when I say light duty, it's a
14 category. It doesn't mean that you're doing less than your supposed to.
15 It's just kind of a category of jobs.
16 Then there's moderate duty, and then there's heavy duty. And
17 then there's kind of in between categories like moderate, sedentary
18 lights. There's, you know, moderate heavy, and so on.
19 Mr. Yahyavi fit best in the sub-sedentary, so even a sitting-down
20 job physically he was incapable of doing, but also, with chronic pain, and
21 medication usage, as well as the psychological issues that we discussed
22 earlier, Mr. Yahyavi is going to have a hard time participating in a job.
23 It -- it's hard to find a job where social interactions are not required and
24 are difficult. His former job that's what he did. He was social. He was
25 able to participate in those.

1 The other issues associated with this is that -- that you would have
2 to find the right employer that was willing to hire him that didn't view
3 him as a liability, because right now he is a liability as an employer with
4 all of the medical problems he has, the medications that he's taking, the
5 hardware that's in his neck. I mean, there -- there are a lot of factors
6 involved to determine that he's totally and permanently disabled.
7 Q Okay.
8 MR. KAHN: Can we approach, Your Honor?
9 THE COURT: Yes.
10 [Sidebar begins at 1:39 p.m.]
11 MR. KAHN: He's a treating doctor. Now he's rendering
12 opinions about beyond what's in his reports.
13 THE COURT: I thought you just told me he was an expert?
14 MR. KAHN: No, he's an non --
15 THE COURT: Is he a treating physician?
16 MR. KAHN: He's an treating only.
17 MR. PRINCE: Yeah, but he's still an expert in the area of pain
18 management, and also work-related injuries. He's described that at
19 length. We're talking about --
20 THE COURT: All right.
21 MR. PRINCE: -- an exhibit -- a document that's in his actual
22 chart note that he reviewed, as part of his ongoing care, and relating to
23 the prognosis.
24 THE COURT: Well, okay. So you can ask if he reviewed it,
25 and did he use that in forming his. What was the actual question?

1 MR. KAHN: There was nothing. He just came up wanted
2 to --
3 THE COURT: What was the --
4 MR. KAHN: There's no reports. He's here as a treater --
5 MR. PRINCE: Well --
6 MR. KAHN: -- and now he's opining about -- if he wants to
7 talk about what's in his records, that's one thing, but now he's describing
8 to the jury the vocational process like a vocational expert. He wasn't
9 designated for that. There are no reports.
10 THE COURT: Well, I didn't hear him talk about vocational
11 yet, other than saying he --
12 MR. PRINCE: Disabled.
13 THE COURT: -- feels he's disabled.
14 MR. PRINCE: Right.
15 MR. KAHN: Well, the question -- the answer didn't track the
16 question necessarily, so I'll be -- I may have to object more, just so the
17 Court knows.
18 THE COURT: All right.
19 MR. PRINCE: Okay.
20 THE COURT: I don't know where we're at.
21 [Sidebar ends at 1:40 p.m.]
22 BY MR. PRINCE:
23 Q Did you also, as part of your review of documents when Mr.
24 Yahyavi returned to you, did you note that Dr. Oliveri performed a PPD
25 evaluation in this case?

1 A Yes. A PPD reading was performed on Mr. Yahyavi. A PPD
2 rating is a -- what they call a permanent -- or I'm sorry -- a partial-
3 permanent disability rating, or a whole-person impairment rating. He
4 rated him as eight percent, in reference to his cervical spine, or his neck,
5 that the rating was done, I want to say in 2014 or 2015, before his
6 surgery, so if we were to re-rate Mr. Yahyavi, which will happen at the
7 end of his workers' compensation claim, when it comes to a close.
8 It is not done at this point, but at the time that he is determined to
9 have reached maximum medical improvement with a stable and rate
10 able condition, that rating of eight percent will be significantly higher,
11 based on the surgery that he's had, the injuries that he's had. That rating
12 was an underestimation. It was appropriate for the time. It is no longer
13 appropriate. It should be much higher at this point.
14 MR. KAHN: Your Honor, I'm going to object and move to
15 strike anything about hypothetical ratings.
16 THE COURT: Counsel, approach.
17 [Sidebar begins at 1:42 p.m.]
18 THE COURT: Has he been re-rated?
19 MR. PRINCE: Not yet. That's what he's going to say. He's
20 going to need to be re-rated. That's what he's telling you.
21 THE COURT: Well, he can say he can be re-rated, but he's
22 not a rating physician.
23 MR. PRINCE: He didn't give a percentage. He said he'll be
24 re-rated higher is all he said. Dr. Oliveri is the rating physician.
25 THE COURT: Right, but he doesn't know or can't testify --

1 MR. PRINCE: I'm not asking anymore -- I'm not asking --
2 THE COURT: -- that he's rated higher --
3 MR. PRINCE: -- any --
4 THE COURT: -- I'm striking the part that he's rated higher--
5 MR. PRINCE: Why are you striking it?
6 THE COURT: He doesn't know that.
7 MR. PRINCE: Yes, he does. Well, let me lay the foundation
8 then.
9 MR. KAHN: This was the same thing you struck from Dr.
10 Oliveri saying he would be 30 percent today, but nobody has ever done
11 it.
12 THE COURT: Right.
13 MR. PRINCE: Right. Because he was told they would implant
14 the stimulator, and they determined him MMI again they're not going
15 to --
16 THE COURT: He can say he's going to get another rating.
17 Yes, but he doesn't -- certainly, he doesn't know, and he's not a rating
18 physician. Right?
19 MR. KAHN: And Oliveri is coming back at some point.
20 MR. PRINCE: Well, that's true. He just said he's going to be
21 re-rated and it'll be at a -- it'll be a higher percentage. He's not going to
22 give you a number. So that's all he said, so this objection is not
23 foundational. He is an expert in the workers' compensation, treatment of
24 injured workers. He uses PPDs.
25 THE COURT: He could get a rating that's not higher and he

1 doesn't know --

2 MR. PRINCE: Oh, no. It will be higher.

3 THE COURT: That's speculation.

4 MR. PRINCE: How wouldn't it be higher? Well, let me lay the

5 foundation then?

6 THE COURT: All right. I'll let you try.

7 MR. PRINCE: That's fine.

8 [Sidebar ends at 1:42 p.m.]

9 BY MR. PRINCE:

10 Q Doctor, how many workers have you treated over the years

11 who have got a PPD evaluation would you estimate?

12 A It's hard to count over thousands. I mean, I don't know.

13 Q Do you -- are you familiar with the rating process?

14 A Yes.

15 Q Do you use that as part of your practice in making

16 recommendations to injured workers about what kind of work is

17 appropriate for them, or if it's even safe for them to return to work?

18 A Yes.

19 Q Are you familiar with the rating process?

20 A I am.

21 Q And in this case, Mr. Yahyavi has not been re-rated yet?

22 A That's correct.

23 Q But at some point after the placement of the stimulator and

24 he kind of plateaus again, and reaches a maximum medical stage, will he

25 be eligible for re-rating --

1 A Yes.
2 Q -- to you knowledge and understanding?
3 A He -- he will be.
4 Q Will it be much higher than eight percent?
5 MR. KAHN: I'm going to object and ask to approach again.
6 THE COURT: I'm going to sustain the objection.
7 MR. PRINCE: Okay.
8 BY MR. PRINCE:
9 Q Will it be higher than eight percent?
10 MR. KAHN: Same objection.
11 BY MR. PRINCE:
12 Q Based on your knowledge and experience of treating injured
13 workers?
14 MR. KAHN: Same objection.
15 THE COURT: I'll allow that general question.
16 THE WITNESS: Yes.
17 BY MR. PRINCE:
18 Q Okay. All right. Now, I want to talk about just briefly the
19 psychological evaluation a little bit further of Dr. Ross. Go to page 356.
20 It's the first paragraph.
21 A Yes.
22 Q It says -- she was assessing his manner in which he
23 responded to the question, and it says, "He did not appear to be
24 exaggerating his symptoms he is experiencing; however, he did
25 demonstrate a mild tendency to be reluctant to admit to shortcomings to

1 which most would admit, but a tendency towards minimizing
2 symptoms." What does that tell you?
3 A Well, that's consistent with my own evaluation -- and
4 multiple evaluations of Mr. Yahyavi, he's a very stoic person. I've said
5 to him often, you know, you're not a big complainer; meaning, that he
6 needs to explain things, you know, to me so that I can understand what
7 he's feeling and experiencing. It's almost that you need to draw that out
8 of him to be able to do that, so in my experience, I would agree with Dr.
9 Ross, he does not exaggerate the symptoms. He's very stoic and has a
10 hard time expressing his symptoms.
11 And in a lot of ways, that is unusual with the chronic pain patients
12 that I see. This discussion that was in here when I read Dr. Ross's report,
13 it was reflective of everything that I knew about Mr. Yahyavi, based on
14 my multiple interactions with him over the course of the past six and a
15 half years.
16 Q Okay. And I want to go to the time he came back to see you
17 in June of 2019, you have him complete what they a "Beck's depression
18 inventory", your own separate assessment of that, right?
19 A Yes.
20 Q And let's just go to the results at 312 of Exhibit Number 92.
21 You could there's the screen?
22 A Sure. The screen is reflected there.
23 Q And it says he had a score of 18. It says, "Borderline clinical
24 depression." What did that mean to you as the pain management
25 physician involved in this case?

1 A Well, again, this is consistent with my previous statements
2 that he is probably not expressing all of his feelings, as well. Maybe he
3 considers that to make him feel weak in some way, if he expresses
4 his -- his opinions, or feelings, but this was consistent -- this number
5 here was consistent with Dr. Ross's report, so again, everything that I
6 knew, or thought I knew about Mr. Yahyavi was confirmed in Dr. Ross's
7 report in a much more eloquent way, but this number also was
8 consistent with the findings and conclusions of Dr. Ross.
9 This finding is not surprising to see in someone who has had
10 chronic pain for as long as he has, you know, since the -- the motor
11 vehicle and forklift accident that occurred in June of 2013.
12 Q All right. Now, that he's been recommended for spinal cord
13 stimulator by now two surgeons -- Dr. Kaplan and Dr. Thalgott -- he's
14 completed a psychological clearance, which Dr. Ross thought he was an
15 appropriate candidate, right?
16 A Yes.
17 Q And did you discuss with Mr. Yahyavi his treatment options,
18 short of the spinal cord stimulator?
19 A Yes.
20 Q Was he apprehensive about placing the spinal cord
21 stimulator?
22 A He's been apprehensive about many of the things that -- that
23 he's participated in along the way because there are risks associated
24 with treatment of the cervical spine, because it's spinal cord in that,
25 which prompted him to participate in the physical therapy. I think he

1 had, you know, over 130 visits of physical therapy; to participate in the
2 chiropractic care; to participate in multiple spine injections; and this is all
3 before he's had the big surgery that he underwent. So he's been
4 apprehensive about things every step of the way.
5 And truthfully, he has a right to be apprehensive, not only
6 because of the risk, but truthfully, he hasn't had the best experience with
7 some of the interventions that have been suggested to him, so I don't
8 blame him for being apprehensive or concerned about the option of
9 additional care, especially when we're talking about interventional
10 things, things that you're doing to him, and in this case, additional
11 surgery.
12 Q Right. Did you discuss options other than the spinal cord
13 stimulator with him, at his recommendation -- or at his suggestion?
14 A We did. When I saw him in the office, we discussed, you
15 know, the risks, the benefits, the options, and the alternatives to him.
16 You know, one of his alternatives would be to live like he is doing
17 with medications, but even with medications, at this point, the option of
18 kind of living like this was unacceptable to him.
19 Remember, his pain level was a seven or eight out of ten, which
20 places him in the severe pain category. So when I talked to him about
21 the option of the spinal cord stimulator, he was very interested in being
22 educated about it, so he could understand it, and I spent a great deal of
23 time with him describing that to him.
24 We also discussed the -- the option of -- of pursuing injection
25 therapy because he had not had any since -- since the -- the surgery was

1 done. Perhaps, the surgery corrected some of the anatomic
2 abnormalities that he had that were related to the accident and perhaps
3 we could now have a better chance of getting him better with injections.
4 We had tried a couple of sets of those, and eventually determined that
5 those were unsuccessful.
6 So now we're back to do you want to live with this, or do you want
7 to look at more surgery, and that was kind of the -- the fork in the road
8 that he was at, at that point, and, you know, we wanted other advice, and
9 he was sent back to Dr. Thalgott to discuss that -- that option, and -- and
10 my understanding is that Dr. Thalgott is moving forward with obtaining
11 authorization for a CT scan that's being scheduled for later this month,
12 prior to offering him the spinal cord stimulator.
13 Q Right. Because is he a candidate for a trial stimulator at this
14 point, given that he had the neck surgery in the posterior part of the
15 spine?
16 A Based on the placement of his surgery, and it being in the
17 back of the spine, there is no normal anatomy back there anymore for
18 me to do a trial stimulator, which I oftentimes refer to as kind of a test
19 drive, and then the permanent stimulator is, you know, and you're going
20 through the test drive before you buy the car, which is more the
21 permanent stimulator.
22 And unfortunately, for him, there really is no difference between
23 the test drive and purchasing the car, so he would have to undergo a
24 permanent stimulator as the trial, so the test drive cannot be separated
25 from the purchase of the car in this scenario.

1 Dr. Thalgott referred Mr. Yahyavi back to me to discuss that so that
2 he was educated on the -- on his options and understood why there was
3 no option for the traditional test drive to determine whether or not a
4 patient was going to be able to improve their pain at least 50 percent;
5 improve their function; and decrease their medication usage, which
6 makes, and -- and defines success when it comes to placement of the
7 spinal cord stimulators.
8 So not only were Dr. Kaplan and Dr. Thalgott recommending this, I
9 was now recommending this, based on his -- the failure of other options
10 for him, because I -- you know, both doctor -- or excuse me -- both Mr.
11 Yahyavi, and I agreed that living with this was not the best option for
12 him, but it took him some time to get to that opinion that this was a
13 reasonable option.
14 Just like he explored every other option before he got to me, we
15 provided him with injections. He even went to other providers to get
16 additional injections, and additional opinions before agreeing to the
17 surgery. He's now gathering opinions in reference to the spinal cord
18 stimulator, which now at least three doctors that have seen him as
19 a patient, I would also include Dr. Oliveri and Dr. Ross in that he is an
20 appropriate candidate for a spinal cord stimulator, as really his last
21 option at this point.
22 Q And I think you just said it, now the spinal cord stimulator is
23 his last option, is there any other available medical options really, other
24 than the stimulator, to help control his pain, and help maybe improve his
25 symptoms and quality of life? Is there any other thing that you're aware

1 of, as of the state of the medicine right now?
2 A There's only one other thing that might be of benefit to him
3 at some point, would be to consider implantation of a different type of
4 device, which is called a morphine pump, which is implanted under the
5 skin, but he's a much better candidate for the spinal cord stimulator.
6 I don't know that the morphine pump would -- would manage his pain
7 quite as well as the stimulator will. And I've done lots of stimulators.
8 I'm very familiar with the technology and I feel comfortable
9 recommending that as an option to him, and perhaps his last option.
10 Q Right. Would that -- assuming the stimulator would work
11 and help, I mean, that's something that he would have to live with for the
12 rest of his life --
13 A Yes.
14 Q -- Doctor? You know, I know you talked a little bit about it
15 before, from the time he left your care in 2014 until he came back in
16 2019, he obviously saw a summary of that care and some additional
17 records of what he underwent. You think that those are reasonable
18 things for Mr. Yahyavi to pursue to try to help control his pain and
19 alleviate his symptoms?
20 A Absolutely. I don't begrudge anybody for trying anything to
21 assist themselves with pain. Nobody cares more about Mr. Yahyavi than
22 he does, and he knows what is best for him, what he's comfortable with,
23 and I don't begrudge anybody for getting second opinions when it
24 comes to this. These are big decisions for him that affect the rest of his
25 life. He's trying to find the best solution, the best fit for him, and I think

1 it's appropriate to go seek, you know, opinions from other physicians,
2 who may have a different point of view, and I --
3 Q Right.
4 A -- I -- I think that's appropriate.
5 Q The care that he was seeking during that interim all
6 throughout, based on what you know, was that reasonable?
7 A It was not only reasonable, it was related to the worker's
8 compensation claim that he had, as a result of the motor vehicle
9 accident, which occurred in June of 2013.
10 Q Do you think that Mr. Yahyavi was a compliant patient?
11 A Absolutely.
12 Q Do you think he put forth a full and fair effort in his
13 healthcare?
14 A I do.
15 Q Okay. Do you think there's anything more he could have
16 done to avoid this prognosis that we've been talking about today?
17 A I think Mr. Yahyavi, not only checked every box that he could
18 have before he underwent these large interventional procedures,
19 especially the multilevel surgery that he had in his neck -- he, not only
20 checked the boxes once, but probably three or four times, just to make
21 sure that this -- that the -- something simpler wasn't going to help him.
22 He was looking for help and he was provided with help. It took him a
23 while to come to the realization that the likely help for him was going to
24 be with scalpels and surgery. He tried that. It didn't work out as well.
25 Now we're trying to correct the symptoms that he has that were not

1 made better with the attempts at surgery. That doesn't mean the
2 surgery was inappropriate for him to undergo. It just means there's no
3 guarantees when you go through surgery, and unfortunately, he had
4 a bad outcome, as it came to that. That does not change the fact that it
5 was an appropriate option for him at that time, that it was offered to him
6 by Dr. Kaplan.
7 Q The bad outcome from the surgery, does that all relate back
8 to this motor vehicle collision of June 2013?
9 A Absolutely. There -- there's no reason for me to believe,
10 based on what I know about Mr. Yahyavi and his medical care to make
11 me think that he would have ended up with this surgery independent of
12 his involvement in this -- in this motor vehicle accident that occurred in
13 2013.
14 Q I mean, when you form this opinions, I mean, in fairness, Dr.
15 Schifini, I mean, you oftentimes are -- or most 80 percent of the time on
16 the Defense side of these. You look at it with a critical eye, based upon
17 my experience. Did you do that here?
18 A I did. I mean, I wouldn't be up here telling you this, and
19 giving you my opinion, if I didn't think this was the -- the right thing to do
20 for my patient and based on the records. Even if I was reviewing this as
21 an independent reviewer, which I'm often tasked with doing, I would
22 have came to the same conclusions. I would have called the attorney
23 that hired me and said, you know, there's really nothing I can help you
24 with here. This all seemed very appropriate.
25 Q Was this the type of discussion that you would have had with

1 a workers' compensation administrator like why he needed the
2 stimulator; he's exhausted all avenues of conservative care, is that the
3 type of discussion you had?
4 A I recently had that conversation with his workers'
5 compensation adjuster. She just simply didn't understand, and not
6 because she was unwilling to understand. It just it was an -- this is an
7 unusual situation, and I had to spend some time kind of explaining to her
8 that he needed the stimulator trial. This was his last realistic option to
9 help treat his. And at that point, they were pending the authorization of
10 the CT scan that Dr. Thalgott had ordered to further his care, and after
11 that they've now approved it, and they're moving forward, so it -- it just
12 required a little bit of education, like I've been doing here with you today.
13 Q Okay. It's a complex case, isn't it?
14 A It is.
15 Q And with regard to Mr. Yahyavi, in terms of your -- the
16 prognosis, do you have an opinion whether he will suffer from ongoing
17 severe chronic pain limitation for the rest of his life?
18 A He will. I'm hoping that that pain will be lessened. That his
19 quality of life will be improved, and that his medication usage will be
20 significantly lessened with the use of the stimulator, but now he's
21 becoming dependent on the stimulator. His symptoms will never go
22 away. The symptoms are lifelong. If he wanted to remind himself of
23 how much pain he was really in, or used to be in, he could simply turn
24 off the stimulator and he will experience the pain. The stimulator tends
25 to cover up some of it, but it doesn't change his disabilities. All it

1 changes -- or his employability -- all it does is perhaps change the level
2 of discomfort and give him better quality of life for the remainder of his
3 life.
4 Q Have all the opinions you've expressed here been stated to a
5 reasonable degree of medical probability?
6 A Yes.
7 Q Thank you.
8 MR. PRINCE: No further questions.
9 THE COURT: Cross-examination.
10 CROSS-EXAMINATION
11 BY MR. KAHN:
12 Q Good afternoon, Dr. Schifini.
13 A Good afternoon.
14 Q My name is David Kahn. I represent the Defendant company
15 that had the forklift. It's named Capriati Construction. You and I have
16 never met before, as far as you recall, correct?
17 A I don't recall, no.
18 Q You said that your opinion was based on doing the right
19 thing for your patient, number one, correct?
20 A When say opinion, I have -- I've expressed a lot of opinions.
21 Is there a specific one that you're referring to?
22 Q At the very end of this questioning about three minutes ago,
23 you were asked what's your opinion based on, and you said your
24 opinion was based on two things: doing the right for your patients, and
25 based on the records, correct?

1 A True.

2 Q And am I correct that nowhere in your records is a reference

3 to any medical reports, treatment, imaging studies, anything like that for

4 Bahram Yahyavi, the Plaintiff in this case -- prior to the car accident? I

5 can rephrase that if you'd like.

6 A I think I understand your question. You're asking me in my

7 reporting, was there any reference to anything before this accident?

8 Q Exactly.

9 A And the answer is no, there is not.

10 Q So you've never seen, as you sit here today, any records

11 related to the Plaintiff's medical condition before the car accident on

12 June 19, 2013, right?

13 A Well, that would have been true, if you would have asked me

14 the question yesterday. I have reviewed a couple of documents.

15 Q I don't want to know about anything you've reviewed since

16 you've provided these documents in this litigation. I don't want to know

17 about anything that you found out about yesterday, or today, that you

18 didn't see. You're not here as a retained expert, correct?

19 A That is correct.

20 Q That means you're talking about what's in your records as a

21 doctor for treating, not what your opinions are, based on reviewing other

22 things in the case, aside from what the psychologist gave you, right?

23 A Well, I was trying to answer your question. My opinions --

24 none of the opinions I've expressed today were based on information

25 that I received today. All of my opinions were based on what's in my

1 chart, as required of a treating physician.

2 Q You didn't write a report in this case, like you would do if you

3 were retained as an expert in litigation, correct?

4 A That's correct. Yes.

5 Q So let's take your opinions before yesterday when you were

6 handed whatever documents you were handed, and let's limit it to

7 what's in your medical records. Up to yesterday, your medical records,

8 all the documents you reviewed in this case, did not include any medical

9 records, imaging studies, or other medical documentation relating to the

10 Plaintiff Bahram Yahyavi, correct?

11 A That is correct. And none of the documentation contained in

12 my chart references anything, other than Mr. Yahyavi's pain-free state

13 prior to this accident.

14 Q So hypothetically, were Mr. Yahyavi to have reported to a

15 doctor that he had pain prior to this accident, that would be new

16 information to you, or it would have been, as of yesterday --

17 A It -- it --

18 Q -- correct?

19 A -- would have been, yes.

20 Q For purposes of your treatment, it would have been new

21 information, right?

22 A That's correct.

23 Q And as far as chronic pain -- you've talked about chronic

24 pain, how do you define chronic pain? Do you define it as six months or

25 more of pain?

1 A Well, I mean, there's lots of definitions. Three months of
2 pain, or more; six months of pain or more; it's probably somewhere in
3 between three and six months. Clearly, he fits that definition, based on
4 what he's going on now.
5 Q Years of pain would certainly qualify under any of your
6 definitions as chronic pain, right?
7 A Yes.
8 Q So if a patient reported I have years of pain, that would be
9 considered chronic pain under the way you and all doctors define it?
10 A Yeah. I think that would fit even the strictest definition using
11 the six-month cutoff. Yes.
12 Q And pain -- you're a pain doctor. And pain is something that
13 medicine can't measure? There is no pain machine you could hook up to
14 me and it'll tell you my pain's an eight, or it's a two. It depends on the
15 patient's information for the most part, other than certain situations,
16 right?
17 A I think that's fair. Yes.
18 Q Okay. If you feel somebody's neck -- a patient's neck, and it's
19 spasming or it's tight, you can feel something physically with your
20 hands, that's an exception, correct?
21 A Yes.
22 Q And if you see an MRI, or an X-ray, or a CT scan, and that
23 shows you a structural problem with somebody's neck, that also maybe
24 an exception, if you can objectively verify it with medical imaging
25 evidence, right?

1 A Well, I mean, an MRI, or an X-ray, a CT scan, all the things
2 that you mentioned, when you see something you -- that also doesn't
3 have any reflection of pain. It might be causing pain. It may be part of
4 that clinical correlation that we discussed extensively earlier, but it
5 doesn't -- you can't look at an MRI, unless there's a broken bone, or
6 something obvious like that to say that that is painful, or that is not
7 painful.
8 Q What about the pain scale of one to ten -- you use a one-to-
9 ten-pain scale, right?
10 A I use zero to ten, because --
11 Q Zero to ten.
12 A -- one still means there's some pain.
13 Q Zero would be completely --
14 A No.
15 Q -- pain free, right?
16 A Yes. That's correct.
17 Q Ten would be the worst pain you could possibly imagine.
18 How do you describe that to your patients, if they ask?
19 A I -- to describe a ten as, you know, if it's a woman, I usually
20 reference labor pain. If it's a man, I say something about kidney stones.
21 Q Okay. So how do we know if somebody reports that they're
22 1 out of 10, I'm going to give you a hypothetical of somebody reporting a
23 low pain and they're really 9 out of 10. How do we know that if they say
24 1 out of 10, that they're not really 9 out of 10?
25 A Well, you'll never really know. But if you measured, let's say,

1 their heart rate, we would expect somebody who's at a 9 out of 10 to
2 have a higher heart rate. They may have a higher blood pressure. They
3 may be sweaty. They may be kind of agitated or anxious. I mean,
4 there's ways that you can tell just by looking at somebody if they're
5 uncomfortable or in some sort of distress.
6 But with chronic pain, those symptoms, the patient may get used
7 to them and you won't be able to tell. So there's really no way to tell.
8 Q Let's go back to the accident. Is it your understanding that
9 no airbags were deployed in this accident?
10 A That is my understanding.
11 Q And there's also a record in here, I can pull it up if necessary.
12 I'm just going to go through these questions. I'm referencing things in
13 your record. So to be fair to you, if you don't remember or you're not
14 sure what I'm talking about, I'll pull them up.
15 A Fair enough.
16 Q But I'm not going to do that unless we have to. One of your
17 records said that the fusion, "Resulted in no changes." Do you recall
18 saying that in one of your reports or records?
19 A I don't recall that, but I was probably referencing his pain,
20 meaning that his pain didn't change despite the fusion being performed.
21 Q So let's go through this for a second. I'm going to have to
22 jump around a little. So Mr. Yahyavi's in an accident in June 19th, 2013,
23 correct?
24 A Yes.
25 Q That's a little over six years ago, right?

1 A It is.
2 Q And then he goes in an ambulance. So maybe we should
3 start with that.
4 MR. KAHN: Can you please pull up the Las Vegas -- oh.
5 Madam clerk, is exhibit, which I think is 4B, is that stipulated, admitted?
6 MR. PRINCE: No.
7 THE CLERK: You're talking B?
8 MR. KAHN: 4B. It's Las Vegas Fire and Rescue.
9 THE CLERK: 4 is Plaintiff's.
10 MR. KAHN: Number 4?
11 THE CLERK: Yes.
12 MR. KAHN: Okay. Let's pull up Number 4 and see if that's it.
13 THE CLERK: But that's in [indiscernible].
14 MR. PRINCE: Exhibit 85.
15 MR. KAHN: 85? 85.
16 THE CLERK: Oh, 85. 85 is admitted.
17 MR. KAHN: Pardon me, ladies and gentlemen.
18 BY MR. KAHN:
19 Q I apologize. There are many medical records.
20 A I understand.
21 Q So Mr. Yahyavi's in the accident. He gets taken by
22 ambulance to UMC which is a Level 1 trauma center, correct?
23 A That's correct.
24 Q They evaluate him, and they do an, I think a CT of his cervical
25 spine; is that right?

1 A That's my understanding.
2 Q And they determine that he has no traumatic injury; is that
3 fair?
4 A It is.
5 Q And you have a copy of that in your records, in your medical
6 file as well, right?
7 A I believe so, yes.
8 Q So when he goes to UMC, they say, no traumatic injury?
9 A Yes.
10 Q On day 1?
11 A Yes.
12 Q Then he a few days later he goes to the chiropractor,
13 Downtown Neck and Back and he sees them for a short period, right?
14 A Yes.
15 Q And they diagnose him with sprain or sprain strain; is that
16 correct?
17 A That's correct.
18 Q And he does some other things, sees some other people. A
19 few months later, in the fall of 2013, about five months or so after the
20 accident, he finds his way to you in your office, correct?
21 A Well, he was referred to me. But, yes. He --
22 Q I'm not implying anything.
23 A No, no, no, I understand. He found his way to me based on a
24 referral.
25 Q Okay. And at that point you performed a few injections on

1 his cervical spine, right?

2 A More than a few. But, yes.

3 Q Okay. And the reason for those injections, there were two

4 reasons to perform injections and yours were kind of combined. I'm kind

5 of jumpy to the point.

6 A You are.

7 Q You can do injections for diagnostic purposes to see what

8 the pain level is and where the pain generators are, what's causing the

9 pain, basically. That's one purpose, correct?

10 A It is.

11 Q And you can do injections also to try to treat somebody like

12 you were saying, an epidural for a woman who's pregnant. You're trying

13 to block the pain. There's a specific medical reason, you're trying to do

14 something with the shot other than just seeing where the pain is coming

15 from, right?

16 A Yes. I mean, a pregnant woman doesn't require any

17 diagnosis there. We know they're pregnant. We could probably figure

18 out what happened nine months before.

19 Q And I understand for you some of this is a little simplistic, but

20 I'm --

21 A I understand.

22 Q -- doing my best to kind of jump across it. So these

23 injections that you performed to Mr. Yahyavi 2013 and 2014, within

24 about the first year of his -- year or 14 months or so of his accident, those

25 had a dual purpose. One was to see where the pain was coming from in

1 his cervical spine, if you could identify that location or locations, correct?
2 A Correct.
3 Q And then the other purpose in reading your records says the
4 injection, the shot you're giving him, the syringe has a liquid in it, it has a
5 needle. In the syringe the liquid contains some steroidal liquid and that
6 steroidal liquid you hope, and on occasion does, provide relief to
7 patients. So you were hoping maybe that would have some therapeutic
8 effect on Mr. Yahyavi, correct?
9 A Yes.
10 Q And then after I think it's the most recent exhibit. The last
11 one.
12 [Counsel and Clerk confer]
13 BY MR. KAHN:
14 Q Okay. It's four letter I's is the exhibit and I think it's been
15 stipulated to. It's the only page I added today. He's pulling it up. But
16 where I'm going with this is at some point --
17 MR. PRINCE: I'll stipulate to it. It's fine.
18 THE COURT: That's fine.
19 BY MR. KAHN:
20 Q At some point in 2014, this is November 4th, 2014, and this is
21 a letter from you to Dr. Perry. So let's talk about that for one second.
22 When people send you referred patients for pain management, you -- by
23 people, I mean other doctors, orthopedic surgeons, primary care
24 physicians, whoever it may be. If somebody sends you a patient, you do
25 that doctor the courtesy of updating them and giving them a status on

1 their patient from time to time, as you see fit, right?
2 A That's correct, yes.
3 Q And in this case, November 4th, 2014, you were telling Dr.
4 Perry that Mr. Yahyavi was scheduled for a visit after some injections
5 and he no showed, correct?
6 A Yes.
7 Q And then you don't see him for about five years; isn't that
8 right?
9 A Yes, I think that's a fair statement.
10 Q And what is the importance to you as a pain management
11 doctor of giving somebody injections and then not having them come
12 back shortly after those injections to explain to you what the effect was
13 of the injections?
14 A So the purpose of the follow up after the injections is to
15 determine whether a patient received any therapeutic or treatment
16 benefit from the steroid medication that we were talking about a few
17 minutes ago. So you're there to assess that.
18 In this particular case, though, Dr. Perry in the work comp system
19 was, even though he's a specialist, was Mr. Yahyavi's treating physician.
20 So he was the main doctor. So Mr. Yahyavi's main responsibility is to
21 report back to Dr. Perry who he could report the same information to.
22 It would be ideal if I was able to gather that information to put it in
23 a more, I guess, concise and perhaps medical fashion for Dr. Perry. But I
24 assume at this point he followed up with Dr. Perry.
25 Q So just to be clear on the timing, Mr. Yahyavi was injured a

1 little over six years ago, correct?

2 A Yes.

3 Q You saw him for about 14 months or so, roughly, correct?

4 A That's correct.

5 Q And then there was about a five year gap, right?

6 A Well, I don't know that it's a gap. I mean, it's a gap in time

7 from my visits. But that doesn't mean he didn't see someone else.

8 A No, no. I'm just asking you. You didn't see him between the

9 injections you did in 2014, after which he didn't show up, you know, in

10 October, November, whenever it was he was supposed to come after

11 and about three months ago, right before this trial, right?

12 A Yes. So there is about four and a half years. Yes.

13 Q And in the intervening time, he got the surgery from Dr.

14 Kaplan, right?

15 A That's correct.

16 Q And in the intervening time, just to be clear for your

17 involvement, you were not involved in his current treatment, correct?

18 A That is correct.

19 Q Now, as far as the spinal cord -- let me go back to some

20 history. When he came to you, he told you he had had arm surgery; isn't

21 that right?

22 A Yes.

23 Q And that's his left arm, right?

24 A Left arm, yes.

25 Q Do you remember any details about the surgery?

1 A I don't remember the specific details regarding the need or
2 the cause of the need for the arm surgery.
3 Q What was -- do you remember the cause or the need?
4 A No, I don't.
5 Q Oh. I thought you said you did. So do you know whether
6 that dates back to his childhood or was it a recent phenomenon?
7 A I don't know.
8 Q And the left arm is one of the areas of his body that he's
9 complaining about in this case, correct? He's saying he has numbness,
10 tingling, his fingers are numb, things like that all the way down from his
11 neck to the tips of his fingers, right?
12 A He has all of that. Yes.
13 Q And I realize I've asked this, but I want to make it very clear
14 before I move on. It's the same arm that he's complaining about, the
15 numbness and the tingling that he had the surgery in, in his life before
16 you ever saw him six years ago?
17 A Yes.
18 Q As far as the spinal cord stimulator, how many times
19 approximately have you been involved in a surgical procedure as the
20 anesthesiologist to install a spinal cord stimulator? Your best ballpark.
21 A Somewhere between probably 50 and 100 times.
22 Q How many of those 50 to 100 approximate times have has it
23 occurred where the spinal cord stimulator has been implanted without
24 any trial?
25 A Maybe one of those times. That's not a very common

1 phenomenon.

2 Q Okay, so 1 out of 50 or 1 out of 100 of the times that you have

3 participated in installing a spinal cord stimulator, only one other time in

4 your career that you can think of, there has been an implantation of a

5 spinal cord stimulator without a trial?

6 A That's correct.

7 Q And you called the trial a test drive, right?

8 A Yes.

9 Q And that's because when you install the spinal cord

10 stimulator test to determine its efficacy to the patient, if it doesn't help, it

11 can be removed, right?

12 A The trial is not put in permanently. So, yes, it's put in there

13 typically for three to five days. The intention is to remove it, whether it's

14 a success or a failure at the end of the trial period. And then the

15 determination will be made whether a permanent one is appropriate.

16 You're correct.

17 Q And I don't have your background, but as I understand the

18 process, the temporary implantation, the test drive, if you will, is

19 installed in a way that it's easy to remove it. It's installed differently than

20 the permanent spinal cord stimulator would be installed, which isn't

21 meant to be removed, right?

22 A Yes. By design, the test drive or the trial is meant to be

23 easily removed. Once you clip a couple of sutures, you can just pull it

24 out because it just goes through the skin.

25 Q So if a permanent spinal cord stimulator is installed in Mr.

1 Yahyavi's neck or his back or both and it doesn't work, it stays in there
2 for the rest of his life, is that how it would work?
3 A No, it can still be removed. It just would be a surgery to
4 remove it rather than taking scissors and cutting a couple sutures and
5 pulling it and putting a Band-Aid on it. So it's a little more involved
6 process to remove it.
7 Q It's certainly more involved than if you were to perform the
8 usual that was done in the other 99 or 98 percent of the cases you've
9 worked on surgically, a test spinal cord stimulator?
10 A It is. But in this case, that's simply not a -- it's not even an
11 option.
12 Q Because the scar tissue from the surgery and the armature?
13 A Well, it's not really the hardware that's in place. It's more
14 that the scar tissue has disrupted the epidural space. So there's no place
15 for me to put a trial lead to accomplish what we just discussed.
16 Q Now, this spinal cord stimulator had anybody wanted to put
17 it in medically, could have been put it at any time over the last six plus
18 years since the accident, correct?
19 A No.
20 Q Why not?
21 A Well, I mean, yes, he had a neck and therefore, we could
22 have put it in. But you don't put a spinal cord stimulator in when you
23 can potentially fix a problem. You put a spinal cord stimulator in when a
24 problem that was attempted to be fixed, which can no longer be fixed, is
25 now just you've given up and now we're covering up something.

1 So you wouldn't want to put a spinal cord stimulator in until you
2 demonstrated that there's a pain that can't be fixed in any other way and
3 needs to just be covered up.
4 Q Did one of your injections result in the Plaintiff actually
5 providing an increased level of pain afterwards?
6 A And when you say afterwards, are we talking about
7 immediately or in a follow up visit?
8 MR. KAHN: Can you pull up P324, please?
9 BY MR. KAHN:
10 Q And again, I'll pull it up in front of you.
11 A Of course. Thank you.
12 THE CLERK: Plaintiff's exhibit?
13 MR. KAHN: Part of Exhibit 92. So it's in it.
14 BY MR. KAHN:
15 Q And this is on your letterhead from your -- at the time your
16 office, correct?
17 A Well, it's from the surgery center. So that's why the surgery
18 center's there. They're just reflecting that I did it. But yes.
19 Q You have authority to write on their letterhead at this time?
20 A Yes. That's correct.
21 Q And then you're writing to Dr. Thalgott who is the one of the
22 doctors that referred Mr. Yahyavi to you initially for the first round six
23 years ago?
24 A No, he's more recently involved in Mr. Yahyavi's care. Dr.
25 Perry was involved. This should be a 2019 letter.

1 Q This is 2013.
2 A No, that's the date of injury.
3 Q Oh, sorry.
4 A So at the bottom you'll see --
5 Q Okay. June 11, 2019?
6 A Yeah. It should be that timeframe.
7 MR. PRINCE: You don't have the bottom of the date of the
8 document. It's on the bottom of the document, the date of the dictation.
9 MR. KAHN: So we'll just double check. So I was looking at
10 the date of injury. Sorry.
11 BY MR. KAHN:
12 Q So you're talking about this notation on the bottom that's
13 highlighted now?
14 A Yeah. The --
15 Q DOT, date of treatment?
16 A Date of transcription.
17 Q Date of transcription. And so that would be the same day or
18 within a day or two whenever you dictated it?
19 A It should have been the same day.
20 Q And this talks about your telling Dr. Thalgott, and I apologize
21 about the timing. "I did perform the initial left C5-6 transforaminal
22 selective epidural steroid injection under fluoroscopic guidance today on
23 your patient, Bahram Yahyavi."
24 So you're telling Dr. Thalgott you did an injection at the left C5-6
25 level of the spine like you showed the jury, right?

1 A Yes.
2 Q And then you said he rated his pain pre-procedure as a 7 out
3 of 10, which was rated at a post-operative level of 7 to 8 out of 10
4 following this injection, despite appropriate numbness.
5 So he comes in telling you he's 7 out of 10. And then after the
6 injection, he's saying he's 7 or 8 out of 10, right?
7 A Yes.
8 Q Is that a common occurrence where after the injection
9 process, somebody reports a higher level of pain?
10 A It's not the most common. The intention is to identify a pain
11 generator. So you'd like to see the number come down. But in this
12 particular case, we were attempting to do things to avoid the spinal cord
13 stimulator.
14 His increased pain was likely due to pain at the injection site or
15 some other source or we just simply may have picked the wrong target.
16 Q So what you're saying, I think, is it happens on occasion, but
17 not very often?
18 A Well, it happens more often than not when you've had a
19 patient who's had a surgery before because you don't know what you're
20 going to expect. This was the first attempt at post-operative injections.
21 So we didn't know what to expect. We were just trying to help him short
22 of doing a spinal cord to stimulator.
23 Q And just so the jury understands, forget about the -- well, the
24 next sentence is the therapeutic part. "Hopefully the steroid medication
25 contained within this injection will provide him with some long term

1 relief." That's the part where you're saying maybe the steroid in the
2 liquid, in the in the syringe will help him feel better, experience less pain
3 on its own, right?
4 A That's fair, yes.
5 Q And that's a hope you always have when you do these
6 injections. But with Mr. Yahyavi in 2013 and '14 and 2019, the last few
7 months, that never really materialized, you never saw medically,
8 clinically any beneficial effect of the steroid within the syringes, right?
9 A I don't disagree with your characterization that he received
10 very little, if any, therapeutic effect from any of the injections I have
11 done.
12 Q Okay. And the importance of monitoring the patient before
13 the injections and after is that's what you used as a pain doctor, I'll say
14 pain doctor. And I'm not meaning to be rude, but you said pain
15 management, pain medicine, anesthesia. I'm just going to say pain
16 doctor and I'm implying all of those good things.
17 A I answer to almost anything. So it's okay.
18 Q But as a pain doctor, when a patient comes to you and you're
19 trying to determine what the injections are doing, where the pain
20 generators are, you're asking the patient, how do you feel today? What's
21 your level of pain on a 0 to 10 scale before the injection? You give them
22 an injection at a certain level or levels, plural. And then afterwards, like
23 you said, an appropriate amount of time afterwards, based on your
24 experience, training and skill, you go to the patient and you say, do you
25 feel -- how do you feel now?

1 And I'm not going to use this exact one. But let's say a patient
2 comes and they say, my neck hurts. It's 5 out of 10 before. And you give
3 them an injection and they say now it's 1 out of 10. You then note that in
4 your records, because that provides you with some information to use to
5 help the patient going forward, right?
6 A Yes, that would be the diagnostic information.
7 THE COURT: Can we take our -- we'll take a break now.
8 MR. KAHN: Sure.
9 THE COURT: During this recess you're admonished, do not
10 talk or converse amongst yourselves or with anyone else on any subject
11 connected with this trial or read, watch or listen any report of or
12 commentary on the trial or any person connected with this trial by any
13 medium of information, including without limitation, newspapers,
14 television, radio or Internet.
15 Do not form or express any opinion on any subject
16 connected with the trial until the case is finally submitted to you.
17 Steve said that someone had suggested or requested that
18 maybe it would speed things up if we took less time at lunch. What you
19 don't understand is when you're taking a break, we aren't necessarily
20 taking a break. So it doesn't happen all the time. But that's a good
21 thought. So you could, I guess, be done quicker, but that's not going to
22 work.
23 So in any event, we'll see you in 10 minutes. Thank you.
24 THE MARSHAL: Please rise for the jury.
25 [Jury out at 2:29 p.m.]

1 [Recess at 2:29 p.m., recommencing at 2:43 p.m.]

2 [Outside the presence of the jury.]

3 THE COURT: -- break so you can go --

4 MR. KAHN: No breaks. No. No.

5 THE COURT: No breaks?

6 MR. KAHN: No. No. We need the breaks.

7 THE COURT: No. Don't worry.

8 MR. KAHN: That's fine.

9 THE COURT: It was a rhetorical question. I mean -- all right.

10 Anything outside the presence?

11 MR. PRINCE: No.

12 THE COURT: Bring them in.

13 [Jury in at 2:44 p.m.]

14 THE MARSHAL: Rise for the jury.

15 [Inside the presence of the jury.]

16 THE COURT: Please be seated. Parties acknowledge the

17 presence of the jury?

18 MR. PRINCE: Yes.

19 MR. KAHN: Yes.

20 THE COURT: Okay. Doctor, you're still under oath. Go

21 ahead.

22 THE WITNESS: Yes. Thank you.

23 BY MR. KAHN:

24 Q Dr. Schifini, when is the last date that you treated the Plaintiff

25 at your office?

1 A July 29th, 2019.

2 Q And am I correct that at this point, I'm saying as you sit here

3 today, that you've made a determination, additional injections are of no

4 medical value for this Plaintiff?

5 A Yes.

6 THE MARSHAL: Mr. Kahn, I'm sorry. Do you have your

7 microphone on?

8 MR. KAHN: I thought it was on. Sorry.

9 BY MR. KAHN:

10 Q Sorry. Your answer is that, yes, additional injections will not

11 provide Mr. Yahyavi with significant medical help?

12 A I agree with that, yes.

13 Q And just to be clear, when you were communicating with the

14 -- you were communicating at certain points in this case in your

15 treatment of Mr. Yahyavi with the worker's compensation system,

16 correct?

17 A Yes. I mean, sometimes I communicated with them as a

18 copy with a letter to a doctor, with a copy to the worker's compensation

19 system. Sometimes it's directly to the adjuster.

20 Q And during that entire process, you had no awareness of

21 whether or not Mr. Yahyavi had any prior complaints of neck pain; is that

22 correct?

23 A My understanding was that he did not based on my

24 interactions with him. So that was my understanding at the time I

25 authored all of my reporting.

1 Q And one of the issues with Mr. Yahyavi is that he has what
2 are called osteophytes in his cervical spine; is that correct?
3 A Yes.
4 Q And those are kind of like bone spurs, their growths, calcific
5 growths?
6 A Just a fancy name for a bone spur. Yes.
7 Q And those in and of themselves, have you ever seen those
8 things, those osteophytes in other patients to cause problems or pains
9 just having those?
10 A They can, depending on where they are. If they're in your
11 heel or something, yes, they can cause pain. In the cervical spine or the
12 lumbar spine, they're very rarely the actual source of pain because they
13 grow so slowly. It's a slow process. So your body kind of
14 accommodates those.
15 Q You anticipated my next question, which is a trauma
16 generally doesn't create instantly some kind of osteophyte, it's a slow
17 growing item, right?
18 A That's correct. Yes.
19 Q I'm going to go through a couple items in the Staci Ross
20 psychological documents. Now before -- what's the date of that, do you
21 recall?
22 A I don't recall specifically. It was before I saw Mr. Yahyavi
23 back. So I can --
24 Q In the summer? I don't know an exactness.
25 A In the summer, I think is a fair assessment.

1 Q That's fine, doctor.
2 A Okay.
3 Q You don't need to [indiscernible]. It's about two, three
4 months ago, whatever the exact date is?
5 MR. PRINCE: April 30th, 2019.
6 MR. KAHN: Thanks.
7 BY MR. KAHN:
8 Q So five months ago, something like that?
9 A Yes.
10 Q Four, five months ago. Before that and before receiving Staci
11 Ross's breakdown of the medical printout, pages and pages and pages of
12 her personally going through and looking at all these different historical
13 treatments of Mr. Yahyavi for purposes of her psych eval or
14 psychological evaluation. You hadn't seen many of those post-accident
15 records; is that fair?
16 A I think that's fair, yes.
17 Q And you don't need to see every record of every treatment
18 for your purposes. You may request certain things, but in other words,
19 you don't see all his medical records if he's seeing three or four different
20 providers, right?
21 A Well, as the treating physician, that's not typical. It would be
22 ideal, but not typical.
23 Q If you, let's say think you want to look at an x-ray or an MRI
24 or you want to get a report from the referring physician, you can contact
25 them in writing, you can call them, on occasion you do that, that's not

1 uncommon. But my questions is more, you don't have any need to look
2 at, let's take Mr. Yahyavi. You didn't have any need to look at all of his
3 medical records for any reason in order to treat him, right?
4 A That's correct.
5 Q So the Staci Ross psychological report is talking about how
6 she thinks he can go forward mentally and get the spinal cord
7 implantation surgery if it is to be done. But it also provides other
8 information about his treatment over the last six years you haven't seen
9 before, right?
10 A Yes.
11 MR. KAHN: If we could pull up P350, please. These are all in
12 the same exhibit, madam clerk. If we could go to the bottom paragraph
13 and blow that up.
14 BY MR. KAHN:
15 Q Okay. And this is something I've raised before, but this is a
16 notation from Ms. Ross that's saying on November 10th, 2014, so a little
17 under five years ago, Dr. Perry is stating that he doesn't feel confident
18 surgical intervention would provide significant clinical improvement in
19 this patient. And then he's essentially sending him to pain management,
20 your bailiwick, right?
21 A Yes.
22 Q So am I correct that this record, which is now in your file
23 because it's in Staci Ross's report from a couple months ago, documents
24 that Dr. Perry was against surgery approximately five years ago for
25 Bahram Yahyavi?

1 A Well, I think that misstates the record. He says he doesn't
2 feel confident. It doesn't say he's against it.
3 Q Okay. Fair enough. Do you think that Mr. Yahyavi brought --
4 MR. KAHN: You can get rid of that one too. Thank you.
5 BY MR. KAHN:
6 Q Do you think Mr. Yahyavi brought osteophytes with him to
7 this accident based on the -- let's put it this way, based on the X-rays you
8 have going back to 2014, 2015 MRI's, whatever is in your file.
9 A Sure, I can understand your question. The reason I smiled or
10 chuckled is because he didn't have them in his pocket. He had them in
11 his neck. And I think they were there the day before his accident. The
12 day of his accident. And continued to be there. Yes.
13 Q Okay. And same question as to degenerative disc disease,
14 one of the big reasons we're here for. Do you think he brought
15 degenerative disc disease to the accident he had at the day before the
16 accident?
17 A Yes, I think those are pre-existing degenerative conditions
18 that were present on the day of the accident that were unrelated to the
19 accident.
20 Q And the distinction you would make as a pain doctor is that --
21 one distinction you'd make as a pain doctor, is that your understanding
22 based on your records and the information provided by this patient to
23 you when you began treating him in the end of 2013, nearly six years
24 ago, was that he had an absence of prior neck pain; is that correct?
25 A Yes.

1 Q And if he had degenerative disc disease, your understanding
2 was that it was asymptomatic, before this accident, right?
3 A Yes.
4 Q And asymptomatic just means no symptoms, right?
5 A Yes.
6 Q And for pain, we've already discussed pain for the most part,
7 pain symptoms as interpreted by doctors and documented by doctors
8 are based upon self-reporting of the patients, right?
9 A Yes. There's no other way to do it. Yes.
10 Q For Mr. Yahyavi, let's be very clear. For Mr. Yahyavi, he
11 doesn't fall within any of those exceptions. You had no -- you've never
12 palpated his neck, touched his neck with your hand and felt the spasm,
13 correct?
14 A I may have. I mean, I'd have to look through my records, but
15 I may have.
16 Q Okay. And rather than do that because you have a lot of
17 records. Let's just put it this way and I'll ask you the general question in
18 -- go ahead.
19 A I do have an answer. On November 25th, 2013, there was
20 tenderness and spasm to palpation of his posterior neck and upper back.
21 Q Okay. So can you explain to the jury what that means?
22 A Sure. So palpation is kind of a process of touching
23 somebody. If they have pain in their neck, for example, your touching
24 either the back or the side of their neck. Spasm is an involuntary muscle
25 contraction.

1 So like when you see like a little kid and you say, you know, make a
2 muscle and they pull up their arm like this, their biceps muscle becomes
3 shorter and fatter when you do this and so the muscle becomes more
4 visible.
5 Now, if the if you do that and you're telling somebody to make a
6 muscle, that's not a muscle spasm, it's a contraction of a muscle. It's a
7 voluntary kind of willing thing.
8 If you're looking for a spasm, though, it's an involuntary thing.
9 Something someone can't fake, they can't influence in another way.
10 You're feeling that independent of them. And so it's what we call an
11 objective finding as opposed to something someone tells you,
12 something you can independently feel, regardless of whether the patient
13 says, I have a spasm here. They usually refer to it as a knot, however.
14 Q And you've documented that you did find that in about five
15 months post-accident?
16 A Yes.
17 Q And in your records anywhere else indicate that you
18 documented some kind of either a spasm or tightness of the muscles,
19 something like that that you can recall without going through all them?
20 A I may have. That's the one I could find fairly quickly.
21 Q Absent a spasm or muscle tightness that you can feel with
22 your hand, assuming you're doing that on that day, an exam, you rely
23 essentially on the information provided by the patient about their pain,
24 correct?
25 A That's correct. Yes.

1 Q You ask them, are you feeling pain? If they say yes, you
2 don't know if that's correct. Most of the time you're documenting that.
3 And I'm not imputing anything wrong with that. That's what you're
4 profession trains you to do, correct?
5 A Yes.
6 Q And so, again, I'll ask the question now having said that. So
7 if somebody says to you they have pain, you write down that they have
8 pain generally, right?
9 A Yes.
10 Q If they say to you, you ask them, what's your pain 0 to 10,
11 and they say it's a level 5, that's what you write down, right?
12 A Correct.
13 Q And you have no way to backstop that. You have no formal
14 way to check it other than as we've said there are a couple exceptions?
15 A Yes.
16 Q So most of the pain reports from this Plaintiff that you've
17 documented in your records or your staff documented are based on his
18 self-reporting other than like we said the one indication of spasm a few
19 months after the accident, five months or so, and anything else that
20 might be in your records, that's similar, right?
21 A Well, yes. All of that documentation, his explanation of pain,
22 his description of pain are coming directly from him, I don't
23 independently get that. I independently document it or someone in my
24 staff does or he writes it down.
25 Q And I'm going to ask you a similar question to what I asked

1 Dr. Kaplan yesterday about medical records and history, because I want
2 to make it clear to you and be fair to you, as a doctor when a patient
3 comes to you, a new patient, whatever they tell you when you document
4 their history, you don't generally go and scour the archives of hospitals
5 and other doctors to find their history. There's no nationwide repository
6 of medical history that would be easily access.
7 In other words, a patient comes to you. If they bring with them an
8 x-ray or a referral from a doctor and a status from a doctor or a referral
9 note something, you might look at that. But typically you're not going to
10 go for a new patient and double check what they tell you about their
11 history, right?
12 A No. I mean, other than, let's say, for example, I received
13 records as part of the referral. And if history provided to me is the same
14 history that was provided to someone else, I'm more confident that the
15 history with that was provided to me was accurate.
16 But if I am in possession of the only history of that patient, I don't
17 have any other records. I'm assuming it is accurate, sometimes
18 incorrectly, but I'm assuming that information is accurate and correct
19 and is consistent with the records of which may or may not exist.
20 Q And since Mr. Yahyavi came to you initially as a Worker's
21 Compensation referral through that system, you had some information
22 about the accident and his initial treatment before he got to you, correct?
23 A Of course. Yes.
24 Q And so worker's comp, is a little bit different than other
25 people. There is a system in place. You have a little bit easier access to

1 some of the records, right?

2 A Yes.

3 Q So it's the sum of the records, right?

4 A Yes.

5 MR. KAHN: Can we pull up 351, please?

6 BY MR. KAHN:

7 Q Again, this -- I think is the Stacy Ross report?

8 A It is.

9 MR. KAHN: And can you please highlight these two

10 paragraphs here. "Mr. Yahyavi underwent," and then going to, "Possibly

11 getting."

12 BY MR. KAHN:

13 Q And this references a functional capacity exam performed on

14 Mr. Yahyavi, March 27, 2015, so a little bit over four years ago, four-and-

15 a-half years ago, and can you explain to -- you deal with -- I'm going to

16 say FCE, because it has less syllables. You deal with FCEs or functional

17 capacity evaluations, or functional capacity exams frequently as a -- in

18 the guise of your Workman's Compensation work, right?

19 A I do, yes.

20 Q And I'm going to ask you to briefly explain to the jury what

21 it's meant for and what it does. It doesn't have -- it can be long or as

22 short as you want, but I want them to at least understand before I ask

23 you about this.

24 A Of course. So a functional capacity evaluation is something,

25 is typically done towards the end of a claim. Once it's determined that

1 the patient has likely reached their limit of treatment, they've reached the
2 plateau, some sort of determination as to whether or not they've --
3 they're kind of towards the end. A functional capacity evaluation is used
4 to determine a patient's safe return to work capabilities. So the idea of
5 that examination, it's done at -- independent of the doctor who's
6 ordering it. It's typically done at a physical therapy establishment, and
7 it's a test that typically takes about two to four hours is kind of how it's
8 designed.
9 And what it's doing is it's taking the patient's job description from
10 the job they had at the time they got injured and it's comparing it to their
11 current abilities to see if those abilities match because if they match, or
12 the patient exceeds their requirements to return to that job, then it is
13 determined that it is safe for them to return to that job without high risk
14 of reinjury.
15 So what they're looking for is consistency, effort. They're looking
16 for all sorts of different kind of factors to determine whether a test is
17 valid or invalid. The bar is set at about a 70 percent consistency to
18 determine if something is valid. So if somebody has a 72 percent
19 consistency, it's considered valid. The results of the test, the
20 determination of the test, are thought to be reliable.
21 If a patient experiences a consistency rating of less than 70
22 percent, 68 percent, 42 percent, whatever, then the test is considered
23 invalid and therefore unreliable, meaning you can't rely on the actual
24 determinations or conclusions of that test.
25 So in this particular situation, based on the test that he had in

1 March of 2015, the test was determined to be unreliable, so it didn't meet
2 that threshold of 70 percent, and so therefore the results or the
3 conclusions were recommended to be invalid. So the discussion was
4 talking about self-limiting pain behavior and probability of less than
5 maximal effort. So that was the conclusion of the physical therapist, the
6 evaluator for several hours that were kind of evaluating Mr. Yahyavi to
7 determine his safe return to work capabilities.
8 That information is then given to the doctor who ordered it. In this
9 case, it was likely Dr. Perry who then made further determinations based
10 on that data.
11 Q And at the time -- at all times that Mr. Yahyavi was seeing
12 you for round one, the first 14 months or so, whatever it is exactly after
13 the accident, he was still working as a car salesman, right?
14 A He was, yes.
15 Q And do you know how long he ended up working before he
16 stopped doing that?
17 A I believe he continued to work through about 2016, is my
18 recollection.
19 Q So about three years is your understanding?
20 A Yes.
21 MR. KAHN: Okay. We can take that down.
22 BY MR. KAHN:
23 Q Now, what about auto fusion of the spine have you seen --
24 have you seen notations that Mr. Yahyavi, at some point, had auto fusion
25 or spontaneous fusion of the C6-7 vertebral levels in his spine?

1 A Yes.

2 Q And that's something that can happen from degenerative

3 disc disease without any trauma, right?

4 A It can happen from degenerative disc disease. It can be

5 congenital as well.

6 MR. KAHN: Speaking of congenital, can you pull up the Las

7 Vegas Fire and Rescue, the third page?

8 BY MR. KAHN:

9 Q This is the ambulance record, or one of the ambulance

10 records for Mr. Yahyavi, and I had a quick question because this is the

11 only place I've seen this, but I'm not saying it doesn't exist anywhere

12 else. And it says here deformative of the left lower ribcage. Now, first of

13 all, you've -- these are records within your records, Las Vegas Fire and

14 Rescue, correct?

15 A Yes.

16 Q And you testified that you relied on these records in some

17 part and for your opinions and testimony here today as a non-retained

18 treating expert, right?

19 A Correct.

20 Q So what can you tell me about that? Have you noticed that

21 before? Do you know anything about that condition with Mr. Yahyavi,

22 deformity of the left lower ribcage?

23 A Well, when you're looking at it as a result of emergency

24 medical personnel being kind of -- doing an examination to look for

25 obvious injury to somebody, a deformity of the left ribcage may indicate

1 that he has rib fractures or something like that, so that's why they
2 document these things. This may be a congenital cause for him. I've
3 never treated it. I don't recall seeing it anywhere else either. I would
4 agree with your assessment there. So that could be congenital. It could
5 be traumatic. It was basically their way of relaying that information to
6 the physicians in the trauma unit at UMC to go, hey, you might want to
7 look at his left ribcage.
8 They may simply have asked him did you have this before? And
9 he may have said yes. Or maybe he was just in a position where it
10 looked like he had a defect and he really did not.
11 Q And just to be clear, there's no issue with Mr. Yahyavi having
12 broken ribs or anything in this lower left ribcage that is in any of the
13 records you've seen, right?
14 A That's correct.
15 MR. KAHN: Okay. We can take that down.
16 BY MR. KAHN:
17 Q Let me ask you some questions about medical recordkeeping
18 and I'm almost done.
19 A Okay.
20 Q So when a new patient comes into your office, you take a
21 history, either written or verbal, or both, of the new patient, correct?
22 A Yes, after they've filled out some paperwork, sure.
23 Q And that's a standard thing all doctors -- almost all doctors
24 do that -- they should do it, but almost all do it, right?
25 A Yes.

1 Q And that's standard practice in the medical field. That's a
2 part of your training. That's what's expected of you and any other M.D.?
3 A All of that, yes.
4 Q And part of that is because when you have a new patient that
5 you haven't met before and you're going to be treating them in any
6 fashion, it's beneficial to know their history of medical problems,
7 medications, heart conditions, high blood pressure, diabetes, anything
8 that might provide you information as a physician to assist in your
9 treatment, right?
10 A Yes, of course. Whether you gather that directly from the
11 patient or you gather it from records you've reviewed, yes, I agree.
12 Q And if a patient does not tell you that -- does not provide to
13 you an accurate history, that's not just a potential failure of a piece of
14 paper, that could cause harm to the patient? For example, if a patient
15 had some kind of serious neck surgery that you couldn't determine by
16 looking at it or had some kind of physical problem that had happened
17 years ago and you couldn't determine by looking at the patient or feeling
18 with your hands, and you tried to do some kind of treatment, a traction,
19 or manipulation, or send him to a chiropractor, physical therapist,
20 whatever it may be, and you did something to that same area, not
21 knowing there was a problem, that could cause harm to a patient, right?
22 A Yes, in this hypothetical situation, that's certainly a
23 possibility.
24 Q And again, to be fair to you, yes, it is a hypothetical situation.
25 And we've already discussed this a little bit, but when the patients -- new

1 patients come to give you a history like Mr. Yahyavi did in 2013, six or so
2 years ago, you take that history and you rely on what they tell you unless
3 you get information otherwise? Unless you see some imaging study or
4 something from another doctor or get more information that contradicts
5 it, you go with what the patients tell you, right?
6 A Yeah. If the patient's telling me things, I may or may not, in
7 certain circumstances, have other information, but I rely on what the
8 patient tells me.
9 Q When Mr. Yahyavi came to see you in 2013 -- at the end of
10 2013, for those initial visits and injections, he represented to you either
11 that he never had neck problems before this accident, or he failed to tell
12 you alternatively that he ever did have neck problems before this
13 accident; is that correct?
14 A Those seem to be the two possibilities, yes.
15 Q And the causation opinions you rendered in your reports,
16 essentially attributing his neck problems, pain, injuries, all those things
17 to this accident were in that context in the absence of that -- of any
18 information about preexisting neck problems before this accident, right?
19 A Well, no. I mean, the causation opinion that I formulated
20 were based on my knowledge of everything involved in this case, but
21 that causation opinion had already been determined before he saw me,
22 based on the acceptance of this industrial or work comp claim. So I
23 wasn't necessarily tasked with that. I agreed with that determination, but
24 that determination had already been made before I even saw Mr. -- or
25 met with Mr. Yahyavi.

1 Q By other doctors?

2 A No, by the Worker's Compensation company.

3 Q So my next question is, is in -- and it's kind of a broad

4 sweeping question, but in all of the records you reviewed -- the -- your

5 records, the imaging studies from UMC, Steinburg Diagnostic Medical

6 Imaging, any MRIs, CAT scans, x-rays, UMC records, any of the records

7 that you obtained from other physicians, your office records and Dr. --

8 not doctor, psychologist Stacy Ross, even her entire breakdown of

9 summarizing all of his medical records, nowhere in there was there any

10 mention that he had neck pain at any time before this accident, correct?

11 A That's correct.

12 MR. KAHN: No further questions. Thank you.

13 THE COURT: Redirect.

14 MR. PRINCE: Yes.

15 REDIRECT EXAMINATION

16 BY MR. PRINCE:

17 Q Dr. Schifini --

18 A Yes.

19 Q -- did anything that Mr. Kahn asked you change your

20 opinions that the sole cause of Mr. Yahyavi's symptoms after June 19,

21 2013, the need for treatment, including injections, surgery, and now the

22 spinal cord stimulator, did your opinions change in any way?

23 A No.

24 Q And in fact, you have seen records from Southwest Medical

25 Associates, haven't you?

1 MR. KAHN: Your Honor, I'm going to object. That exceeds
2 the scope of direct.
3 MR. PRINCE: He --
4 THE COURT: Counsel, approach.
5 [Sidebar begins at 3:12 p.m.]
6 MR. PRINCE: He did -- he brought it up again. You brought it
7 up again about records. You've never seen any records? He said, yes, I
8 did review records.
9 MR. KAHN: All right. All right.
10 MR. PRINCE: And I'm not going to go into detail, I'm just
11 going to say those don't change any of your opinions at all?
12 MR. KAHN: I got snookered yesterday with Kaplan. I backed
13 away from it. All I said was you got records yesterday and I was very
14 clear, I said I don't want to know anything about yesterday or today.
15 He's a treating doctor. He had no reports. He can't look at records
16 yesterday, then today when his last treatment that he testified to was
17 months ago.
18 MR. PRINCE: And the deal --
19 MR. KAHN: He doesn't get to do that.
20 THE COURT: And the one question he asked was a
21 hypothetical.
22 MR. KAHN: Correct.
23 THE COURT: So I'm sustaining the objection on the new
24 records, other than you can -- you want to revisit the hypothetical, that's
25 fine. But other than that --

1 MR. PRINCE: Thank you.
2 THE COURT: -- yes.
3 [Sidebar ends at 3:13 p.m.]
4 THE COURT: Objection is sustained.
5 MR. PRINCE: Okay.
6 BY MR. PRINCE:
7 Q You heard Mr. Kahn asked you about he reviewed additional
8 records earlier?
9 A Yes.
10 Q And the answer to that -- what is the answer to that question,
11 yes or no?
12 A Yes.
13 Q Okay. And I want you to assume that Mr. Yahyavi, one time
14 in 2011, reported that he had neck -- it's documented that he had neck
15 complaint for years, but no -- he had pain free range of motion and no
16 muscle spasm. I want you to assume that exists, okay?
17 A Okay.
18 Q And assuming -- is that consistent with somebody who's got
19 multilevel disc and facet pain, as we saw after June 19th, 2013?
20 A Without any physical examination, abnormalities, if there
21 were only one record reflecting pain in the neck, maybe the same body
22 part that's involved in this accident, without physical exam findings or
23 follow up requests for additional treatment, referrals to specialists, I
24 don't know that that would change any of my previously held opinions.
25 Q If the records -- I want you to assume the records have

1 established that that's the one and only time there was a reference to
2 such a report of neck symptoms, but then a year later, about seven
3 months allegedly before this collision occurred, I want you to assume
4 that he went for another follow up checkup for this primary care doctor
5 that said he had no physical complaints, he had no muscular pain, and
6 no arm or anything, any problems with his arms, and full pain-free range
7 of motion in the neck; is that consistent with someone who has
8 multilevel discogenic and facet pain?
9 A That would be inconsistent with someone who had
10 significant pain arising from multiple levels in the cervical spine.
11 Q Okay. Is there any question in your mind that Mr. Yahyavi
12 was an accurate historian dealing with you or any other care providers
13 that's based upon your knowledge and experience in this case?
14 A Based on everything I've reviewed, my opinions and the
15 opinions of the other doctors, I saw no inconsistencies that would lead
16 me to believe that he was not an accurate historian in reference to this
17 historical recollections or representations to me or any other doctor that
18 he interacted with.
19 Q If he pain free and had no positive exam findings under no
20 medications and have not undergone any treatment, say for a year or
21 two years, even before this collision, if he's told people he had no
22 problems with his neck before, would that be an accurate statement,
23 immediately before this?
24 A Yes.
25 Q Okay. Would it change your mind if there's one record out

1 there from two years earlier that said he had ongoing neck complaint for
2 years with no positive exam findings, no treatment, or any medication
3 regimen?
4 A Well, those two statements, if they exist, would be
5 inconsistent with each other, so I don't know what to make of it. It
6 sounds like a nonspecific kind of a finding.
7 Q Fair enough. Now, with regard to Mr. Yahyavi, there was a
8 letter you sent to Dr. Perry indicating that he did not show up for a follow
9 up appointment in November of 2014; do you recall that?
10 A I do.
11 Q Okay. And I know he didn't show up for that. It doesn't --
12 would you consider him a noncompliant patient or a compliant patient?
13 A He was compliant the entire time I treated him. I don't
14 consider one no-call, no-show, sometimes people -- appointments slip
15 their mind, but that doesn't mean that he didn't follow up with someone
16 else. There was evidence -- I think I was presented with evidence earlier
17 that showed he actually followed up with Dr. Perry, which is his
18 responsibility in the Work Comp system.
19 Q Okay. And based upon your review of the medical record
20 and summary by Dr. Ross, do you recall him being seen by Dr. Fisher,
21 another pain manager, in December of 2014, just a few weeks after that
22 last appointment he was scheduled with you?
23 A I do recall seeing those notations.
24 Q Okay. Do you also recall he also had additional pain
25 management with Dr. Peter Su, who is another pain physician in Las

1 Vegas?

2 A Yes.

3 Q Okay. With regard to the statement that Dr. Perry didn't feel
4 confident that surgery would provide significant clinical relief; do you
5 recall that?

6 A I do.

7 Q Does that mean that Mr. Yahyavi was not a surgical
8 candidate?

9 A No. Dr. Perry was simply stating that he was unsure as to
10 what the outcome would be, and I don't know how any surgeon could be
11 sure of an outcome, but that does not mean that Mr. Yahyavi was not a
12 surgical candidate.

13 Q Right. And at that time in 2014, was it your understanding
14 that Mr. Yahyavi was hoping to avoid a surgery?

15 A I think that's been his hope the entire time I've known Mr.
16 Yahyavi.

17 Q Right. If Mr. Yahyavi had stopped working in 2016 because
18 he was physically no longer capable of doing that and he kind of reached
19 his wits' end and exhausted all forms of conservative care, including
20 pain management injections --

21 MR. KAHN: I'm going to objection, Your Honor. That's
22 during the treatment gap and it goes beyond his role as a treating
23 physician.

24 MR. PRINCE: I wasn't finished with the question actually.

25 THE COURT: Finish the question, and then I'll --

1 BY MR. PRINCE:
2 Q I'll restate the question so it's fresh in your mind.
3 A Okay.
4 Q You testified a few moments ago that it's your understanding
5 that Mr. Yahyavi stopped working sometime in 2016 because of his pain
6 and problems?
7 A Yes, pain problems, disability, poor performance at work,
8 yes, that's my understanding.
9 Q Okay. And you've also read records that he obviously
10 continued to seek medical treatment during the period of time after he
11 left you in 2014, up until the time he had the surgery in January of 2018?
12 A Yes. Although there was approximately four-and-a-half-year
13 gap in care with me, but that doesn't mean that he did not seek
14 treatment from other physicians during that timeframe.
15 Q In fact, he did, right?
16 A He did, yes.
17 Q Right. Do you believe that it was reasonable, because he
18 was not -- of his level of pain complaints, that he tried multiple rounds
19 of -- as you described it, he checked each box two or three times of
20 treatments, could no longer live with the level of the severity of the pain
21 in his neck and his arm; was it reasonable for him to choose to undergo
22 surgery by Dr. Kaplan in January of 2018?
23 A I think it was reasonable and necessary and related to the
24 motor vehicle accident from June of 2013.
25 Q Now, this surgery -- that wasn't just because of some

1 osteophytes or degeneration, was it?

2 A No.

3 Q Okay. It's because of severe symptoms in addition to the

4 multiple levels of disc and facet pain, right?

5 A Yeah. I mean, you don't operate on somebody just because

6 they have disc degeneration. Again, everybody, by a certain age will

7 have that and not everybody needs an operation. Osteophytes are very

8 commonly associated with degenerative changes, and unless somebody

9 is symptomatic from degenerative changes, osteophytes trauma, you

10 don't offer them treatment. You certainly don't offer them multilevel

11 surgery.

12 When people become symptomatic and cannot longer live with

13 them -- their symptoms and are experiencing symptoms that cannot be

14 managed well with other more conservative modalities, that is the

15 option. He chose that because that was the next logical step. I agree

16 with that even though it turns out that that didn't give him the relief that

17 he was hoping for, or perhaps expecting, that doesn't mean it was the

18 wrong decision. I would still, under the same circumstances, give him

19 the same advice today that surgery was the option for him.

20 Q Is it fair -- let me restate the question. Is it unfair to say, well,

21 you didn't have a good outcome from the surgery, therefore, you

22 shouldn't have had it in the first place? Are you following what I'm

23 asking?

24 A Well --

25 Q You just kind of like, 20/20 hindsight and say, well, you could

1 have had -- you've experienced some complications, therefore you really
2 shouldn't have done it in the first place? Is that a fair way to evaluate if
3 surgery was reasonable and appropriate?
4 A Well, and that's kind of almost the I told you so attitude, and I
5 don't think that it's consistent with the data that was available, which led
6 to the decision to offer Mr. Yahyavi surgery in the first place. There are
7 no guarantees with the surgery other than the two that I explained to you
8 earlier. You're going to have a scar and you're not going to be the same.
9 You're either going to be better or worse. Unfortunately, he became
10 worse, but there's still a way to correct some of the symptoms,
11 hopefully, and to give him better quality of life that isn't going to change
12 the results of the surgery, which was necessitated by the accident.
13 So it's not just the surgery that caused the need for additional
14 treatment, it was the accident that caused the need for the surgery,
15 which caused the need for additional treatment. So you can't forget the
16 accident.
17 Q Got you. So Mr. Kahn asked you, hey, in your records there
18 are noted some kind of a left arm issue from before this, from before the
19 collision?
20 A Yes.
21 Q Assume that Mr. Yahyavi testifies that when he was five
22 years old he fell down while playing outside and he broke his forearm,
23 and had it dealt with orthopedically. Would that make any clinical
24 difference in any way concerning this case and its outcome?
25 A Not unless you showed me records that showed that he had

1 consistent pain from age 5 to age 51, no. Otherwise -- no, it doesn't
2 make any difference to me at all.
3 Q Right. And the numbness we're talking about would be
4 caused -- and the pain would be caused coming from a disc in the neck
5 down the arm, right? Not an arm issue?
6 A That's correct.
7 Q Not a peripheral nerve issue, right?
8 A That's correct.
9 Q More of a central nerve issue?
10 A Yes.
11 Q Okay. Now, I want to talk about the spinal cord stimulant.
12 Well, hang on a second. Mr. Kahn asked you a question about isn't it
13 true the chiropractor diagnosed a soft tissue strain?
14 A Yes.
15 Q Mr. Yahyavi had soft tissue strains, didn't he?
16 A He did, yes.
17 Q Right. Generally speaking, don't you try to treat patients
18 conservatively first? Like, well, I didn't see a fracture in the CT scan, but
19 we're going to try to treat you as a sprain or strain, but if symptoms
20 don't improve, we're going to look at what else might be causing your
21 problems?
22 A That's the general way things go, yes.
23 Q Is that what happened in this case?
24 A It is.
25 Q Right. Now, the mere fact that the CT scan -- UMC didn't

1 show any sort of, quote/unquote, "Traumatic injury." Does that mean
2 that multiple levels of his disc and his spine did not become
3 symptomatic following this collision?
4 A No, it just means there was nothing that they could point at
5 and say, ah-hah, that happened a few minutes ago. I mean, that's the
6 only thing that that proved. Again, you have to take this information -- to
7 be clear, you have to take this information and correlate it with
8 symptoms. So Mr. Yahyavi had symptoms at the time of this accident
9 that were documented by emergency medical personnel. He had
10 symptoms in his neck. He had symptoms in his arm. Those symptoms
11 are what prompted the ordering of the CAT scan.
12 So those symptoms were what was being treated, not necessarily
13 -- we're not treating his CAT scan or not treating his MRI, we're treating
14 his symptoms, his pain levels, which persisted from that point to today. I
15 just talked to him earlier during a break. His symptoms persisted to this
16 point in time. So those symptoms didn't really go away. They didn't
17 improve.
18 If he had a sprain or a strain, you would have expected somewhere
19 in a 4 to 12-week timeframe, those symptoms would have improved.
20 What they were saying at UMC is there is no acute traumatic injury,
21 otherwise he would have probably needed emergency surgery on that
22 day in that hospital admission. There was time to kind of sort this out,
23 which is what we did, what happened over the following six years.
24 Q Great. I mean, while at UMC with a CAT scan, are they
25 looking for, like, a recent fracture or dislocation of the spine, which

1 would be an emergency medical situation?
2 A Yes, they're looking for things that are going to cause him
3 harm or kill him or paralyze him in the next hour or two. So they're
4 looking to rule out that kind of stuff so that they can then release him to
5 someone else so that we can more appropriately and more effectively
6 sort those things out. There was no emergent need for the surgery at
7 that moment. That's what they were trying to rule out during that
8 evaluation.
9 MR. PRINCE: If you could put the hardware up, please?
10 THE CLERK: Is this demonstrative?
11 MR. PRINCE: Demonstrative.
12 BY MR. PRINCE:
13 Q We're going to show you an image of postoperatively with
14 all the hardware in place. I want to ask you a question based upon the
15 place of the hardware, why a trial stimulator is not appropriate in Mr.
16 Yahyavi's case.
17 A Of course.
18 Q Okay. Can you explain -- I mean, he has five levels fused,
19 right?
20 A He does.
21 Q I mean, that obviously has a significant effect on his range of
22 motion and mobility?
23 A Yes.
24 Q And obviously this is all done in the back, right?
25 A It is.

1 Q What they call posterior?

2 A Yes.

3 Q And based upon the type of surgery, the extent of the
4 surgeries, why would the placement of a trial stimulator be unsafe in Mr.
5 Yahyavi's case?

6 A Because the anatomy has been altered by the surgery
7 performance, not only the hardware -- the hardware in and of itself is not
8 a problem, it's the fact that the hardware was placed in areas where the
9 bone is now missing, so --

10 Q Right. And so along these areas here -- oh, let me get on this
11 side. Bone was removed on the laminectomy, right?

12 A Yes.

13 Q And so now he's scarred down at all those levels, right?

14 A Yeah. So the normal anatomy that we use to place needles
15 has been altered significantly, so it would be unrecognizable. To place a
16 trial spinal cord stimulator in a patient like Mr. Yahyavi with this
17 anatomy, which has been significantly altered, would be not only
18 unlikely to be placed in the right place, it would be dangerous for him to
19 pursue.

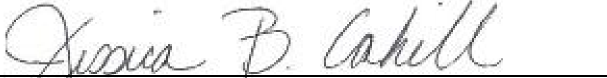
20 In a normal patient, it would be a fairly simple procedure that could
21 be done, but because of this procedure -- if it had been done from the
22 front, sure, he can have the stimulator trial, but because it was done
23 from the back, bone was removed, scar tissue has replaced that area of
24 bone, and the anatomy is totally different.

25 Not only would it be more difficult to place a stimulator, it would

1 likely be impossible to place it appropriately, and it would put Mr.
2 Yahyavi at significant risk, and I want to have nothing to do with harming
3 a patient, so even though I make money doing trial spinal cord
4 stimulators, I told Mr. Yahyavi that it would be unwise to make that
5 decision. I've informed his surgeon that -- that -- you know, of my
6 opinion, and that we're going to need to put this in -- more permanently.
7 Everyone was hoping that I would be able to come in and save the
8 day and figure out a way to do this; I cannot do this safely for him, and
9 so therefore I'm not going to offer something unsafe to him. Putting it in
10 permanently is under direct visualization. The scar tissue can be dealt
11 with. It can be removed. It can be moved out of the way to
12 accommodate the surgical lead placement in that area, and that can be
13 done safely and efficiently.
14 The only thing you're missing is you're buying the car without the
15 test drive, and that's, you know, potentially a problem. But I evaluate
16 patients all of the time for this type of device, whether it's effecting their
17 neck and their arm, or their low back and their leg, and I would consider
18 myself an expert in these types of procedures.
19 Mr. Yahyavi is an excellent candidate for a trial. He's also an
20 excellent candidate for a permanent stimulator. Unfortunately, he's --
21 he -- based on the surgery, he -- you know, his symptom make him a
22 candidate for the trial and the permanent. His -- when reality sets in, he's
23 only a candidate for the permanent one. But I am very confident that this
24 will help to cover up his pain, improve his life by improving his quality of
25 life, but it's not going to get rid of all the hardware in there.

1 It's not going to get rid of his difficulty performing tasks. It may
2 make the rest of his life better, which is the reason why I am encouraging
3 him to have it done. Dr. Thalgott has done so and has proceeded with
4 getting authorization. And before him, Dr. Kaplan has done that. Dr.
5 Ross has signed off on it, saying he's an appropriate candidate. He has
6 realistic expectations. He's now needing to decide whether or not he is
7 going to be willing to do this and take the risk because there are no
8 guarantees with anything that we're offering him at this point, but I am
9 confident that this is the right answer for him.
10 Q Okay. And one other thing, do you recall, and did Dr. Oliveri
11 perform the permanent partial disability rating?
12 A Yes.
13 Q We talked about that earlier. And did Dr. -- based on your
14 review of Mr. Ross -- Dr. Ross' records, he obviously considered the FCE
15 done in 2015, which was determined to be invalid?
16 A Yes.
17 Q Just because an FCE is invalid, does that mean someone's
18 lying or faking or anything like that?
19 A No, it doesn't. I mean, patients that I have who undergo
20 FCEs, you know, I will receive invalid reports, and sometimes it's invalid.
21 What I was missing from this was the specific number that made it
22 invalid. If he was a 69 percent reliability, is that much different from 70?
23 I don't know. If he was a -- you know, a 12 percent, then you know, he
24 wasn't putting forth effort, but that still doesn't mean that he doesn't
25 have a problem. He clearly has issues of pain that is reflected in his -- in

1 the comments that were made there that he was at -- I believe the
2 comment was that he was kind of concerned about his pain and he self-
3 limited.
4 If somebody is asking you to do something painful, you may not
5 give full effort and therefore it may be interpreted in that basic test as
6 something that is invalid or inconsistent with other things that may be
7 present.
8 So to me, this all has to be put into perspective, and I would say
9 that that finding is really an outlier and it doesn't really change my
10 opinion on Mr. Yahyavi or his need for care. I mean, because remember,
11 after that, he continued to work in his capacity until he couldn't.
12 Q Right. And so then in 2019, Dr. Ross documented he had a
13 valid FCE in 2019, so I guess you've seen both ways in this case?
14 A Yes.
15 Q All right. And finally, Doctor, I mean, do you have any
16 financial stake in the outcome of this case in any way?
17 A No, I've already been paid.
18 Q Right. I mean, your -- that's done, right? So those expenses
19 have already been incurred?
20 A Those have already been incurred. I've already been
21 reimbursed for those.
22 Q Right. You're not -- you have no lien or no financial stake in
23 the outcome of this case?
24 A None whatsoever.
25 Q Right. You're just -- very good. Thank you.

1 MR. PRINCE: I have no additional questions.
2 MR. KAHN: No further questions, Your Honor.
3 THE COURT: Questions from the jury, raise your hand.
4 Questions? No questions?
5 Thank you, Doctor. You may step down.
6 THE WITNESS: Thank you.
7 THE COURT: Counsel, approach.
8 [End of designated testimony at 3:35 p.m.]
9
10
11
12
13
14
15
16
17
18
19
20
21 ATTEST: I do hereby certify that I have truly and correctly transcribed the audio-visual recording of the proceeding in the above entitled case to the
22 best of my ability.
23

24 Maukele Transcribers, LLC
Jessica B. Cahill, Transcriber, CER/CET-708
25