

1 down in the left arm. A positive axial compression test is
2 indicative of pain that is generated from the axial elements,
3 that means from the elements of the vertebral column including
4 the discs and the joints.

5 MR. EGLET: And could you highlight the radiographs
6 please now, too, Brendan?

7 BY MR. EGLET:

8 Q Now at your initial evaluation of Mr. Simao, did you
9 review any radiographic testing on him?

10 A Yes, sir.

11 Q Okay. And was that an MRI of his cervical spine
12 from September 2007?

13 A Yes, sir.

14 Q And what is an MRI?

15 A MRI is a magnetic resonance imaging. It's an
16 imaging scan through a magnetic field that's -- the largest
17 advantage is that it's not radioactive, so it doesn't have any
18 negative effects on the patient. And it's especially valuable
19 in the assessment of soft tissue, in this case, soft tissue of
20 a cervical spine such as --

21 Q This cervical MRI.

22 A Well, I stated that there was evidence of a
23 possibility of some facet tropism in the segments at the C3-4
24 and C4th level.

25 Q Okay. What is meant by that popism (sic)?

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1 A Well, the facets are the posterial joints. And I
2 can show you this --

3 Q Could you come out of the stand with the spine and
4 explain -- point out to the jury where the joints are located.

5 A This is the -- and this is the back of the spine.
6 As you can find, spinal -- comprised of segments -- these are
7 the vertebral bodies and these are the spinous processes.
8 And --

9 Q Let's slow down a little bit as you're going through
10 this. The vertebral bodies, is that the bones?

11 A Right here.

12 Q Okay.

13 A The bones. And these are the discs that are the
14 shock absorbers, the cushions in between the vertebral bodies.

15 Q Okay.

16 A Now we're looking from the back. The spinous
17 processes are these sharp structures here pointing out --

18 Q Back when we were kids when we were all skinny, we
19 could feel that -- actually see it?

20 A Yes, yes.

21 Q The bone back there.

22 A Yes.

23 Q That's what we saw?

24 A Yes.

25 Q Okay.

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1 A Yes, sir. And the vertebrae are connected by joints
2 from the back. And these joints, we call it posterior
3 intervertebral joints. These joints are the facet joints.
4 Now these are the facet joints in the cervical spine. And
5 obviously in the lumbar spine, those are the joints --

6 Q Okay.

7 A -- that connect the vertebrae from the back side.
8 And these joints, we call those joints facet joints. On
9 review of the MRI scan there was a facet tropism. And tropism
10 means that there was asymmetry of the facet joints.

11 Q Asymmetry?

12 A Asymmetry.

13 Q Okay.

14 A Those joints were not symmetrical. Ideally those
15 joints should be symmetrical, but in his case those were
16 asymmetrical.

17 Q Okay. And was -- you can sit back down. Thank you,
18 Doctor. What was the interpretation of that study by the
19 radiologist, Dr. Momii?

20 A Dr. Ruben [phonetic]?

21 Q Was it Dr. Momii?

22 A Oh, Mo- --

23 Q Or was it Doctor --

24 A 3/22 of '06. Can I see a copy of --

25 Q We're putting it up on the screen.

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1 A I don't have it.

2 Q By Dr. George Momii. What was his impression?

3 A His impression was negative MR for -- of the
4 cervical spine for age.

5 Q Now is Dr. Momii's interpretation incompatible with
6 your documented findings?

7 A Well, my documented findings were that there is some
8 changes in the facet joints. And obviously this was not
9 reported.

10 Q Is that interpretation incompatible with yours?

11 A Well, I think that it's -- it -- I think what I saw
12 on the MRI scan, what I read was not documented by the
13 radiologist.

14 Q Okay. Do you see that in your practice?

15 A Yes.

16 Q Is that unusual?

17 A It's not unusual.

18 Q Does it necessarily mean anything?

19 A Not necessarily.

20 Q Okay. And what is a negative MR -- and that's short
21 for MRI; right, MR -- of the cervical spine for age mean? He
22 emphasizes or he states for age.

23 A Well, he apparently states that there's nothing to
24 be seen on the MRI scan considering the patient's age.

25 Q Okay. And what does that mean? I mean what does

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1 that have to do with the age?

2 A Well, sometimes with age you can find some changes
3 in the MRI scan.

4 Q Okay. All right. Now the changes, the -- well, I
5 don't even want to use the word changes, but the facet
6 tropisms that you documented, is -- are -- were those unusual
7 for his age, for Mr. Simao's age, or are those something that
8 would be age related at all?

9 A Well, not necessarily. You can have congenital
10 facet tropism. That means --

11 Q Okay.

12 A -- you have it by birth. You can have it as a 15 or
13 20-year-old.

14 Q Okay.

15 A But typically you don't get MRIS at that age unless
16 there's a reason for it. So it doesn't necessarily -- it's
17 not necessarily age related. Can be something that's been
18 there, you know, it's been there, you know, since birth.

19 Q Okay. Exhibit 32, page 4 please, Brendan. After
20 your initial evaluation of Mr. Simao, what was your clinical
21 impression?

22 A That the patient was having suffering from
23 persistent neck pain, interscapular pain, with occasional left
24 upper extremity radiculopathy following a motor vehicle
25 accident.

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1 Q What is radiculopathy?

2 A Radiculopathy is a term that indicates an
3 inflammation of the spinal nerve. And in this case, coming
4 off the cervical spine, that causes pain. Numbness or
5 tingling, for example.

6 Q All right. Now, Doctor, can radiculopathy occur
7 with neurologic compression of the spinal cord or spinal nerve
8 roots as with a bulging disc, herniated disc, or spinal canal
9 or neuroforaminal stenosis?

10 A Yes, sir.

11 Q Use -- if you could come back down out of the stand.
12 Using the spine model, could you explain how this occurs in
13 those various parts of the body. Point those out -- or in the
14 spine. Point those out to the jury, explain how that occurs.

15 A Okay. Again, we're looking at the cervical spine
16 from the front. And those yellow structures are actually the
17 spinal nerves. Those nerves are responsible for sensation,
18 feeling in -- between the shoulder blades, across the shoulder
19 blades, around the shoulders, but also in your upper
20 extremities, in your arms and your hands, feeling and motor
21 function. So as you can probably appreciate the cervical
22 spine is a very tight compartment. Everything is packed
23 together very tightly and there's not much room between the
24 structures.

25 And as you can see, those intervertebral discs, the

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1 -- which are, as I pointed out earlier, cushions or shock
2 absorbers in between the bones here, in between the vertebral
3 bodies, those discs are fairly close to the corresponding
4 thing, spinal nerve. So if there's a disc bulge, disc
5 protrusion, it can easily cause an irritation of that nerve
6 over time and can cause some numbness, some tingling, some
7 radiating pain into the extremity.

8 Q Okay. And so what is a bulge, a herniation of the
9 disc?

10 A Well, a bulge or disc protrusion means that the disc
11 -- the disc is comprised of a core. It's called the nucleus.
12 It's like a jelly type structure, very soft. And surrounded,
13 to keep it in place, is the annulus, the ring structure. It's
14 a very dense fiber structure. And a bulge means that the
15 nucleus -- that the core can actually push out and cause a
16 bulging of the whole disc, and that can sometimes protrude and
17 cause an irritation of the adjacent nerve. A herniation is
18 where the disc is protruding beyond its margins and it's
19 impinging upon a nerve.

20 Q What is axial pain, axial neck pain?

21 A Axial neck pain is typically caused by pain that's
22 generating within the axial components of the vertebral
23 column, which is -- which are the discs in and of itself and
24 the facet joints, as opposed to radicular pain, which is pain
25 that's caused by irritation of the nerve, the spinal nerve.

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1 So we have radicular pain and we have axial pain.

2 Q And can radiculopathy or radicular pain occur
3 without the presence of the neural compressive signs you just
4 showed us, without the compression of nerves?

5 A Yes.

6 Q How does that happen?

7 A We have two types of radicular nerve irritation. We
8 have a mechanical nerve irritation that is often due to a
9 protruded herniated disc and we have a chemical nerve
10 irritation. And a chemical nerve irritation's often due to a
11 disc that has a tear where it's leaking out disc material,
12 which is very inflammatory. In fact, in a study they used the
13 spinal nerves of rats and put a little cadaver disc material
14 on -- under the microscope on that nerve, rat nerve, and
15 caused a swelling and a redness and an inflammatory response
16 of the rat nerve. So it's a very inflammatory substance
17 within the disc and that can cause chemical irritation, and
18 thereby chemical induced radiculopathy.

19 Q So that can cause radicular symptoms as well?

20 A Yes, sir.

21 Q Okay. Now what is the clinical term applied to
22 patients that develop axial spine pain with or without
23 extremity radicular symptoms absent findings of neurologic
24 compression, but mediated as you have just described by
25 chemical and/or motion segment abnormalities at a disc to

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1 create this discogenic pain you're talking about?

2 A Well, that's what -- you just mentioned discogenic
3 pain. It's pain that's generated by the disc.

4 Q And is that with -- is that commonly referred to in
5 your practice as internal disc disruption?

6 A Yes, sir. Internal disc disruption means that the
7 architecture, the internal architecture of the disc is
8 disrupted. Thereby allowing a leakage of disc material onto
9 the surrounding elements, the spinal nerves, causing
10 radiculopathy.

11 Q Okay. So can internal disc disruption or discogenic
12 pain be present in a patient with either normal findings on an
13 MRI of the spine or with findings of age appropriate changes,
14 degenerative -- age appropriate degenerative changes in an MRI
15 of the spine?

16 A Yes, sir. There is in fact a study in the Spine
17 Journal in 1996 by Shellhas and Smith. And they compared
18 studies of -- MRI studies of symptomatic and asymptomatic
19 patients with neck pain and without neck pain. So they
20 compared the MRI findings with the discography study. What
21 they found out was that there were a significant amount of
22 patients, symptomatic and asymptomatic patients, who had in
23 fact a tear on the discography study which did not show on the
24 MRI. That means that the MRI, even though you have a normal
25 MRI with no evidence of a tear, it does not rule out that

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1 there is in fact a tear which later can be documented and
2 proven by a discography study.

3 Q Now is an MRI best suited for findings of
4 compressive symptoms on the spine related to disc bulges or
5 herniations or stenosis as opposed to disc -- internal disc
6 disruption?

7 A Yes, sir.

8 Q Okay. And do MRIs -- you talked about these tears
9 in the disc. Are these tears referred to oftentimes as
10 annular tears?

11 A Correct, sir.

12 Q Do MRIs always show the presence of annular tears?

13 A No, sir.

14 Q Okay. So hypothetically, if someone stood in front
15 of this jury yesterday afternoon and told them that Mr. Simao,
16 because he did not have any disc disruption shown up on his
17 MRI, that he didn't have any disc injuries, would that be
18 accurate?

19 A No, sir.

20 Q And that is why?

21 A As I pointed out, that the MRI does not necessarily
22 show annular tearing, or the absence of an annular tear on the
23 MRI scan does not exclude a internal disc disruption.

24 Q You can sit back down, Doctor. Okay. Doctor, what
25 I want to ask you now is what are the tools that are utilized

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1 by a clinician such as yourself or a orthopedic spine surgeon,
2 what are the tools that are utilizes -- utilized in
3 establishing a diagnosis of discogenic mediated pain,
4 discogenic pain?

5 A Well, first we start off with examining -- taking
6 the history of the patient.

7 Q So one is history?

8 A Correct, sir.

9 Q And what is the history? What does that mean?

10 A Well, we want to see -- we want to first find out
11 where's the pain, what kind of pain the patient has, was there
12 any precipitating event, was it a slow onset, insidious onset
13 over years, or was it a rather acute onset.

14 Q So was it a traumatic event that brought it on
15 suddenly or is it something that developed over time?

16 A Correct, sir.

17 Q Okay. All right. What is the next tool that you
18 utilize?

19 A Well, then you perform a physical examination.

20 Q Okay. And the physical exam in order to determine
21 if there's a potential for discogenic pain, would that
22 necessarily include the provocative physical examination you
23 talked about? That needs to include that?

24 A Yes, sir.

25 Q Okay. And if it doesn't include that, then it's

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1 inconclusive?

2 A Correct, sir.

3 Q Okay. What is the next tool that's utilized by
4 clinicians such as yourself?

5 A Well, then you're using imaging scans to help you to
6 come up with a diagnosis.

7 Q So imaging scans. And imaging scans would include
8 MRIs?

9 A Yes, sir.

10 Q What else?

11 A CT scans.

12 Q CTs. Anything else?

13 A These are the most common.

14 Q Okay. What other tools are utilized by clinicians
15 such as yourself to diagnose discogenic pain?

16 A Injection therapy.

17 Q Injection. What is injection therapy.

18 A Injection therapy, it's performed to delineate or to
19 see where the patient is coming from -- excuse me. Where the
20 pain is coming from, which level the pain is originating. It
21 is being performed for diagnostic purpose to see if this nerve
22 or this disc is involved in the pain, but also for a
23 therapeutic purpose, to see if, after the injection, there is
24 some significant long-lasting pain relief.

25 Q What other tools do you use then to reach a

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1 diagnosis or to determine or rule out discogenic pain?

2 A Well, we do cervical selective nerve root blocks.
3 We do --

4 Q Is that part of the injection therapy?

5 A Yes, sir.

6 Q Okay. All right, go ahead.

7 A We will do transforaminal or epidural steroid
8 injection.

9 Q Okay. And when you say injection therapy, do these
10 injections have both a therapeutic component to them as well
11 as a diagnostic component?

12 A Yes, sir.

13 Q Explain that.

14 A Again, the diagnostic component is if this
15 particular level is involved in the patient's pain and
16 reproduction. The therapeutic component is your goal is
17 obviously not just to diagnose where the pain is coming from,
18 but hopefully also to alleviate the pain for a significant
19 amount of time.

20 Q Okay. Now what other tools do clinicians use in
21 this bag of tools?

22 A Well, then we have the discography study.

23 Q Okay. Let's -- before we get to that, are there
24 other things that clinicians like yourself will do, other
25 conservative treatments?

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1 A Sure. Often we initiate conservative treatment
2 modalities such as physical therapy, chiropractic treatment.

3 Q Okay. Physical therapy, chiro treatment. Why do
4 you do that?

5 A Well, you hope -- most pain, neck pain or back pain
6 in general, is improved or is going to get better with your
7 basic conservative treatment modalities such as physical
8 therapy and chiropractic care.

9 Q Okay. And so you try conservative treatment?

10 A Yes, sir.

11 Q And why do you try conservative treatment before you
12 get to more aggressive treatment?

13 A Well, it's a tailored approach and you want to try
14 to stay as conservatively as possible. And as I pointed out,
15 most of the pain will improve, if not subside, with the
16 implementation of conservative treatment modalities such as
17 physical therapy.

18 Q Okay. And let me just back up a minute. My partner
19 just pointed something out to me. The imaging scans, the MRIs
20 and CTs, if you're looking to determine whether the patient
21 has a discogenic pain or disc injury, let's say in this case
22 to the cervical spine, is it important that the MRIs or CT
23 scans, the imaging studies be to the cervical spine as opposed
24 to the brain or something like that?

25 A Yes.

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1 Q Okay. In other words, a brain MRI wouldn't assist
2 in this determination; is that correct?

3 A It would not be helpful.

4 Q Okay. Now these are the tools that clinicians like
5 yourself, pain management clinicians, orthopedic spine
6 surgeons, to diagnose discogenic pain; right?

7 A Yes, sir.

8 Q And these tools can be used?

9 A Yes, sir.

10 Q Now what is the tool along with -- that is used to
11 diagnose definitively internal disc --

12 A It's the tool of discography study or discogram,
13 cervical discogram.

14 Q So to diagnose internal disc disruption, IDD, the
15 tool that's used is called discography?

16 A Yes, sir.

17 Q I just have trouble spelling that.

18 A D-I-S-C-O-G-R-A-P-H-Y.

19 Q Thank you. Okay. Now is discography the only
20 method, according to ISIS, for diagnosing internal disc
21 disruption, the only tool aside from these other tools? Is
22 that the definitive tool that's used?

23 A ISIS endorses a discography study as the tool, the
24 definitive tool to determine internal disc disruption, yes,
25 sir.

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1 Q Okay. I'm going to have you explain discography in
2 a few minutes, but --

3 MR. EGLET: Your Honor, I would ask that this be marked
4 as plaintiff's next in order.

5 THE COURT: Very well. What's the next in order?

6 MR. EGLET: Oh, what's our exhibits up to? We actually
7 stipulated the exhibits in, so I'll give you the --

8 THE COURT: We probably need to put it on the record
9 though.

10 [Counsel Confer]

11 MR. EGLET: Your Honor, so 1 through 65 is -- or 1
12 through 63 is stipulated to, Your Honor.

13 THE COURT: That's what I understood Mr. Rogers to say.

14 [Counsel Confer]

15 MR. EGLET: We'll straighten this out during the break,
16 Your Honor.

17 THE COURT: Okay.

18 MR. EGLET: We won't waste the jury's time.

19 THE CLERK: It's 64.

20 MR. EGLET: Okay. Your Honor, I would move for
21 admission.

22 THE COURT: Any objection?

23 MR. ROGERS: Of what?

24 THE COURT: Admission of item 64.

25 MR. ROGERS: Oh, this is 64?

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1 MR. EGLET: This is 64.
2 THE COURT: It's just been marked.
3 MR. ROGERS: Okay. I could -- just a moment.
4 [Pause]
5 MR. ROGERS: All right.
6 THE COURT: Any objection, Mr. Rogers?
7 MR. ROGERS: No.
8 THE COURT: Very well. 64 is admitted.
9 [Plaintiffs' Exhibit 64 Received]
10 MR. EGLET: Thank you, Your Honor.
11 [Pause]
12 BY MR. EGLET:
13 Q Okay. Now, Doctor, can annular tears or disc
14 disruption be present as part of age related or degenerative
15 changes in a patient's spine, but be asymptomatic or
16 nonsymptomatic?
17 A Yes, sir.
18 Q Okay. So these annular tears or tears in a disc,
19 they can be present by the normal -- process of a -- of any
20 person, but be -- but not be -- hurt them, not be in pain?
21 A Yes, sir.
22 Q Okay. Can trauma such as a motor vehicle accident
23 cause these -- related or degenerative related annular tears
24 or internal disc disruption that were present before the
25 traumatic event but not symptomatic, can these type of trauma

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1 cause these conditions to become symptomatic as a result of a
2 traumatic event?

3 MR. ROGERS: Objection, Your Honor, as to this type of
4 trauma. There's no description, foundation.

5 MR. EGLET: I just said a motor vehicle accident, Your
6 Honor.

7 MR. ROGERS: But again, the objection --

8 MR. EGLET: May we approach, Your Honor?

9 THE COURT: Yes.

10 [Bench Conference Not Transcribed]

11 MR. EGLET: The objection is overruled, Your Honor?

12 THE COURT: It was.

13 MR. EGLET: Thank you.

14 BY MR. EGLET:

15 Q All right. Let me try that question again, because
16 it's been a few moments. Can trauma cause a age related,
17 degenerative related, annular tear or disc disruption that was
18 previously present in a patient, present before the trauma,
19 and was asymptomatic? Can a traumatic event such as a car
20 accident cause it to become symptomatic as a result of the
21 traumatic event, the car accident?

22 A Yes, sir.

23 Q Okay. Can trauma cause internal disc disruption?

24 A Yes.

25 Q In other words, can it actually cause a tear in the

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1 disc?

2 A Yes, sir.

3 Q Okay. And can internal disc disruption, or a tear
4 in the disc -- just to finish this circle, can internal disc
5 disruption, or a tear in the disc, be asymptomatic in people?

6 A Yes, sir.

7 Q And then can a traumatic event cause that
8 asymptomatic preexisting condition to become symptomatic as a
9 result of the trauma.

10 MR. ROGERS: Your Honor, same objection.

11 THE COURT: Noted for the record.

12 BY MR. EGLET:

13 Q I'm sorry. Your answer?

14 A Yes, sir.

15 Q Okay.

16 MR. EGLET: Now are we on page 4 still? Okay.

17 BY MR. EGLET:

18 Q What did you recommend for Mr. Simao after your
19 initial evaluation of him, Doctor?

20 A I had recommended for the patient to undergo a
21 cervical selective nerve root block on the left side at C4 and
22 C5 nerve.

23 Q Okay. And why did you feel it was appropriate to
24 recommend a left C4 and C5 selective nerve root block for Mr.
25 Simao?

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1 A It was within the patient's clinical presentation,
2 the pain. And it was also recommended by Dr. Grover, who sent
3 the patient to me.

4 Q Okay. The spine surgeon?

5 A Yes, sir.

6 Q Now what are the risk of selective nerve root
7 blocks?

8 A The risks are -- general risks are infection,
9 bleeding, nerve injury, cardiovascular collapse, accidental
10 injection into a artery, into a blood vessel that feeds the
11 spinal cord, with paralysis as a result or a stroke if the
12 blood vessel goes up to the brain.

13 MR. EGLET: Exhibit 28, page 3, please Brendan.

14 BY MR. EGLET:

15 Q Doctor, when did you perform a left-side C4 and C5
16 selective nerve root blocks on Mr. Simao?

17 A I performed those on May 10th of 2008.

18 Q If you could come back down out of the box, please.
19 And using the spine model, if you could explain to the jury
20 and demonstrate for the jury exactly what this surgical
21 procedure is, where it's done, who's there, what happens, and
22 describe for us how this procedure is performed.

23 A Okay. Well, the patient comes back for the
24 injection therapy and, typically, lies on his back. So the
25 head is up.

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1 Q Is this in a surgical suite?

2 A Yes, sir.

3 Q Okay. So it's in a surgical suite, and you --
4 there's people there in the room?

5 A Yes, sir.

6 Q Okay. Tell us about the equipment. What's going
7 on?

8 A Well, there's equipment such as a fluoroscope, which
9 is x-ray machine, a mobile x-ray machine.

10 Q Is it live x-ray?

11 A Live x-ray, yes, sir.

12 Q Okay.

13 A And then there's different equipment such as
14 needles, syringes, and pointers like this. There are
15 different types of medications, numbing medication, local
16 anesthetic as well as cortical steroid.

17 Q Okay. So go ahead and demonstrate for us the
18 procedure.

19 A Well, the patient comes into the procedure suite,
20 and we prep the area to be injected, the surgical area, the
21 neck, really carefully. And then you drape some sterile
22 towels over the face and on both sides and down the chest.
23 And then I have to use x-ray to make sure that I'm injecting
24 the right level. And the only way for me to find the right
25 level is knowing my anatomy and correlating this with the

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1 x-ray machine. So I have live x-ray and which points to the
2 level that I want to inject.

3 Now keep in mind the x-ray does not show me the
4 nerve, but it shows me the bony structures adjacent, or where
5 the nerves travels through. So indirectly, I can find the
6 path of the nerve by looking at the x-ray. Then I place a
7 needle, a small tiny needle, carefully and cautiously, under
8 continuous live x-ray unto the spinal nerve at the respective
9 level, on the left side, at C4 -- it's the fourth -- and C5,
10 the fifth spine nerve, and inject a small amount of IV dye
11 first. It's contrast. And the IV dye kind of lines out where
12 the medication normally would go. Most importantly, you need
13 this to allow that you don't inject into a blood vessel,
14 because that can cause complications.

15 And once you have ruled that out, once you know you
16 have placed the needle appropriately, once the dye shows the
17 appropriate area where the medication will go, then you can --
18 you will inject a small amount of medical, namely a numbing
19 medication, such as Lidocaine, which you get when you go to
20 the dentist, and a small amount of cortical steroid. The
21 cortical steroid is there to reduce inflammation, hopefully,
22 provide some long-lasting relief.

23 Q Okay. What were --

24 MR. EGLET: If you could highlight pre-operative pain
25 score and post-operative pain score, please, Brendan.

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1 BY MR. EGLET:

2 Q What were the immediate results of this procedure?

3 A Well, the immediate results was -- the immediate
4 result was the patient's pain score drop from a six out of 10
5 to a one out of 10.

6 Q Okay. And what is the clinical significance of this
7 spine --

8 A That the medication is injected in that area caused
9 reduction in the patient's pain.

10 Q Did it indicate -- would that indicate that this was
11 -- that these disc levels were pain generated sources from the
12 C4 and C5 nerve roots on the left?

13 A Yes, sir.

14 Q Okay. Now, hypothetically, if someone stood in
15 front of this jury yesterday afternoon and told them that them
16 that the C3/4 and C4/5 discs were not pain generators, would
17 that be accurate?

18 A That would not be compatible and accurate with the
19 finding I -- or with the result I obtained through the
20 injection.

21 Q So that statement would be incompatible with the
22 diagnostic finding of this procedure you performed?

23 A Yes, sir.

24 Q Okay.

25 MR. EGLET: Page -- Exhibit 32, page 7, please, Brendan.

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1 BY MR. EGLET:

2 Q You can sit back down now. Thank you. What was Mr.
3 Simao's clinical status when you reevaluated him on July 9th,
4 2008?

5 A The patient returned for a follow-up visit. He was
6 complaining of ongoing symptoms of neck pain, pain in between
7 the shoulder blades, pain radiating in his left arm. He did
8 not sustain any long-term improvement through this injection
9 therapy I performed.

10 Q And what is the clinical significance of the fact
11 the selective nerve root blocks did not provide him any long-
12 term improvement to control his chronic pain?

13 A That there was an ongoing irritation of the nerves
14 by those disc was not responsive to the injection therapy.

15 Q So it didn't -- is it fair to say it didn't provide
16 the therapeutic relief that you sometimes get, but it gave you
17 the diagnostic information that these -- the two discs were
18 pain generators?

19 A Yes, sir.

20 Q What was your clinical impression of Mr. Simao at
21 that time?

22 A That he was having ongoing cervical symptoms of
23 neck, interscapular pain, left periscapular pain, with a disc
24 compromise at those two levels, at C3/4 and C4/5.

25 Q And what do you mean by disc compromise at those two

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1 levels?

2 A There was a pathology within the disc that
3 compromised the integrity of the disc.

4 Q What does pathology mean?

5 A Like a disc disruption, for example.

6 Q Okay. What did you recommend for Mr. Simao at that
7 time?

8 A At that time, given Dr. Grover's recommendation for
9 him to undergo a discography study, I recommended to pursue
10 this diagnostic test.

11 Q All right. Now you mentioned discography earlier.
12 What is discography?

13 A Discography is a provocative test to elicit, number
14 one, is there a morphologically abnormal disc. That means is
15 there a disc that doesn't -- it doesn't look normal. And
16 number two, is there a painful disc? Is there a disc that is
17 causing the patient to have these symptoms.

18 Q Are there controversies that exist regard the
19 clinical usefulness of discography and, in particular,
20 cervical discography?

21 A Yes. Compared to the lumbar discography study,
22 they're all controversies of cervical discography. There is a
23 higher incidents of false positives. That means that these
24 disco- -- or there's a higher occurrence of pain that is, in
25 fact, not really related to disc -- originating from the disc.

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1 False positive means the pain is not really coming from the
2 disc.

3 Q Now are there defined guidelines by spine societies,
4 such as the North American Spine Society, NASS, and the
5 International Spine Intervention Society, ISIS, which are
6 utilized by pain management physicians in the performance and
7 interpretation of discography?

8 A Yes, sir. The ISIS, the International Spine
9 Intervention Society, endorses the use -- the judicial use of
10 disco- -- cervical discography, even knowing that there is
11 higher incidents of false positives. And in fact, I learned
12 cervical discography at a cadaver course that was sponsored by
13 ISIS.

14 Q And did you follow these guidelines with respect to
15 the cervical discography you performed on Mr. Simao?

16 A Yes, sir.

17 Q What are the risks of cervical discography?

18 A Well, in general, cervical discography is one of the
19 most challenging procedures performed in intervention of pain
20 management. It's a procedure that's not to taken lightly.
21 It's, in fact, a procedure that should only be done by the
22 well-trained pain management specialist because of serious --
23 potential serious complications, such as discitis. That is an
24 inflammation of the disc. It's just -- arthritis is an
25 inflammation of the joint. Discitis is an inflammation of the

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1 disc that you introduce an infection into the disc, which can
2 be very detrimental. And there's the risk of bleeding and
3 infection. And there's the risk of bleeding and infection.
4 There's the risk of puncturing the esophagus, the food pipe.
5 There's a risk of puncturing the trachea, the windpipe.
6 There's a risk of traversing the disc and going into the
7 spinal cord, and potentially injecting IV dye into the spinal
8 cord, which can be catastrophic. There's a risk of puncturing
9 the carotid artery, which is the major blood vessel that
10 brings blood to the brain from the heart.

11 There's a risk of puncturing the jugular vein, which
12 is the main draining vessel that drains blood from the brain
13 back to the heart. So there's a multitude of challenges here.
14 And again, this is a procedure that shouldn't be taken lightly
15 and should only be used judiciously because of potential
16 catastrophic adverse effects.

17 MR. EGLET: Exhibit 28, page 5, please, Brendan.

18 BY MR. EGLET:

19 Q And, Doctor, when did you perform cervical
20 discography on Mr. Simao?

21 A I performed this procedure on August 8th of 2008,
22 sir.

23 Q Come back down out of the box, please. And using
24 the spine model, if you could demonstrate for the jury how you
25 performed this discography, the setting for us, and what's

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1 done.

2 A In a -- the procedure is being performed in a
3 procedure suite. Typically, with this procedure everybody is
4 kind of heightened a little, because it's a procedure that can
5 potential result in significant complications. Again, we make
6 -- we give the patient 30 minutes prior to the procedures --
7 or roughly 30 minutes prior to the procedure, an antibiotic.
8 I explain the risk of discitis, of infection of the disc.
9 Also, the IV dye I am injecting into the disc has a small
10 amount of antibiotic too.

11 The disc -- the area to be injected is then prepped with
12 alcohol or iodine based solution. And then everything is
13 draped sterilely. And the access of the disc is from the right
14 side, by pushing with your left hand, the voice box, the
15 trachea, and the esophagus to the left, so you don't hit those
16 two structures.

17 Q Is the patient awake when you do that?

18 A Well, ISIS now endorses, and I quote: merciless --
19 mercifully, ISIS endorses now a sedation for this particular
20 injection, because it's very painful. As you can probably
21 imagine, if I would come from the back and would grab your
22 voice box and move it over to one side, you wouldn't like
23 that. You would feel like you're choking. You can't -- I
24 meant that's -- you can't hold still. So you give a small
25 amount -- you give a sedation where you're able to tolerate

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1 this procedure, so I can place safely these needles. I cannot
2 -- we cannot allow the patient to move due to the very
3 delicate anatomy in the cervical spine, and the fact that when
4 you place the needle in the wrong place, it can be potentially
5 catastrophic. So you like to have the patient sedated. And
6 ISIS has not -- has now recognized that.

7 Once the disc -- once the needles are placed into
8 discs, you let the patient wake up. So you wait. And then
9 you inject a small amount of IV dye. And I want to show you
10 how small an amount it is. This is a little syringe, and this
11 is three milliliter, three CCs. I inject a tenth of this.
12 This is half a CC. That is .03 CCs. This is the amount of IV
13 dye I inject into the disc.

14 Q Why so little?

15 A These discs are very tiny. They're very small.
16 They cannot accommodate any larger amount of liquid, of IV
17 dye. So this is the amount I inject. And as I inject, I will
18 ask the patient whether he or she feels that this is painful.

19 Q Okay. Let's back up a second before we get to the
20 provocative portion of it you're about to describe. So the
21 patient is sedated, and you place the needles. And you do
22 that in a fluoroscopy, the live x-ray?

23 A Yes, sir, we do.

24 Q And how many discs did you do discography on, on
25 this day, on August 8, 2008?

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1 A I did three discs.

2 Q Okay, three discs. So while the patient is sedated,

3 do you put three needles into three different discs?

4 A Yes, one at a time.

5 Q Okay.

6 A Yes.

7 Q And so, there's three needles in -- okay. And then

8 once the needles are placed -- how do you know whether the

9 needles are placed at the right place in the disc?

10 A You know by looking at the fluoroscopy. And in AP

11 and in lateral -- in the AP view, that means view from the --

12 straight from the view, and lateral view, from the side.

13 Q Okay. Does the patient have any idea what discs

14 you're putting the needle into?

15 A No.

16 Q Okay. So is the -- the patient is blind to that?

17 A Correct.

18 Q Okay. And then you say -- after you place the

19 needles and you let the patient wake up from this sedative

20 completely.

21 A Yes.

22 Q Okay. I think -- you don't completely knock them

23 out, right?

24 A You make them comfortable.

25 Q Okay. It's not like the type of anesthesia you

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1 would get for open heart surgery or something?

2 A No.

3 Q Okay. So you allow them to wake up, and then you
4 said you -- you indicated you would inject the discs.

5 A Correct.

6 Q Do you inject all three discs at once, or one at a
7 time? Or how would that work?

8 A One at a time.

9 Q Okay. Does the patient have any idea which disc
10 you're injecting when you're doing that?

11 A No, sir.

12 Q You don't tell him hey, I'm about to inject the C2/3
13 or C3/4 disc or anything like that. You just say tell me if
14 you what?

15 A Tell me if this is painful.

16 Q Okay.

17 A And if this is painful, tell me whether this
18 resembles your normal pain or exacerbates your normal pain, or
19 if it's the pressure sensation in the neck.

20 Q Okay. And when you say this resembles your normal
21 pain, is that we see in the records when we hear the term
22 concordant pain?

23 A Yes, sir.

24 Q That's what concordant pain means?

25 A Yes.

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1 Q In other words, is this the pain you feel normally
2 from your neck?

3 A Yes.

4 Q Okay. So go ahead. You say you pressurize the disc
5 by injecting this dye.

6 A Yes. And again, it's .03 CC. It's a very, very
7 small amount, because a cervical disc cannot accommodate more.

8 Q Okay. And you do this at each disc?

9 A You do this at each disc, yes.

10 Q Okay. Now you had done a selective nerve root block
11 earlier, and you had found that two -- you felt that two discs
12 were pain generators, right?

13 A Yes.

14 Q Which ones were those?

15 A The C3/4 and C4/5.

16 Q C4/5.

17 A Uh-huh.

18 Q And you did discography on three discs. Which
19 levels did you do?

20 A At C3/4, C4/5, and 5/6.

21 Q Why did you -- if you already knew from the
22 selective nerve root blocks that the C3/4 and C4/5 were the
23 pain generators, why are you doing discography now on three
24 levels?

25 A Because I wanted to see if I can find a normal non-

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1 painful disc, which would serve me as a control disc.

2 Q What does that mean, control disc?

3 A A control disc is if the -- theoretically, if I
4 would perform discography on all disc of the cervical spine
5 and all were painful, this is non-conclusive result. What has
6 to be there is a negative or control disc which you can then
7 compare the other positives.

8 Q Okay. So what were the findings on your -- from
9 your discography? First of all, as you're doing this, you're
10 documenting this?

11 A Yes, sir.

12 Q Okay. You're documenting where the needles are and
13 you can see where the needles are?

14 A Yes, sir.

15 Q Okay. And you're documenting the dye that's going
16 in and what's happening?

17 A Yes.

18 Q You see this on the live x-ray?

19 A Yes.

20 Q Okay. So what were the results of this discography?

21 A The results were that the discs at 3/4 level and 4/5
22 level were, in fact, positive. That means that those discs,
23 by injecting dye into those discs, those discs were causing
24 the patient's usual pain, very severe, very severe -- whereas,
25 the C5/6 disc did not reproduce any pain.

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1 Q Now this is your operative report?

2 A That's the post-operative diagnose. That's a
3 summary of the procedure. Yes, sir.

4 Q Okay. This -- I just read that. It says operative
5 report. So --

6 A Yes, sir.

7 Q Okay. And this is the post-operative. What's
8 highlighted here is the post-operative diagnosis. And you've
9 got these three different levels, and it says positive
10 provocation discography at C3/4, C4/5, and negative
11 provocation disc at 5/6, is that right?

12 A Yes, sir.

13 Q So 5/6 was the control level --

14 A Yes.

15 Q -- we discussed. And there was no pain reported at
16 that level.

17 A Correct.

18 Q And the patient had no idea which level you were
19 pressurizing?

20 A Correct.

21 Q Okay. There was pain reported at the C3/4 and C4/5
22 level, is that correct?

23 A Correct.

24 Q And you documented this as concordant pain reported
25 at those two levels?

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1 A Yes.

2 Q Okay. And the patient rated this as a 10 out of 10
3 in pain?

4 A Yes.

5 Q Now 10 out of 10, I mean when you said the worst
6 pain you could -- when you did that -- what's it called, the
7 anal- --

8 A Visual analog scale.

9 Q Visual analog scale earlier, when you were talking
10 about -- you know, you said to the patient 10 out of 10 is the
11 most -- is the worst pain imaginable that -- you know, the
12 vision that came to my mind is that end of the scene in
13 Braveheart where they, you know, take the guy apart basically.
14 I can't remember that actor's name, but --

15 A Mel Gibson.

16 Q Always in trouble. But that to me was the
17 visualization I have. So when I see this 10 out of a 10 pain,
18 I mean what does that mean? I mean --

19 A Well --

20 Q I mean, obviously, you're not disemboweling the guy,
21 right?

22 A No. No. But at that moment, it may feel that way.
23 But what it is is that the patient is underlying -- his
24 average pain is anywhere between six to seven out of 10, as we
25 had documented many times before. And with this provocative

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1 test, his usual pain was even exacerbated. And it's not
2 unusual that this causes a worsening of the patient's
3 underlying symptomatology.

4 Q Okay. Now what is the clinical significance of
5 these findings on this cervical discography?

6 A Well, the clinical significance is such that the two
7 discs at C3/4 and C4/5, where abnormal pain appearance, in
8 those two discs we're also generating the patient's usual
9 pain. So we have basically now narrowed down where's the pain
10 coming from, which also correlates to my previous injection,
11 the selective nerve root block at these levels.

12 Q So the selective nerve root block confirmed for you
13 that the C3/4 and C4/5 levels were pain generators, is that
14 correct?

15 A Yes, sir.

16 Q And now the discography confirms that as well.

17 A Yes, sir.

18 Q Okay. And the discography also showed what along
19 with the concordance pain? You indicate there was evidence of
20 disc disruption.

21 A Yes.

22 Q And what does that mean?

23 A That there was a tear within the disc, a complete
24 tear where, in fact, condros material that in a normal disc
25 would only be confined to the nucleus, the jelly part of the

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1 disc, leaked all the way through the fibers of the annulus.

2 Q Now did you obtain a post-discogram CT scan of Mr.
3 Simao?

4 A Yes, sir.

5 Q Why?

6 A The CT scan, following the discography study, allows
7 us to look at the distribution of the dye in a little bit more
8 detail. So it doesn't show us pain. That was confirmed by
9 the discography study. But it allows us look a little bit
10 more detail as to how bad the tears are.

11 Q Okay.

12 MR. EGLET: Could you put page -- Exhibit 30 page 2,
13 please, Brendan?

14 BY MR. EGLET:

15 Q Now what were the results of the CT discogram?

16 A That the patient had three annular tears and he has
17 what's called annular fissure, which a fissure is equivalent -
18 - same as a tear. He had -- at the C3/4 level he had a grade
19 four annular fissure. At C4/5 he had a grade five annular
20 fissure. And at the C5/6 level, he had a grade five annular
21 fissure as well.

22 Q When you explain this -- when you say Grade 4, Grade
23 5, can you explain this grading system to us?

24 A Grading systems is the Dallas Classification of
25 Annular Tears by a gentleman with the name of Dallas.

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1 Q What is it, then?

2 A It grades the significance and the extent of the
3 tear within the annulus. Again, we have the nucleus, which is
4 the jelly part, the inner part of the disc. And it's
5 surrounded by a rim, by a ring structure; it's called the
6 annulus, which is fibrous.

7 And we kind of divide the annular -- the annulus
8 into three layers: the inner third layer, the middle third
9 layer, and the outer third layer. So obviously a Grade 0 tear
10 is no tear, a Grade 1 tear is a tear that just tiny reaches
11 into the inner part of the -- or the inner layer of the
12 annulus. A Grade 2 and Grade 3 tear, the tear reaches into
13 the middle third of the annulus, the middle third -- layer.
14 And a Grade 4 tear is a full thickness tear where the tear
15 goes all the way through all the inner, the middle, and the
16 outer layer of the annulus. And a Grade 5 is a little bit
17 more; it kind of disrupts the disc.

18 Q What is the clinical significance of the Grade 4 and
19 Grade 5 annular tears or fissures noted in Mr. Simao's CT --
20 post-discography CT scan?

21 Q Well, the significance has to be taken in context
22 with the actual study. Because, as you remember, you can have
23 painless tears. But the fact that the patient had a
24 concordant pain reproduction at C4 and C4-5 -- it means his
25 usual pain was reproduced, exacerbated. In addition to that,

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1 there was evidence of tearing -- significant tearing -- all
2 the way through all layers of the annulus. That is important.
3 It gives you the clinical impression of the internal disc
4 disruption, the disc --

5 Q Well, what is the clinical significance of the
6 Grade 5 tear noted in the C5 -- C5-6 disc in Mr. Simao's
7 cervical spine, where he didn't complain of any pain during
8 the discography?

9 A It's an incidental finding. An incidental finding
10 means it's a finding we obtained without any clinical
11 significance, in a sense that the patient was not complaining
12 of any pain -- if I would take an MRI scan of -- or if I would
13 do a discography study on all of you, I would probably find
14 some tears -- you know, you're not complaining of any pain.
15 So these would be findings that don't have a clinical
16 correlation.

17 Q And is that what we talked about earlier when we
18 said asymptomatic or non-symptomatic tears or degenerative
19 age-related changes that could occur?

20 A Yes, sir.

21 Q All right. Now, at the time of your performance of
22 discography do you document by multiplanar fluoroscopy the
23 adequate placement of the needles in the central intranuclear
24 substance before proceeding with injection of the discs?

25 A Yes.

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1 Q Was that done with Mr. Simao?

2 A Yes.

3 Q What is multiplanar fluoroscopy?

4 A Multiplanar fluoroscopy mills -- means different
5 planes, different view angles. And the typical view angle, as
6 I pointed out, is the AP, the anterior-posterior view that's
7 from the front; and the lateral view from the side. Those are
8 two planes, two angles; hence, multiplanar.

9 Q Is part of Mr. Simao's chart that you brought with
10 you here today, do you have those fluorosca- -- images from
11 his August 8, 2008, cervical discography?

12 A Yes.

13 Q Could you get those for us, please?

14 [Pause]

15 BY MR. EGLET:

16 Q So what I'm going to ask you to do, Doctor, is I'm
17 going to ask you to place one of those, one at a time, on the
18 Elmo. And if you could explain to us -- review these
19 diagnostic images and explain for us what they show?

20 These were taken while you were performing your
21 discography?

22 A Yes, sir.

23 Q Okay. Explain to us what these show.

24 A Well, this is obviously the mandible -- teeth --

25 Q What's a mandible?

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1 A Well, it's the jaw.

2 Q Okay. All right.

3 A So. This is the cervical spine. And here are the
4 spinous processes. You can see here those needles are into
5 the -- in the discs, in the respective discs at C3-4, C4-5,
6 and C5-6.

7 Q When you say these needles, are you talking about
8 these, these black --

9 A Yes.

10 Q Gray things right there? Okay. So, what do those
11 show, now?

12 A They are within the intervertebral discs, inside the
13 disc.

14 Q Do they demon -- does this picture demonstrate that
15 they're in the intranuclear substance?

16 A Yes, with the second picture. Obviously, the
17 intranuclear substance is in the middle, and you can see that
18 these needles are all within the middle of the disc.

19 Q Would you proceed with injecting these discs in the
20 cervical -- in this cervical discography without confirming,
21 under this fluoroscopy, that these needles were in fact in the
22 middle or the nucleus portion of the discs?

23 A Yes, sir.

24 Q No, no. We didn't say that right. Let me -- I made
25 a mistake, so let me try again.

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1 Before you inject the discs do you confirm on
2 fluoroscopy that the needles are in the middle of the discs?

3 A Yes, sir.

4 Q Would you ever proceed with injecting that dye in
5 these -- through these needles before confirming that they
6 were in the middle of the disc?

7 A No, I would not.

8 Q Why not?

9 A Because it is the safety of the patient that comes
10 first, so you have to make sure that the needles are placed
11 properly. You may go through the disc and be in the spinal
12 cord. In the spinal canal.

13 Q Okay.

14 A Or you may not be in the disc at all.

15 Q All right. Now, would you be able -- if that needle
16 was in the cervical spine, would you be able to push that --
17 what is the stuff you put in there, the --

18 A IV dye.

19 Q The IV dye. Would you be able to push that into the
20 disc if it was in the fibrosis portion, the outer portion of
21 the disc?

22 A No, you would not. Because the disc, as I pointed
23 out, the cervical disc can only accommodate a very small
24 amount, between zero point three and zero point four CCs,
25 which I have shown with the syringe of volume.

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1 If I went in the annulus, I would immediately --
2 immediately -- feel resistance and I would not be able to
3 push. Because the annulus cannot contain that amount of
4 medication. So I would know immediately, this is not the
5 proper place for the needle to be in. The only place that can
6 accommodate that amount of medication in the cervical spine is
7 the nucleus, the center, the jelly part, and not the annulus.

8 Q If a radiologist hired by the Defense in this case
9 were to be critical of your cervical discography after
10 reviewing the post-discography TC (sic) scan, in interpreting
11 your discography based on that scan as showing that the C4-5
12 and C5-6 levels showed intra-annular rather than intranuclear
13 injections and therefore rendered the discograms
14 nondiagnostic, how would you respond to that?

15 A Well, what in fact the radiologist is saying that
16 there's chondrus material in the annulus. Because he
17 obviously doesn't see my needle in the annulus, because I took
18 the needle out before the patient went to the CT scan. So
19 what he sees is chondrus material in the annulus. Which
20 tracked into the annulus following the injection because what
21 happens as I inject dye into the nucleus it can track into the
22 annulus that has a tear, and that is what the radiologist sees
23 later when he does the CT scan.

24 And by the way, the first CT scan we pulled -- or
25 the only CT scan we pulled, did not -- the radiologist did not

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1 read any intra-annular injection, so I don't know. I think
2 it's -- the radiologist is mistaken and he sees the chondrus
3 material in the annulus which, as I pointed out, is a result
4 of tracking of the chondrus material upon pressuring the disc.

5 Q So the radiologist who read and interpreted the
6 post-discography CT scan immediately that day didn't read that
7 like the radiologist hired by the Defense?

8 A Correct.

9 Q Okay. You can sit back down. Thank you.

10 Now, Doctor, was propofol used during the cervical
11 discography you used -- you performed on Mr. Simao?

12 A Yes, sir.

13 Q What is propofol?

14 A Well, propofol has become a very bad reputation
15 unfortunately in this town and also with what happened to
16 Michael Jackson.

17 Propofol is a -- it's not an anesthetic. It's a
18 hypnotic. It's a sedative to basically have the patient
19 sleepy. Propofol doesn't have any analgesic or pain-relieving
20 component to it. Propofol is being used for gastroenterology,
21 for colonoscopies, for gastroscopies. Propofol is also being
22 used in -- or can be used in the setting of cervical
23 discography study.

24 Now, the caveat with propofol is, number one, you
25 have to be trained to administer propofol. So a radiologist

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1 who performs or who can conceivably perform cervical CT
2 discography studies, he cannot administer propofol or his
3 nurse cannot administer propofol. It has to be administered
4 by an anesthesiologist. Because propofol can also stop
5 breathing, and that's what happened to Michael Jackson. So --
6 if it's not properly used.

7 The advantage propofol has, compared to other
8 sedatives such as Versed, which is a Valium-type medication,
9 is it's a quick onset and a very quick offset. And that's
10 what you want. You want to have the patient relaxed and
11 sedated for the placement of the needles, and then you want to
12 have the patient come out of it and be responsive.

13 And that's -- propofol is the ideal drug, because it
14 doesn't cloud the pain perception because it doesn't have any
15 pain component to it. And it doesn't linger around for a
16 prolonged period of time, such as Versed can do, which is a
17 Valium derivative. Also, Versed can cause sometimes in
18 patients the opposite effect. Patients can get agitated, and
19 that's certainly not what we want in this type of procedure.
20 So I am very comfortable performing this procedure under
21 propofol.

22 I also want to point out, in another field of pain
23 management spinal cord stimulators, where spinal cord
24 stimulators are being implanted in the patient's body,
25 literally, there's a incision being made. There is some bone

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1 chipped away to get to the spinal cord. These paddles of the
2 spinal cord stimulator are being placed into the epidural
3 space and then the patient has to be awakened to assess the
4 proper lead placement of the spinal cord stimulator. And the
5 only way it's being done is with propofol. So you have the
6 patient asleep, but it's very important that the patient comes
7 out of it and is clear so he can tell you exactly if those
8 leads are in proper placement so this procedure is going to be
9 a success.

10 So it's being used in other arenas of pain
11 management, and I use it here judiciously and carefully, and I
12 think it's of the benefit of my patients.

13 Q Doctor, hypothetically, if a physician hired by the
14 Defense, who is not an anesthesiologist, were critical of you
15 for using propofol at the time Mr. Simao's disco -- at the
16 time of Mr. Simao's discography because, according to the
17 Defense doctor, it sedated him too much to be valid, what
18 would your response be?

19 A Well, I would say that this is not true. It's a
20 matter of how comfortable you are and how qualified you are in
21 administering propofol. And again, I think if it's used in a
22 proper way, shape, and form, it is a very valuable medication
23 to perform this procedure accurately and safely.

24 MR. EGLET: Brendan, could you put up Exhibit 32,
25 page 10, please.

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1 BY MR. EGLET:

2 Q Doctor, when -- what was Mr. Simao's clinical status
3 when you reevaluated him to review the results of his cervical
4 discography on August 28, 2008?

5 A The patient's symptomatology has not changed or had
6 not changed at that time. He was still complaining of ongoing
7 severe neck pain, interscapular pain, periscapular pain. He
8 had undergone discography study, which revealed positive
9 provocation at the levels C3-4 and C4-5.

10 Q Based upon your pain management evaluation of
11 Mr. Simao, including the diagnostic cervical injections, what
12 did you recommend to him at that time?

13 A I had recommended for the patient to follow up with
14 my associate, Dr. Grover, the spinal surgeon again, to discuss
15 perhaps more definitive treatment options.

16 Q At this point in time had Mr. Simao -- now more than
17 three years after his motor vehicle crash -- failed a
18 reasonable course of aggressive medical treatment for his
19 chronic, intractable pain syndrome?

20 A Yes, sir.

21 Q Was surgical reconstruction of his cervical spine a
22 reasonable thing for Mr. Simao to consider at that time?

23 A Although I'm not a spinal surgeon and who will make
24 the determination whether the patient is surgical or not, I
25 think the option -- a surgical option was certainly

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1 reasonable.

2 Q After your extensive pain management evaluation and
3 diagnostic cervical spine injections of Mr. Simao, have you
4 reached any conclusions with respect to what injuries he
5 sustained directly and causally related to the April 15th,
6 2005, motor vehicle crash?

7 MR. ROGERS: Objection, Your Honor. Foundation as to
8 cause.

9 MR. EGLET: He's established foundation, Your Honor.

10 THE COURT: Ask for you to rephrase it.

11 MR. EGLET: May we approach, Your Honor?

12 THE COURT: Yes.

13 [Bench Conference Not Transcribed]

14 THE COURT: We're going to take about a ten-minute break,
15 ladies and gentlemen.

16 [Court Admonishes Jury]

17 [Recess]

18 THE COURT: Outside the presence of the jury.

19 Do you have that question for me, Mr. Eglet?

20 MR. EGLET: Oh, yes. Sure, Your Honor. Look at
21 my notes.

22 The question is, "Based on your extensive pain
23 management evaluation and diagnostic cervical spine
24 injections of Mr. Simao, have you reached any conclusions
25 with respect to what injuries he sustained directly and

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1 causally to the April 15th, 2005 motor vehicle crash?"

2 THE COURT: And did you want to restate your
3 objection for the record, Mr. Rogers?

4 MR. ROGERS: Yes, please.

5 Are the objections up here being recorded?

6 THE COURT: They are.

7 MR. ROGERS: Okay. The objection is that the
8 doctor lacks foundation to testify about cause of a motor
9 vehicle accident on at least a few fronts. One is
10 factually, and the other is his qualifications. There's
11 been no foundation laid establishing that he has any
12 expertise on causation. So on those two fronts, the
13 testimony shouldn't be permitted. And if you're inclined
14 to permit it, the defense requests the opportunity to voir
15 dire the witness.

16 MR. EGLET: Well, first of all there's no reason
17 to voir dire. First of all, the Nevada Supreme Court has
18 made it clear, abundantly clear in multiple Supreme Court
19 cases that, in fact, it is a medical doctor and only a
20 medical doctor who can give testimony regarding medical
21 causation. So as far as qualifications go, he's clearly
22 qualified. He's been accepted by -- as an expert in this
23 court, and he's qualified.

24 Second of all, with respect to the foundation,
25 again Counsel is wrong because every doctor -- I mean I've

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1 never had a case where the doctor was standing there
2 witnessing the accident. I've never had a case where the
3 doctor went out and looked at the -- you know, has studied
4 the scene of the accident and did crush-damage studies of
5 the cars. You know, he's basically trying to argue, well,
6 he's not a biomechanical engineer. Well, so what. Guess
7 what? The Supreme Court has said, in fact, it's a doctor
8 who gives medical causation, not a biomechanical engineer.
9 The doctor, like every doctor's causation opinion is based
10 upon the patient's history. He's already testified that
11 the patient gave him the history of the motor-vehicle
12 accident, period. That's all that's necessary. In other
13 words, he was pain free, which he testified, before this
14 accident. Immediately subsequent to the accident, he
15 became painful in these areas and remained painful when he
16 saw him, and his diagnostic studies show he isolated these
17 discs as the pain generators. The foundation has been
18 laid, Your Honor.

19 THE COURT: I think it has. The objection is
20 overruled. Noted for the record, Mr. Rogers.

21 MR. ROGERS: May I just make an offer of proof
22 then?

23 THE COURT: Sure.

24 MR. ROGERS: Okay. And the offer of proof is
25 that the doctor will establish either admittedly or on

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1 questioning that he doesn't know the first thing about this
2 accident. He's got to know something. I'm confident that
3 while Mr. Eglet has never seen a case, as he says, where a
4 doctor hasn't been permitted to testify, he's also never
5 seen a case where a doctor hasn't been asked a single
6 question about the incident to establish some foundational
7 understanding of the thing to which he's attributing cause.
8 None of that has been laid.

9 THE COURT: Do you want to respond, Mr. Eglet?

10 MR. EGLET: None of that has to be relayed. He
11 bases his opinion upon the patient history, which every
12 doctor does. It's what doctors base their opinions on and
13 their conclusions.

14 So the -- he doesn't have to know exactly what
15 the speed of the vehicles was, how much crush damage or
16 anything else. It's based upon the patient history, that
17 he had no symptomology before this. The trauma occurred,
18 and suddenly the symptomology occurred with the -- at the
19 time of or shortly after the traumatic event. That's all
20 that's necessary, Your Honor.

21 THE COURT: I think we've made our record.

22 Can we bring our jury in?

23 MR. EGLET: Yes, you can.

24 [Jury In]

25 THE COURT: Can't start without Ms. Prince.

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1 Okay. Now, please be seated, ladies and
2 gentlemen.

3 Will counsel stipulate to the presence of the
4 jury?

5 MR. EGLET: Yes, Your Honor.

6 MR. ROGERS: Yes, Your Honor.

7 THE COURT: Very well.

8 Mr. Eglet?

9 MR. EGLET: Thank you, Your Honor.

10 BY MR. EGLET:

11 Q Okay, Doctor. The question that was pending --
12 let me repeat it for you -- when we took the break was
13 after your extensive pain management evaluation and review
14 with the patient and examinations and diagnostic cervical
15 spine injections of Mr. Simao during discography, have you
16 reached any conclusions with respect to what injuries he
17 sustained directly and causally as a result of the April
18 15th, 2005 motor-vehicle crash?

19 A Yes, sir.

20 Q And what are your conclusions?

21 A My conclusions are that the patient's
22 symptomology he was presenting to me and his subsequent
23 treatment are more likely than not related to the
24 motor-vehicle accident.

25 Q Okay. And specifically what was -- what is your

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1 conclusions regarding the diagnosis of his specific
2 injuries?

3 A It is my impression that the patient sustained as
4 a result of the motor-vehicle accident in 2005
5 post-traumatic disc disruption with a subsequent
6 development of severe cervical symptoms which were not
7 amenable to conservative treatment without his physical
8 therapy injection therapy were finally diagnosed with
9 discography study.

10 Q And are your conclusions regarding causation of
11 these injuries more likely right than wrong?

12 A More likely right.

13 Q And beyond that are you certain?

14 A I'm certain.

15 Q Okay. And would you please explain for us how
16 you causally relate the diagnosis you have just detailed
17 for us to Mr. Simao's April 15th, 2005 motor-vehicle crash?

18 A Well, when I saw the patient first in 2008 in his
19 initial visit, he related his symptomology to this
20 motor-vehicle accident in 2005. To my knowledge -- and the
21 patient deny it -- that there was a history of similar such
22 symptoms prior to this motor-vehicle accident in 2005. The
23 patient had not seen a pain specialist prior to the
24 motor-vehicle accident in 2005. He had not undergone any
25 imaging scan, such MRI scan. He had not undergone any

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1 injection therapy, diagnostic blocks for cervical pain. He
2 was not complaining of these symptoms then was involved in
3 this motor-vehicle accident and subsequently developed
4 these symptoms as a result of this motor-vehicle accident.

5 Q Now, has the medical care and treatment rendered
6 by you to Mr. Simao that you have described for us here
7 today been necessary, reasonable and causally related to
8 the injuries he sustained from the April 15th, 2005
9 motor-vehicle crash?

10 A Yes, sir.

11 Q Okay.

12 MR. EGLET: Could I have Volume I of Plaintiff's
13 exhibits, please. Just the whole volume. Thank you.

14 [Pause]

15 MR. EGLET: If I may approach the witness, Your Honor?

16 THE COURT: Yes.

17 BY MR. EGLET:

18 Q Doctor, I'm handing you Volume I of Plaintiff's
19 exhibits, and I'm going to turn to tab 16 which is a tab
20 which contains your medical billing for all of the
21 treatment and procedures you've rendered to Mr. Simao.

22 A Yes, sir.

23 Q Okay. Does that look like your medical billing
24 from your clinic?

25 A Yes.

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1 Q And was the billing associated with the treatment
2 you provided to Mr. Simao customary and reasonable for
3 patients in Clark County, Nevada?

4 A Yes, sir.

5 Q Are your conclusions regarding the care you
6 rendered to Mr. Simao and its associated costs more likely
7 true than not true?

8 A More likely true, sir.

9 Q And beyond that are you certain?

10 A Yes, sir.

11 Q Okay. The total amount for your billing for the
12 various treatments you provided him is -- how much is that,
13 the total there at the bottom?

14 A It's seven thousand three hundred and seventy-one
15 dollars and zero cents.

16 Q Okay. Have all the conclusions you have shared
17 with us here today been to a reasonable degree of medical
18 probability?

19 A Yes.

20 Q And by that do you mean that your conclusions are
21 based upon medical reason?

22 A Yes.

23 MR. EGLET: Thank you, Doctor.

24 Thank you, Your Honor. I pass the witness.

25 THE COURT: Okay. Mr. Rogers?

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1 MR. ROGERS: May we approach while he switches --

2 THE COURT: Sure.

3 [Bench Conference Not Transcribed]

4 THE COURT: There were some questions submitted
5 by some of the jurors, Doctor. I want to read them into
6 the record and then allow you an opportunity to answer them
7 if you can.

8 THE WITNESS: Sure.

9 THE COURT: The first one reads, "Does a MRI show
10 the age of the torn/bulging disc is?"

11 THE WITNESS: No, it does not necessarily show
12 this. The MRI can show some longstanding chronic
13 degenerative changes due to degenerative disc, but it
14 doesn't have to. In older folks who have severe disc
15 degeneration with loss of disc height, over time there can
16 be a remodeling of the adjacent vertebral bodies in between
17 the disc is located, and we call it modic changes that
18 would be indicative of -- indicate -- it would be
19 indicative of a longstanding degenerative process. But
20 that doesn't necessarily have to be on the MRI scan. In
21 other words, if I see a disc protrusion on the MRI, it
22 doesn't necessarily -- or it cannot necessarily tell me
23 whether this is a longstanding, degenerative or acute.

24 THE COURT: Okay. Thank you.

25 A follow-up question: "Can a torn or bulging

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1 disc cause or make migraine headaches worse?"

2 THE WITNESS: Yes, it can. Any type of pain in a
3 patient with chronic migraines can cause a worsening of the
4 migraine, can cause more frequent migraine attacks, can
5 cause a longation (sic) of migraine attacks.

6 THE COURT: Okay. Next question, Doctor: "Does
7 Dr. Rosler have hospital privileges at Centennial Hills
8 Hospital? If no, why not? I did not hear him mention this
9 hospital."

10 THE WITNESS: I don't have privileges at
11 Centennial Hills Hospital. I don't intend to go over
12 there. It's very impractical to be all over town
13 especially in this town where traffic is so bad. So I kind
14 of try to be more central. So, no, I don't have hospital
15 privileges there. And also it's a fairly new hospital. So
16 I did not really make an effort to get on staff there.

17 THE COURT: Okay. And final question: "Could
18 dye, D-Y-E, cause continued pain after discography and for
19 how long?"

20 THE WITNESS: A very good question. It's a
21 provocative test, and the dye in the disc is causing pain.
22 And that typically takes 24 to 48 hours, the exacerbation
23 of the pain until the pain settles back to baseline level.
24 So, yes, it can cause a brief period of increased pain,
25 more than usual.

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1 THE COURT: Do the attorneys have any follow-up
2 questions based on these questions and answers?

3 MR. EGLET: No, Your Honor.

4 MR. ROGERS: I'll follow up during my cross, Your
5 Honor.

6 THE COURT: Okay. Now I'll ask these be marked
7 as Court's Exhibits 1, 2 and 3.

8 Now, Mr. Rogers, wherever you're ready.

9 MR. ROGERS: Very good.

10 CROSS-EXAMINATION

11 BY MR. ROGERS:

12 Q Doctor, how are you?

13 A I'm doing fine. Thank you, sir.

14 Q Very good. I'm going to remain seated for the
15 better part simply because I have a lot of paper to juggle.

16 Now, first off, have you ever published on the
17 subject of cause of injury from a car accident?

18 A No, sir.

19 Q Do you have any specialized training in a field
20 relating to cause of injury from a car accident?

21 A No, sir.

22 Q You base your opinion, as you testified a moment
23 ago, on the patient's word?

24 A I base my opinion on the history the patient has
25 given to me, yes, sir.

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1 Q Which is the patient's word? That's what he told
2 you?

3 A Yes, sir.

4 Q Is there a proven measure of reliability of this
5 method, relying on the patient's word?

6 A Well, we are trained in medical school in our
7 training that the most important aspect of evaluating a
8 patient is taking a history and listening to the patient --

9 Q Oh, this question doesn't go to your evaluation.
10 It goes to your causation opinion. Is there a proven
11 measure of the reliability of reaching a causation
12 determination based on the patient's word?

13 A Not to my knowledge, sir.

14 Q The medical field hasn't tested the reliability
15 of this method?

16 A It may have, but it's not to my knowledge, sir.

17 Q You're not aware of any scientifically-proven
18 tests or data or research on the reliability of reaching a
19 causation determination based upon the patient's word?

20 A Not to my knowledge, sir.

21 Q Well, is a causation based on the patient's word
22 a scientific method formed and controlled then by known
23 standards in the medical field?

24 A I don't understand the question.

25 Q Well, much of what you do in medicine is governed

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1 by formed and controlled standards, things that have been
2 done in the past and tested for reliability.

3 My question goes to your opinion on causation.
4 Has your causation opinion, which is based on the patient's
5 word, been proven reliable as a scientific method through
6 formed and controlled standards and protocols?

7 MR. EGLET: Objection. Compound.

8 THE COURT: Could counsel approach, please, off
9 the record.

10 [Bench Conference Not Transcribed]

11 BY MR. ROGERS:

12 Q If I understand your testimony, Doctor, from the
13 direct examination, you really don't know anything about this
14 car accident.

15 A All I know what -- is what the patient told me, sir.

16 Q Which was that he was involved in a rear end
17 accident.

18 A Correct.

19 Q And beyond that, you don't know anything.

20 A That he hit his head on a metal cage, and that he
21 subsequently developed symptoms of neck pain.

22 Q With regard to hitting or bumping his head, do you
23 know if there were any signs of trauma?

24 A Well, obviously, the patient underwent a subsequent
25 scanning of the brain. So there was some worry to -- that

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1 there might have been some significant trauma. And to rule
2 that out, these imaging scans were done. Obviously, I was not
3 there at the time of the accident, so I can't --

4 Q That scan did rule it out, actually. My question is
5 are you aware of any affirmative or positive signs of trauma
6 as a result of bumping his head?

7 MR. EGLET: Objection, asked and answered.

8 THE COURT: Sustained.

9 MR. ROGERS: Your Honor, he didn't answer.

10 MR. EGLET: Objection. I think you ruled, Your Honor.

11 THE COURT: I think he did answer, Mr. Rogers.

12 BY MR. ROGERS:

13 Q So beyond the CT scan that was normal, you're not
14 aware of any findings with regard to this bumping of the head?

15 A That's correct, sir.

16 Q Do you know anything about what happened to Jenny
17 Rish and her passengers in this accident?

18 MR. EGLET: Objection, irrelevant, Your Honor. Pretrial
19 motion on this.

20 THE COURT: It is. Sustained.

21 BY MR. ROGERS:

22 Q To the extent that your patient would have provided
23 an incorrect history, your opinion on cause is compromised,
24 correct?

25 A Correct, sir.

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1 Q He told you that he had experienced neck pain ever
2 since the car accident.

3 A The patient stated that he developed symptomatology
4 of neck pain after the car accident.

5 Q And your understanding was that that neck pain
6 persisted from the date of the accident forward.

7 A No.

8 Q Oh, it was not?

9 A My understanding was that the patient was initially
10 evaluated for severe headaches and then subsequently developed
11 neck symptoms that he developed over a period of time.

12 MR. ROGERS: Just one moment here.

13 BY MR. ROGERS:

14 Q So in your record, which counsel has been showing
15 the jury, where it reads that he hit his -- hit the back of
16 his head on the metal cage on the vehicle upon impact, and
17 since this accident, has been suffering from neck pain, what
18 -- that didn't mean that your understanding was that he'd been
19 experiencing neck pain ever since the accident?

20 MR. EGLET: Objection, argumentative, Your Honor. The
21 record speaks for itself.

22 THE WITNESS: It was my understanding that the patient
23 hit his head and developed cervical symptomatology as the --
24 as a result of the motor vehicle accident. Now I don't -- I
25 can't state that the patient had, immediately thereafter,

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1 throughout the whole period of time, always in the same
2 quantity and intensity of pain. But what was important for me
3 to know is that the patient developed these symptoms as a
4 result of a motor vehicle accident -- of this motor vehicle
5 accident.

6 Q Did you meet with Plaintiff's counsel in preparation
7 for today's testimony?

8 A Yes, sir.

9 Q Did they discuss with you the fact that there were
10 no neck complaints for nearly six months following the date of
11 the incident?

12 MR. EGLET: Objection, Your Honor. That misstates the
13 evidence in this case.

14 THE WITNESS: I was --

15 THE COURT: Ask you to rephrase the question, Mr. Rogers.
16 Sustain the objection.

17 MR. ROGERS: Okay.

18 BY MR. ROGERS:

19 Q Were you advised by Plaintiff's counsel that
20 following the date of the incident, there was a period of
21 nearly six months during which neck complaints were never once
22 reported in the medical records?

23 A I was aware of that.

24 Q Okay. When were you made aware of that?

25 A By looking through charts, preparing for this

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1 testimony.

2 Q So you were made aware of that after you filled out
3 this report in April of 2008, in which you wrote that he's
4 been experiencing neck symptoms since the car accident?

5 A Since the car accident, in fact -- or in a sense
6 that prior to the car accident, he did not complain of any
7 neck symptoms.

8 Q Doctor, if the Plaintiff did not complain of neck
9 symptoms for nearly six months following the date of the
10 accident, wouldn't that decrease the likelihood that this car
11 accident caused a neck injury?

12 MR. EGLET: Objection. It misstates the evidence in this
13 case, Your Honor.

14 THE COURT: Counsel, approach, please.

15 [Bench Conference Not Transcribed]

16 BY MR. ROGERS:

17 Q If following the date of this accident the Plaintiff
18 did not complain of neck pain for a period of nearly six
19 months, wouldn't that decrease the likelihood that traumatic
20 neck injury was caused by the accident?

21 MR. EGLET: Same question, same objection that was just
22 sustained, Your Honor.

23 THE COURT: It's exactly the same question. The
24 objection is sustained again.

25 MR. ROGERS: I'll try again.

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1 BY MR. ROGERS:

2 Q Doctor, you're aware, given your meeting last night
3 with Plaintiff's counsel, of the medical records following the
4 accident.

5 MR. EGLET: Objection, misstates his testimony. He did
6 not meet with us last night. He didn't say that.

7 THE COURT: I don't know --

8 MR. EGLET: He didn't say that. He asked him that, and
9 he didn't say that.

10 THE COURT: No, he didn't. Sustain the objection.

11 BY MR. ROGERS:

12 Q You're aware of the medical records immediately
13 following the car accident now, aren't you?

14 A Yes, sir.

15 Q You weren't when you were treating the Plaintiff.

16 A That is correct.

17 Q You're aware, from those records, that on the date
18 of the incident, that he was diagnosed with a neck sprain,
19 correct?

20 A Correct.

21 Q And you're aware that for nearly six months
22 following the date of the incident, he never once complained
23 of neck pain to any of his providers.

24 MR. EGLET: Objection, misstates the evidence, Your
25 Honor.

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1 THE COURT: It does, sustained.

2 MR. EGLET: Lack of foundation.

3 THE COURT: Sustained.

4 BY MR. ROGERS:

5 Q Doctor, did you see anywhere in the Southwest
6 medical records, between the date of the incident through
7 October, nearly six months following the incident, where he
8 complained of neck pain?

9 MR. EGLET: Objection, lacks foundation. May we
10 approach, Your Honor?

11 THE COURT: Yes.

12 [Bench Conference Not Transcribed]

13 BY MR. ROGERS:

14 Q Let me try it this way, see if this is permissible.
15 When you were made aware that the Plaintiff didn't complain of
16 neck pain for a period of time following the incident, didn't
17 that, even in the slightest amount, in your view, decrease the
18 likelihood that traumatic injury was caused by this accident?

19 MR. EGLET: Objection to the question, no -- lack of
20 foundation.

21 THE COURT: I'll allow it.

22 THE WITNESS: Well, the initial diagnosis was a cervical
23 strain. So there was a complaint of neck symptoms. The
24 patient had severe headaches. It's not unusual for traumatic
25 injuries to the spine -- to the intervertebral discs of the

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1 cervical spine to take some time to develop to become
2 symptomatic, especially if you have overlying other problems,
3 such as his increased migraine symptomatology that overshadows
4 the pain. So it's not unusual for the patient, or for a
5 patient in general, to develop those symptoms gradual (sic)
6 over a period of time.

7 BY MR. ROGERS:

8 Q So you're telling this jury that when you discovered
9 this new information, it had no effect at all on your opinion?

10 A Yes, sir.

11 Q All right. And that's despite the fact that you
12 previously thought the pain was continuous?

13 MR. EGLET: Objection, Your Honor, misstates his prior
14 testimony and it's argumentative.

15 THE COURT: Sustained.

16 MR. EGLET: That's not what he said.

17 THE COURT: Sustained.

18 BY MR. ROGERS:

19 Q No. Plaintiff's counsel pointed out that the
20 Plaintiff did not tell you about his preexisting history of
21 headaches when you first met him, is that correct?

22 A That's correct, sir.

23 Q Are you aware what medication the Plaintiff was
24 taking for those headaches right before the accident?

25 A Well, the patient was complaining of migraines. And

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1 I am not aware of the exact type of mi- -- but I assume that
2 the patient took some medication to alleviate his migraines.
3 But that doesn't -- in this respect, it doesn't influence my
4 judgment.

5 Q Are you aware that he was taking Butalbital?

6 MR. EGLET: Objection asked and answered. He just said
7 he wasn't aware of what he was taking.

8 MR. ROGERS: Well, I'm -- I never --

9 THE COURT: Overruled. I'll allow it.

10 BY MR. ROGERS:

11 Q Okay. Now that you're aware of that, you're aware
12 too that Butalbital is a medication commonly prescribed for
13 tension headaches?

14 A It can be prescribed for tension headaches. It can
15 also be described for some other type of headaches, migraine
16 type headaches.

17 Q When the Plaintiff presented to you, did he have the
18 classic aura commonly associated with migraines?

19 A I'm sorry?

20 Q When the Plaintiff presented to you, did he ever
21 complain of the aura commonly associated with migraines?

22 A No, I have not asked him this. I don't --

23 Q Did he ever complain of unilateral or one-sided
24 headaches?

25 A He complained of occipital headaches.

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1 Q You've said that. But go to 32, page 1. The pain
2 diagram doesn't look like occipital headaches here.

3 MR. EGLET: Objection, Your Honor.

4 BY MR. ROGERS:

5 Q It covers --

6 MR. EGLET: Counsel is testifying.

7 MR. ROGERS: I'm cross-examining.

8 THE COURT: Well, ask you to rephrase the question,
9 Mr. Rogers.

10 BY MR. ROGERS:

11 Q You see how the pain covers not just the occipital
12 shelf, the lower base of the skull. It goes entirely over the
13 top of the head. And it appears that the front of the head is
14 covered as well on the left image.

15 A I don't see the front of -- but often, you have
16 occipital headaches. And occiput is the back of the head.
17 And it's radiating up into the higher areas of the occiput.
18 So I think this is a very consistent drawing of patients with
19 occipital headaches.

20 Q It could also be consistent with a tension type
21 headache.

22 A I think it's more specific for occipital headaches,
23 because tension type headaches typically also are radiating
24 into the parietal region, into the front of the head. And I
25 don't really see a pain drawing there that would show this.

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1 Q You weren't aware that the Plaintiff complained of
2 pain radiating to the occipital and frontal areas following
3 this accident?

4 A Of the occipital areas I was aware, yes.

5 Q What about the front?

6 A No.

7 Q But if he did complain of pain toward the front,
8 that would be more consistent with a tension headache.

9 A It could also be consistent with a migraine type
10 headache.

11 Q So it sounds like we don't know what kind of
12 headache it was, is that correct?

13 A I think the patient clearly described occipital
14 headaches following this accident in -- apparently, he's a
15 migraine headache suffering, and which he did not tell me at
16 that time.

17 Q Do you know anything about his pre-car accident
18 medical history as it relates to these headaches?

19 A No.

20 Q Do you know then whether the headaches that he
21 complained of following the car accident were simply a
22 progression of his preexisting headaches?

23 A What I believe is that with the car accident he
24 exacerbated his migraine type headaches, which became of a
25 significant intensity and overshadowed his underlying cervical

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1 injuries and pain that subsequently developed over a period of
2 time.

3 Q And you believed this, as you've said, without
4 knowing anything about his pre-accident headaches.

5 MR. EGLET: Objection, argumentative, Your Honor.

6 THE COURT: It is. Sustained. Ask you to rephrase.

7 BY MR. ROGERS:

8 Q Your belief is based on no understanding then of
9 what his preexisting condition was.

10 MR. EGLET: Same objection, Your Honor.

11 THE COURT: Same ruling. Sustained.

12 BY MR. ROGERS:

13 Q When the Plaintiff presented to your office, as
14 we've discussed, it wasn't until roughly three years after
15 this car accident. And before he came to you, he visited your
16 partner, Dr. Grover, right?

17 A Yes, sir.

18 Q At the time, you worked for Dr. Grover?

19 A I never worked for Dr. Grover, sir. I'm an
20 independent practitioner.

21 Q But you share office space with him?

22 A That is correct, sir.

23 Q And then you work in -- at a surgicenter that he
24 owns?

25 A That's correct, sir.

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1 Q Now when he referred the Plaintiff to you, he
2 recommended not only selective nerve root blocks but facet
3 blocks. You never did those, is that right?

4 A A possible facet block. I did the selective nerve
5 root blocks, and the patient followed up with Dr. Grover
6 again, who then recommended -- was his impression to recommend
7 cervical discography study, which I then performed.

8 Q So the answer is no, the facet blocks were never
9 performed.

10 A That is correct.

11 Q He also -- Dr. Grover -- suggested an EMG. To your
12 knowledge, that was never done either.

13 A Not to my knowledge, sir.

14 Q Now as we turn to the MRI, you've had a discussion
15 with Plaintiff's counsel about how the one you observed from
16 September 2007 was interpreted as a normal study, right?

17 A Normal study for age, I believe, yes.

18 Q Right. You also reviewed the prior MRI. And did
19 that -- could that MRI also be interpreted as a normal study
20 for age?

21 A Well, I saw some facet tropism which I had pointed
22 out earlier.

23 Q Right. And aside from the facet tropism, the other
24 MRI appeared normal for age.

25 A Appeared to be, yes, sir.

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1 Q And the fact tropism, just so that the jury gets it
2 -- I didn't know this before. What it means is an arthritic
3 or overgrowth of that joint through which the nerve root
4 exits, right?

5 A Not necessarily. It means an asymmetry of the facet
6 joints, which can be congenital by birth, but it also can come
7 as a part of aging. However, there is a clear difference if
8 you have a face inflammation facet arthropathy. You wouldn't
9 call it face tropism.

10 Q Okay. So whether it's congenital, so from at birth,
11 or it's degenerative like arthritis, the point is that that
12 foramen or that hole through which the nerve root travels was
13 constricted, right?

14 A Yes, sir.

15 Q All right. And that condition was not caused by
16 this car accident.

17 A Well, we're talking about two things. We're talking
18 about condition and about symptoms. And --

19 Q I'm focusing on condition at this point.

20 MR. EGLET: Can the witness --

21 BY MR. ROGERS:

22 Q We'll get to symptoms soon.

23 MR. EGLET: -- answer the question, Your Honor?

24 THE COURT: I think so. He was about to.

25 MR. ROGERS: The question was as to condition.

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1 MR. EGLET: Your Honor, he's arguing with the Court now.

2 THE COURT: I think the witness should be allowed to
3 answer the question.

4 BY MR. ROGERS:

5 Q Go ahead.

6 A Now I lost my train of thought.

7 THE COURT: If you remember.

8 BY MR. ROGERS:

9 Q Do you want me to start over? Okay. My question
10 was that whether that tropism in the facet joint that
11 constricted that nerve root was there from birth or it was
12 there due to arthritis, whatever the cause, it wasn't this car
13 accident.

14 A The -- that is correct. That is correct.

15 Q Okay. And the conditions that you observed on the
16 MRI aside from that facet tropism can exist without a single
17 traumatic event, like a car accident.

18 A Well, there's no such condition on the MRI scan.
19 It's a finding. But again, we don't look at an MRI scan and
20 come up with a diagnosis. We look at an MRI scan and put this
21 in consideration with the presentation of the patient, with
22 his complaints, with his -- with a physical examination. So
23 as I pointed out earlier, you can have a normal MRI with no
24 evidence of any disc tearing. But in a patient who's
25 complaining of severe neck pain. So we have to put the

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1 symptomatology, the presenting symptoms, and the MRI scan into
2 consideration. And the same thing with the facet tropism. It
3 may have been there for many years, but the patient did not
4 have any symptoms.

5 Q Now that you bring this up about the MRIs, the
6 Plaintiff had two of them before he came to see you. We've
7 discussed both of them. And I believe one was performed by
8 the MRI group that Dr. Grover, your partner, owns. Did you
9 see that MRI?

10 A I believe so, but I'm not 100 percent sure.

11 Q If that MRI taken by Dr. Grover's office did show
12 tears and the other MRIs didn't, doesn't that increase the
13 likelihood that those tears developed subsequent to the car
14 accident?

15 A I had to look at both MRIs, obviously, to compare
16 if there are tears. I'm not entirely sure that there were
17 even tears on the second MRI. It was performed at the --

18 Q There weren't.

19 A There weren't.

20 Q The one in 2007.

21 A Yes.

22 Q Okay. Now Dr. Grover hired you or uses you as an
23 independent contractor in his office to perform the injections
24 that you've described to this jury, correct?

25 A He doesn't use me. He's ask me to perform the

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1 injection as a --

2 Q I didn't mean that in a derogatory way at all. What
3 I mean is that's the purpose for your presence there, is to
4 perform those tasks for that office.

5 A No, not necessarily. The purpose of me in this
6 office is to evaluate patients who are in pain and treat
7 patients who are in pain. And we have an office that offers
8 comprehensive spinal care, which includes pain management
9 modalities, including injection therapy, as well as surgical
10 modalities.

11 Q Dr. Grover is the surgeon, right?

12 A Yes, sir.

13 Q He doesn't do the epidurals or selective nerve root
14 blocks. You do.

15 A That is correct, sir.

16 Q Is there a reason that Dr. Grover isn't doing them
17 himself?

18 A Well, Dr. Grover has no training to do these
19 injections, just like I don't have training to perform
20 surgery.

21 Q Okay. How many selective nerve root blocks like the
22 one you performed on the Plaintiff have you performed over
23 your career?

24 A Many and hundreds.

25 Q How long does a selective nerve root block procedure

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1 take?

2 A Anywhere between five to eight minutes I would say.

3 Q I want to discuss your testimony regarding the
4 findings from that selective nerve root block. You were asked
5 by Plaintiff's counsel what the significance was of the
6 Plaintiff's drop in pain from a six of 10 to a one of 10
7 during the procedure or immediately following it. You recall
8 that testimony?

9 A Yes.

10 Q Isn't it true that you don't consider the
11 Plaintiff's immediate pain relief or response to be
12 diagnostic?

13 A I don't consider the patient's immediate pain relief
14 therapeutic in a sense that the patient got -- will get long-
15 term pain relief. The patient received very short term pain
16 relief, which immediately told me that his symptomatology has
17 not gotten worse. And in fact, it has improved immediately,
18 which is due to the local anesthetic. On his follow-up visit,
19 he was having ongoing cervical symptoms. And it was my
20 impression, therefore, that the injection therapy was not
21 helpful to alleviate the patient's symptomatology.

22 Q Isn't it true that an immediate pain response
23 following the injection does not tell you whether the block
24 has worked or not?

25 MR. EGLET: Objection to -- vague and ambiguous to work,

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1 because there's two -- it's diagnostic as well as therapeutic.
2 So what does he mean by worked.

3 THE COURT: Well, let's have some clarification.

4 BY MR. ROGERS:

5 Q Isn't it true that patient's pain response right
6 there in the surgicenter does not tell you whether the
7 injection has been diagnostic?

8 A Well, the patient -- medication was injected on that
9 particular level, on two levels in this case, C3/4 and C4/5
10 from the left side for the respective C4 and C5 selective
11 nerves, the spinal nerves. And he got an immediate pain
12 response. Or in terms of lessening of the symptomatology,
13 which is contributed to the local anesthetic that was used in
14 that area. But he failed to improve over a period of time.
15 And the main -- what I mainly want to do is to see if I can
16 get the patient better with the injection therapy, and that
17 has not proven successful.

18 Q Isn't it true that you wait until the follow-up
19 procedure to make any determination about whether that
20 injection was diagnostic?

21 A Well --

22 MR. EGLET: Objection. It's vague and ambiguous.
23 Diagnostic of what?

24 THE COURT: Ask for some clarification, Mr. Rogers.

25 MR. ROGERS: Is -- okay.

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1 BY MR. ROGERS:

2 Q As to whether the levels that you've just injected
3 are, in fact, the pain generators.

4 A Well, it wasn't diagnostic enough, because we then,
5 subsequently, did the discography study, which then correlated
6 with the result from the selective nerve root block. So we
7 have the positive discography study at those two levels, and
8 we have a very short term improvement, which is contributed to
9 the local anesthetic from those two blocks. And that combined
10 was giving us the information where the pain was coming from.

11 Q I'll get into the discogram shortly. But my
12 question is this. Didn't Dr. Grover determine that that
13 injection was not diagnostic, and on that basis, he ordered
14 that discogram?

15 A I just stated it was not diagnostic enough to
16 satisfy -- to make -- come up with a firm diagnosis. And that
17 is why you proceed with the discography study, to be certain.
18 And then you, once you have done the discography study, you
19 compare those two procedures and see if there's a correlation.

20 Q So if Plaintiff counsel's questions hypothetically
21 gave the impression that it dropped from six to 10 to one of
22 10, suggested that that selective nerve root block was
23 diagnostic, that suggestion was mistaken.

24 MR. EGLET: Objection, argumentative.

25 THE COURT: I'll allow it. I'll allow it.

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1 THE WITNESS: I don't think that it's a suggestion. It's
2 not a definitive answer. It's a suggestion that the pain
3 might be generated from those two level. And then Dr. Grover
4 recommended to further proceed with a -- the diagnostic
5 discography study.

6 BY MR. ROGERS:

7 Q You never found that the Plaintiff was experiencing
8 nerve root problems, correct?

9 A But the patient was having radiating pain in his
10 arms, in his left arm, which is caused by a radiculopathy,
11 which is a nerve root irritation.

12 Q However, the only nerve root issue with regard to
13 that facet tropism was at C4, right?

14 A It was -- there was facet tropism on two levels.

15 Q Okay. Did those level innervate the area in the arm
16 that the Plaintiff complained of?

17 A Facet joints don't innervate the area.

18 Q Not the joint but the tropism, meaning the
19 constricting of those nerve roots.

20 A That's not necessarily a constriction of the nerve
21 roots. There might be some narrowing of the canal. If there
22 had been a constriction of the nerve root with this tropism,
23 the patient would have probably had these symptoms a long time
24 ago, because we're talking about either a degenerative process
25 or a congenital process that's been going on for a long time,

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1 and the patient was asymptomatic.

2 Q Well, the Plaintiff's attorney discussed bulges,
3 protrusions, and things like that in the disc. Did you see
4 any evidence that any nerve roots were being impinged or
5 encroached?

6 A Well, as I pointed out earlier, it was my impression
7 that we are not talking about a radiculopathy that is causing
8 about an impingement, a mechanical radiculopathy but, rather,
9 a chemical radiculopathy due to a disrupted disc.

10 Q So no, there were no impingements or encroachments
11 of the nerve roots, causing radicular symptoms.

12 A I did not see any.

13 Q Okay. Now let's turn to the discography. You
14 discussed problems with false positives on this study,
15 correct?

16 A Yes, sir.

17 Q What that means, just for clarification for the
18 jury, is that someone can have a positive response, meaning a
19 painful response, where there really is no physiological
20 problem.

21 A That is correct. That -- I had pointed that out.
22 Yes, sir.

23 Q Chronic pain syndrome can be a risk factor for false
24 positives, correct?

25 A It could conceivably be a risk factor. That is

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1 correct, sir.

2 Q There was also higher incidents of false positives
3 where patients have problems in the spine unrelated to the
4 discs.

5 A I don't understand your question.

6 Q Okay. You're a member of ISIS, correct?

7 A Yes, sir.

8 Q Do you subscribe to the proposition that cervical
9 discography is indicated to test discogenic pain of the
10 cervical spine in individuals who have been properly selected
11 and screened to eliminate other sources of cervical pain?

12 A Yes, sir.

13 Q The Plaintiff has a potential other source of
14 cervical pain in this facet tropism. Could that increase the
15 incidents of false positives on discography?

16 A Again, as I had pointed out, the patient was
17 asymptomatic in the past. And the facet tropism is obviously
18 something that is either of a degenerative nature that takes a
19 long time to come on, or a congenital nature by both. So he
20 would, therefore, have these symptoms long time ago. He
21 didn't have any symptoms. Also, the discography study then
22 showed that there was annular tearing and there was concordant
23 pain reproduction. And I pointed out that this is a procedure
24 that has to be done judiciously and carefully, which I believe
25 was performed with this patient.

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1 Q Let's discuss that concordant issue. The Plaintiff
2 never once complained of pain at 10 of 10 until you performed
3 the discography.

4 A Correct.

5 Q His pain was six of 10. You said that concordant
6 means reproduction of the same pain.

7 A Well, that -- it was an average between six to seven
8 out of 10. It is important to document the same pain as it
9 relates to the distribution of the pain. Obviously, as
10 everybody stands, this is a painful disc and I inject -- if
11 it's a painful disc without any pressurization, and I inject
12 dye into a painful disc, it's obviously -- it's obvious that
13 this will exaggerate the patient's normal pain. What's
14 important is does it follow the usual pattern, and that it
15 did. I absolutely expecting the discograms I do and the few I
16 do in the cervical spine and in the lumbar spine, they all
17 have increased pain that is often worse than their usual
18 baseline pain. It's a provocative test.

19 Q Let's talk about that CT that was taken after the
20 discogram. You discussed that with Plaintiff's counsel.

21 MR. ROGERS: Do we have a copy of that available, the CT
22 scan, the report?

23 UNIDENTIFIED SPEAKER: Exhibit number and a page number?

24 MR. ROGERS: Yeah. Let me take a look.

25 [Counsel Confer]

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1 BY MR. ROGERS:

2 Q Well, while we search for that, Doctor, do you
3 recall the discussion with Plaintiff's counsel?

4 A Yes, sir.

5 Q And you recall talking about seeing fissures in the
6 disc.

7 A Yes, sir.

8 Q Fissures, you said, are synonymous with tears.

9 A Yes, sir.

10 Q Only a tear sounds a little more traumatic. These
11 fissures, in other words, can exist without trauma.

12 A Absolutely. So can a tear.

13 Q Okay. It's Exhibit 30, page 2. All right. The
14 discogram was done at three levels. Two of them you found
15 were positive.

16 A Yes, sir.

17 Q The third was not.

18 A Yes, sir.

19 Q The third, which is the bottom of the three discs --
20 to show the jury, roughly, you know, C3/4, C4/5, C5/6, right,
21 just walking down?

22 A Yes, sir.

23 Q It was C5/6, the lower one, that you found was
24 negative.

25 A Yes, sir.

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1 Q However, at C5/6, there was a much bigger fissure
2 than there was at C3/4.

3 A Not much bigger. It was a grade five versus a grade
4 four tear, which is both a full thickness tears.

5 Q Yes.

6 A We're not talking about a grade one versus a grade
7 four tear.

8 Q So you can have these abnormalities without having a
9 painful disc.

10 A I have pointed it out before. Yes, sir.

11 Q And as you pointed out earlier, the films, whether
12 they're MRIs or CT scans, do not date the abnormalities in the
13 disc. You don't know how long that's been there.

14 A That is correct. A normal MRI scan take does not
15 rule out that there is a painful annular -- painful disc with
16 an annular tear.

17 Q What are some of the other risk factors for a
18 positive discogram -- or a false positive discogram? In other
19 words, why is it that this study can turn out to be false,
20 whereas an MRI or the others don't?

21 A Well, the MRI is an imaging study. It's a plain
22 imaging study. There's no interaction with a patient, with an
23 individual.

24 Q Okay. You could have false positives on any
25 injection then, right?

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1 A You can have false positives on any procedure in the
2 medical field. It has nothing to do with injections or
3 specific to injections. With any procedure -- you can get a
4 colon polyp that says it's cancer, and it's a false positive.

5 Q There's a placebo response to some of these
6 injections.

7 A That's correct, sir.

8 Q That would be one such false positive.

9 A Correct.

10 Q Well, the question is what's causing these false
11 positives? Why are they unlike films? In other words,
12 where's the error coming in?

13 MR. EGLET: Let me just object to the form of the
14 question. There's been no testimony that it's an error. It's
15 a false positive. There are two different things.

16 THE COURT: Ask you to rephrase it.

17 MR. EGLET: It's vague and ambiguous. I mean I -- what
18 procedure is he talking about.

19 THE COURT: Ask you to rephrase your question,
20 Mr. Rogers.

21 MR. ROGERS: We're talking about interactive injection
22 procedures.

23 MR. EGLET: Which one?

24 BY MR. ROGERS:

25 Q You're talking to the patient --

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1 MR. ROGERS: I'm not limiting it to one.

2 MR. EGLET: Well, then it's vague and ambiguous, because
3 you have --

4 THE COURT: Can I see counsel at the bench, please?

5 MR. EGLET: -- dozens of different procedures.

6 [Court Admonishes Jury]

7 [Bench Conference Not Transcribed]

8 [Recess]

9 THE MARSHAL: Please remain seated.

10 THE COURT: Okay. Back on record. Counsel stipulate the
11 presence of the jury?

12 MR. ROGERS: Yes, Your Honor.

13 MR. EGLET: Yes.

14 THE COURT: Mr. Rogers, whenever you're ready.

15 MR. ROGERS: Okay.

16 BY MR. ROGERS:

17 Q Let's see if I can speed things up. It's getting
18 close to the end of the day. We were talking about potentials
19 for false positives. Isn't it true that there -- that there's
20 a higher incident of false positives among workers
21 compensation claimants?

22 MR. EGLET: We just -- objection. Can we just have some
23 clarification. Are we talk about false positives in
24 discographies? In selective --

25 MR. ROGERS: Yes.

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1 MR. EGLET: -- nerve root blocks? What injury?

2 THE COURT: Sustained as to clarification.

3 BY MR. ROGERS:

4 Q You understand I'm asking discography?

5 A Okay.

6 Q Aren't there studies demonstrating that there are
7 higher incidents of false positives among workers
8 compensations claims among discography?

9 A I'm not aware of those studies. But I wouldn't
10 disagree.

11 Q Okay. What, then, is it about people in that
12 demographic that might bring this problem of false positives?

13 MR. EGLET: May we approach please, Your Honor?

14 THE COURT: Yes.

15 [Bench Conference Not Transcribed]

16 THE COURT: Okay. Back on record. The Court's inclined
17 to sustain the objection as to relevancy since this is not a
18 worker's compensation claim case.

19 MR. EGLET: Thank you, Your Honor.

20 BY MR. ROGERS:

21 Q Did you ever take the Plaintiff off work?

22 A Not that I recall. I may have after the procedure
23 and certainly for the procedure he was off work.

24 Q Do you know whether he was taking any time off work
25 while you were treating with him?

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1 A To my knowledge, the patient continued to work.
2 Q And you don't know anything about his employment?
3 A As I pointed out earlier, to my knowledge, he was
4 employed in the cleaning business.
5 Q Now, you found that the Plaintiff was debilitated
6 due to pain. Correct?
7 A Yes.
8 Q That he had a six or seven of ten of pain?
9 A Yes, sir.
10 Q How long had he had a six or seven of ten of pain?
11 A Throughout my interaction with the patient.
12 Q Okay. Well, your interaction began three years
13 after the incident.
14 A Yes, sir.
15 Q You don't know about his pain level before he
16 presented to you?
17 A I did not see the patient before, sir.
18 Q What pain medications was the Plaintiff taking when
19 he presented to your office?
20 A We -- off the top of my head, I don't know. I have
21 to look this up, sir.
22 Q Okay. Well, take a look.
23 A It's in our computer system in our office.
24 Q It's not in the chart you brought with you?
25 A No.

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1 Q Would it surprise you if he wasn't taking any pain
2 medications before he came to see you?

3 A Not necessarily, sir.

4 Q As far as you know then, he wasn't taking any pain
5 medications and he was going to work.

6 A That is correct.

7 Q Now, you wrote that he was in severe and
8 debilitating pain and yet he didn't get the surgery that he
9 ultimately got until a year after you saw him. Is that
10 right?

11 A That appears to be correct, sir.

12 Q Now, while he was in severe and debilitating pain,
13 he was still able to do floor cleaning?

14 A He was -- due to the fact that he had to make a
15 living, he was performing his work activities.

16 Q Could he do things like lift heavy objects?

17 A That was at the discretion of the patient if he
18 could do that or not, whether he could tolerate that, sir.

19 Q Well, that's my question is what's your
20 understanding of his tolerance. He's told you now that he has
21 pain at six to seven of ten.

22 A Well, he was in constant pain but yet he remained to
23 be employed and continued to work due to the fact that he had
24 to make a living. So he struck, I believe, a compromise which
25 is not unusual for patients who are in pain. They still work.

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1 Q Okay. Then could he lift heavy objects at that
2 time?

3 MR. EGLET: Objection. Asked and answered, Your Honor.

4 THE COURT: I believe it was answered. Overruled.

5 THE WITNESS: Well, again, as I had pointed out, it was
6 up to the patient whether his pain permits him to lift heavy
7 objects.

8 BY MR. ROGERS:

9 Q Doctor, that's the point of my question, is --
10 you're describing his pain to the jury. And I'm trying to
11 understand what that pain limited him from doing. Did it
12 limit him from lifting heavy objects?

13 MR. EGLET: Your Honor, he's -- objection. Asked and
14 answered. He's clearly answered the question now.

15 THE COURT: I think he may answer to the best of his
16 ability. I guess you can follow up if you wish. But I think
17 he's attempted to answer your question.

18 MR. ROGERS: Okay.

19 BY MR. ROGERS:

20 Q And same answer?

21 A Same what I said. I think his pain was his limiting
22 factor.

23 Q Okay. Could he go motorcycle riding?

24 A I don't know. I'm not aware of it.

25 Q So you don't really know the nature of his activity

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1 level at the time you were seeing him?

2 A Not to that extent, sir, whether he was riding a
3 motorcycle or any other activities.

4 Q You mentioned at the outset that you're board
5 certified. Are you board certified by the American Board of
6 Anesthesia?

7 A Yes, sir.

8 Q All right. Plaintiff's counsel discussed with the
9 jury before the trial began the fact that doctors were going
10 to get paid to appear. How much are you being paid?

11 A I get \$5000 for half a day, sir.

12 Q Let me ask you something, you've seen Dr. Grover's
13 records.

14 A Yes, sir.

15 Q They're from the same office you work at.

16 A That is correct, sir.

17 Q Are you aware that Dr. Grover testified that he had
18 concerns that the Plaintiff had inflated expectations of the
19 surgery?

20 A I'm not aware of that. But it doesn't surprise me
21 generally. We have the patients, they always think that
22 surgery is going to be the magical solution to it and have a
23 lot of hope, especially in patients who have been dealing with
24 pain for a long time. They just grasp any straw of hope they
25 can get. And often I see patients who have somewhat too

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1 optimistic hopes. That is not unusual.

2 Q Are you aware that Dr. Arita expressed the same
3 concern and recommended against surgery?

4 MR. EGLET: Your Honor -- objection because he -- this is
5 outside the scope. This witness hasn't read Dr. Arita's
6 deposition or even Dr. Grover's deposition. He's limited to
7 his records. Dr. Arita's records. He's limited to his -- to
8 treating physician. Period.

9 MR. ROGERS: This gets back to the question of false
10 positives, Your Honor.

11 MR. EGLET: Your Honor, he's asking about Dr. -- what Dr.
12 Arita testified to. He can ask Dr. Arita that when Dr. Arita
13 comes to testify.

14 THE COURT: Sustain the objection.

15 BY MR. ROGERS:

16 Q You at one time reported that due to the Plaintiff's
17 level of anxiety, monitored anesthesia care was provided.

18 A Yes, sir.

19 Q Does that elevated anxiety level contribute to the
20 potential for false positives on discograms?

21 A I wouldn't think so. It is -- I have -- most of my
22 patients are anxious, especially if they undergo a fairly
23 risky procedure which I have to tell them all the risks about
24 it. In fact, it's a normal, natural response to have an
25 elevated anxiety for undergoing this procedure.

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1 Q You've already testified that a discogram can be
2 positive for non-traumatic causes.

3 A Uh-huh.

4 Q And something unrelated to a car accident. Right?

5 A That is correct, sir.

6 Q Does the fact that the surgery evidently didn't work
7 because the Plaintiff claims that his pain continues raise any
8 questions in your mind about whether this discogram was a
9 false positive?

10 MR. EGLET: Objection. Beyond the scope, Your Honor.

11 THE WITNESS: It's beyond my scope.

12 THE COURT: I think it may be. Sustained.

13 MR. ROGERS: If I could have just a moment, Your Honor.
14 I may be done.

15 THE COURT: Sure.

16 MR. ROGERS: Thank you.

17 THE COURT: Very well. Mr. Eglet, any follow-up?

18 MR. EGLET: Yes. Thank you, Your Honor.

19 REDIRECT EXAMINATION

20 BY MR. EGLET:

21 Q Doctor, can a patient fake the results of a
22 discogram? A patient with no medical training, can they come
23 in, the way you described how a discogram is performed, blind
24 to a patient, can they fake the results?

25 A They cannot fake the results cause they don't know

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1 what disc I inject, what I'm looking for. They're just
2 getting questions -- very simple questions and then they
3 answer in a -- I make my conclusions following these answers.

4 Q Okay. Was there any evidence in this case of a
5 false positive on the discogram that you performed on Mr.
6 Simao?

7 A No, sir.

8 Q Okay. If there had been any inclination or evidence
9 of a false positive, would you have documented that in your
10 records?

11 A Yes, sir.

12 Q Is that your normal procedure?

13 A Yes, sir.

14 Q Is that what you are trained to do?

15 A Yes, sir.

16 Q Is that what the ICES guidelines provide?

17 MR. ROGERS: Your Honor, this is leading.

18 THE COURT: It is.

19 BY MR. EGLET:

20 Q Do you comply with the ICES guidelines?

21 A Yes, I do.

22 Q Do the ICES guidelines provide that if you suspect
23 it's a false positive that that should be documented in your
24 records?

25 A Yes, sir.

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1 Q Did you have any basis to conclude that the facet
2 tropisms was Mr. Simao's pain generators in this case?

3 A No, sir.

4 Q If the facet tropisms would have been the pain
5 generators, is that something you would have documented in
6 your records?

7 A I had thought about this, yes, sir.

8 Q We talked about the difference -- when I was
9 examining you -- of radiculopathy caused by a mechanical
10 abnormality where there's an impingement on a nerve and then
11 you talk about radiculopathy caused by internal disc
12 disruption, the tear in the disc when you have the leaking of
13 the chemicals that are irritating. Do you recall that
14 testimony?

15 A Yes, sir.

16 Q What was your conclusion after the diagnostic
17 studies in this case as to what was causing the radicular
18 symptoms?

19 A It's my conclusion that the patient was suffering
20 from a post traumatic internal disc disruption with a chemical
21 induced irritation of the nerve root.

22 Q Mr. Rogers talked to you at the very beginning of
23 his cross-examination about the fact that well, you know, your
24 conclusions regarding causations are at least partially based
25 on the history that the patient provides you. Do you recall

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1 that?

2 A Yes, sir.

3 MR. ROGERS: I'm going to object, Your Honor. That
4 misstates the testimony. His testimony was that it was
5 entirely based.

6 MR. EGLET: Well, I don't think that's what it was.
7 But --

8 THE COURT: Overrule the objection. I think the jurors
9 can sort it out.

10 BY MR. EGLET:

11 Q At any rate, is part of your medical training, your
12 residency, your internship, your fellowship, and as you
13 practice over the years, in your experience, do you get
14 training and experience on how to detect when a patient is not
15 being forthright or credible with you?

16 A Yes, certainly.

17 Q Okay. And are you trained to spot those things?
18 Are there things that doctors -- things that doctors look for
19 that give them clues on that?

20 A Yes.

21 Q Okay And in your examinations, in your interactions
22 with Mr. Simao, did you find anything that would make you
23 think that he was not a credible historian?

24 MR. ROGERS: Your Honor --

25 THE COURT: Yes.

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1 MR. ROGERS: -- he's opening the door.

2 THE COURT: To what? Counsel, approach, please.

3 MR. ROGERS: Yes.

4 [Bench Conference Not Transcribed]

5 BY MR. EGLET:

6 Q Do you remember the question, Doctor? I'll try to
7 repeat it. During your interactions and your examinations of
8 Mr. Simao, did you find anything in your experience, in your
9 training, in all the things you were trained to look for, that
10 would indicate to you that Mr. Simao was not being truthful
11 with you or was not a credible historian?

12 A I did not see any indication nor did I have the
13 impression that the patient was not truthful or honest.

14 Q If you thought that or had those indications is that
15 something you would normally document in your records?

16 A Yes. And I have worked with the patient. And
17 things have been clarified.

18 Q Okay. And did you document any sort of concerns
19 like that in your record?

20 A Yes, sir.

21 Q You did document?

22 A I do document if that happens.

23 Q But in this situation, did you document any
24 concerns?

25 A I'm sorry. I misunderstood. No, I did not, sir.

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1 Q Okay. And if that would have -- strike that. I've
2 asked question. In the past has that occurred in patients
3 you've had or patients you've seen where you felt that they
4 were less than credible or --

5 A Absolutely.

6 Q And is that something you have, in the past,
7 documented in your records?

8 A Absolutely.

9 Q Okay.

10 MR. EGLET: Now, Brendan, could you bring up Slide 1 for
11 us, please.

12 BY MR. EGLET:

13 Q Do you see this -- do you see this -- well, let me
14 ask you this. Take a look at this. And then let me ask you
15 this. Hypothetically, Doctor, if the medical history on the
16 day of the accident was -- post motor vehicle accident.
17 Complaining of neck, back and left shoulder pain. The patient
18 is a 41-year-old who was involved in a motor vehicle crash at
19 3:30 p.m. hours today. His chief complaint is left elbow
20 pain. The patient is a 41-year-old who -- excuse me -- and
21 tenderness in the back of his head. He was the driver of a
22 large van which was rear ended at an unknown speed, nearly
23 stopped, on the freeway. He states he had a hyperflexion and
24 extension movement of his head which caused him to strike the
25 back of his head on a cage in the inside of his work van.

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123

1 That's say -- I think it's supposed to be van. He denies loss
2 of consciousness.

3 Would this be substantially similar to the history
4 that Mr. Simao reported to you in your medical records?

5 MR. ROGERS: Your Honor already prohibited the defense
6 from inquiring about the Southwest medical records from this
7 doctor.

8 MR. ROGERS: He -- I didn't say this is Southwest. First
9 of all, I'm pulling up a record and asking him if this -- if
10 this was his chief complaint on the day of the accident, would
11 this be substantially similar to what the patient provided
12 this doctor on his first day. He is the one who went into
13 this issue on -- well, he only -- you know, this is only what
14 the patient told him. So I'm entitled to show it's
15 consistent.

16 THE COURT: If he can answer the question, he can.

17 THE WITNESS: Well, the patient was presenting to my
18 clinic with the symptoms of neck pain and left periscapular
19 pain, which is in the shoulder -- left shoulder area. So
20 there is a similarity there.

21 BY MR. EGLET:

22 Q Okay. And Mr. Rogers asked you if there was any
23 essentially objective signs of injury to the back of his head.
24 And it's your -- on the day of the incident -- do you recall
25 that testimony?

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1 A Yes, sir.

2 Q Scrapes, bumps, bruises, things like that.

3 A Yes.

4 Q Hypothetically if the medical records on the day of
5 the incident document that Mr. Simao had a contusion on the
6 back of his scalp, would that be objective evidence that he
7 struck the back of his head on something?

8 A Yes, sir.

9 Q And were the results of the diagnostic injections
10 and discography that you performed consistent with the history
11 that the patient told you? In other words, objective medical
12 evidence that confirms Mr. Simao's history?

13 A That confirms Mr. Simao's complaints, yes, that's
14 correct.

15 Q Now, Dr. Rosler, just so the jury understands what
16 medical records that you were permitted to review, have you
17 ever seen the medical records from Southwest Medical
18 Associates pertaining to Mr. Simao?

19 A No.

20 Q Okay. Other than the one injection procedure that
21 Dr. McNulty performed, have you seen any other medical records
22 from Dr. McNulty?

23 A No, sir.

24 Q Have you seen any physical therapy records regarding
25 Mr. Simao?

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1 A No, sir.

2 Q You have never seen the surgical report of
3 University Medical Center regarding Mr. Simao's two level
4 fusion at C-3/4 and C-4/5 have you?

5 A No, sir.

6 Q Okay. Would it surprise you to learn that the pain
7 management injections that Dr. McNulty performed also
8 identified the C-3/4 and C-4/5 discs as pain generators?

9 A It would not surprise me, sir.

10 Q Would it surprise you to learn that Dr. McNulty
11 performed surgery at the same two surgical levels where you
12 identified as disruptive discs?

13 A That does not surprise me, sir.

14 Q Why not?

15 A Cause I think we have enough scientific and medical
16 evidence that the patient's symptomatology was originating
17 from those two levels.

18 Q Okay.

19 MR. EGLET: Can I have -- is it Volume 1? Volume 2,
20 please? Thank you.

21 BY MR. EGLET:

22 Q Doctor, I'm handing you Volume 2 of Plaintiff's
23 exhibits. And I've turned to Exhibit 26.

24 A Yes.

25 Q And if you could turn to Page 7 of that -- of

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1 Exhibit 26, please. You see the Bates stamps on it?

2 A 0007?

3 Q Yes. Now, Doctor --

4 MR. EGLET: Do we have this?

5 BY MR. EGLET:

6 Q Now, Doctor, is this the pain questionnaire that Mr.
7 Simao completed for his first visit with Dr. Grover?

8 A Yes, sir.

9 Q And do you recognize this document?

10 A Yes.

11 Q What is the date of this document?

12 A 3/28/08, sir.

13 Q Okay. And could you please turn to Page 8.

14 A Yes, sir.

15 Q Okay. At the top of that page, what does Mr. Simao
16 state his worst pain is?

17 A It's 10 out of 10, sir.

18 Q 10 out 10. So when Mr. Rogers stated earlier that
19 the only time that Mr. Simao experienced pain of a 10 out of
20 10 was at the time of your discography, was that accurate?

21 A No.

22 Q Now, certainly this record was completed even before
23 you saw the patient for the first time. Correct?

24 A Yes, sir.

25 Q Now, you've talked a little bit about this in

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1 response to -- well, first of all, let me ask you a couple of
2 other questions. Mr. Rogers asked you -- he asked you a
3 question that basically was to the effect that when Mr. Grover
4 sent Mr. Simao to you originally, he sent him with a request
5 for selective nerve root blocks. And then I think you said a
6 follow-up or a potential for -- a potential -- facet blocks.
7 Correct?

8 A Possible facet blocks, correct, sir.

9 Q Facet blocks. And you indicated -- and then he said
10 to you, the facet blocks were never performed. Correct?

11 A Yes, sir.

12 Q Okay. Now, the selective nerve root blocks, when
13 you performed them, your testimony earlier was that you were
14 able to determine that the pain generators were the C-3/4, C-
15 4/5 disc levels. Correct?

16 A Yes.

17 Q Okay. So at that point, with that finding from the
18 selective nerve root blocks, is there any reason to go forward
19 with the facet blocks at that point?

20 A No.

21 Q Why?

22 A Because it appeared to -- that the patient's
23 symptomatology was coming from those two levels, at 3/4 and
24 4/5, from those discs.

25 Q And when you sent the patient back to Dr. -- you

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1 sent the patient back to Dr. Grover after you performed the
2 selective nerve root blocks?

3 A Yes, sir.

4 Q Okay. And when -- and then Dr. Grover saw him again
5 and referred him back to you for more procedures. Correct?

6 A For the discography study, correct, sir.

7 Q When he sent Mr. Simao back a second time, did he
8 say, "Darn it, Dr. Rosler, you didn't do the facet blocks I
9 told you to do the first time."

10 A He did not.

11 Q Okay. And what did he ask you to do at that point?

12 A He asked me to do the cervical discography study,
13 sir.

14 Q And did the cervical discography confirm what the
15 facet -- selective nerve root block, the injections, showed
16 you that the pain generators were the C-3/4, C-4/5 discs?

17 A Yes, sir.

18 Q So after the discography was done, would there be
19 any reason to do the facet blocks?

20 A No, sir.

21 Q Now, he also asked you -- at one point, there was
22 consideration of an EMG being performed. Correct?

23 A Yes, sir.

24 Q Okay. Now, a negative EMG, does that rule out
25 internal disc disruption?

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1 A No --

2 Q A positive EMG is when you -- when you have a
3 positive EMG, is that consistent when you have a structural
4 abnormality or injury that is impinging upon a nerve?

5 A It can be, sir, yes.

6 Q Okay. And as you said, that's not what your
7 conclusion in this case was. This was internal disc
8 disruption with a tear and a chemical irritation. Correct?

9 A Yes.

10 Q Okay. In these type of situations, since it was a -
11 - the conclusion based on the selective nerve root blocks and
12 the discography that this was an internal disc disruption with
13 an annular tear and that the chemicals leaking from the disc
14 were causing the -- the nerve root irritations were causing
15 the irritation in the radicular symptoms, in those types of
16 situations, do EMGs normally come back as negative?

17 A They can come back as negative, yes, sir.

18 Q Okay. So in this situation, would there be -- after
19 -- since you've already confirmed that this is internal disc
20 disruption through the selective nerve root blocks and then
21 the discography, would there be any medical reason or
22 necessity to perform the EMG?

23 A Yes. The EMG wouldn't provide any further
24 information that's necessary for the diagnosis of --

25 Q All right. Now, finally, I want to talk to you

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1 about the -- Mr. Rogers brought this up. And you talked about
2 this a little bit about in cross-examination about how the --
3 these internal disc disruptions -- the symptoms from internal
4 disc disruption can be progressive over time. Do you recall
5 that?

6 A Yes, sir.

7 Q Okay. And when Mr. -- since Mr. Simao had an
8 aggravation, he had the occipital headaches and aggravation of
9 his migraine headaches that that would have been the -- I
10 think you said the primary complaint or something and then
11 over time the neck may have showed up.

12 A Yes.

13 MR. ROGERS: Your Honor, that's the compound and leading.

14 THE COURT: Yeah. Ask him to rephrase.

15 MR. EGLET: Yeah. It's late in the day, Your Honor.

16 THE COURT: I know. I know.

17 BY MR. EGLET:

18 Q Let me just start this way. Do you know what the
19 gate theory of pain is?

20 A Yes.

21 Q Could you explain to the jury what the gate theory
22 of pain is.

23 A Well, in short, it's the pain that persists for a
24 prolonged period of time and can cause an opening of other
25 channels that -- first of all, there's an overshadowing of

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1 symptomatology. If you have more than one potential pain
2 source, the patient typically perceives the most significant
3 pain. And there is some underlying pain that's being
4 overshadowed. And over time, this pain can substantiate and
5 become chronic and therefore become more and more and more
6 apparent to the fact that now all of a sudden the patient is
7 realizing this type of pain that he wasn't necessarily
8 realizing before due to the fact that there was other
9 overshadowing symptomatology. Like, with Mr. Simao, his
10 headaches -- occipital symptoms.

11 Q Mr. Wall, in his opening statement gave an example
12 to the jury. And I want to ask you, is this consistent with
13 the gate theory of pain. He gave an example to the jury where
14 he could be suffering from very significant low back pain.
15 Hypothetically. He could have severe low back pain. And he
16 could place his thumb on a table and somebody could hit it
17 with a hammer extremely hard. And that he's not going to
18 notice that back pain until that thumb pain subsides. Is that
19 essentially what you mean by overshadowing?

20 A Exactly. That's a very good example. And part of
21 it is, what is pain? Pain is an unpleasant stimulus, but it's
22 also a protection. So again in this case, for the body, for
23 the brain, the pain is much more damaging and threatening to
24 the person -- the pain that's resulting from a hammer. So you
25 perceive this more. So you can react. Then the low back pain

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1 that is much less threatening to the person. So therefore,
2 that's a very good example of the gate theory. Yes.

3 Q All right. One more subject I'm going to ask you
4 about, Doctor. And then I'll sit down, I promise. Mr. Rogers
5 was talking to you about two different MRIs, maybe it was
6 three, I don't remember exactly, taken over a period of time,
7 with respect to Mr. Simao. And he said -- he talked -- I
8 can't remember the question exactly. But it was something to
9 the effect that one MRI was read to say one thing and one MRI
10 was read to say another thing. And one may have been worse
11 than the other. You recall that testimony?

12 A Yes, sir.

13 Q All right. Now, as part of your practice, do you
14 look at MRIs all the time?

15 A Yes, sir.

16 Q Okay. As part of your practice, do you read the
17 radiology reports by the radiologists who initially reviews
18 the MRI and sends their report along with the films to you?

19 A I do read the reports, sir.

20 Q Okay. Is there a difference between different
21 radiologists on how they read and interpret films?

22 A Yes, sir.

23 Q Do some radiologists -- I've heard the term, and you
24 can correct me if I'm wrong, I've heard there's this term
25 called under-reading and over-reading. What does that mean?

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1 A Under-reading means that the radiologist or the
2 person who reads the film doesn't pick up a potential
3 pathology, abnormality on the film or picks it up and just
4 says, oh, it's just a mild process. Over-reading is when
5 there's a fairly mild process on the film and the radiologist
6 states that this is a significant abnormality. So it's --
7 it's somewhat along that lines.

8 Q So the jury has an understanding, do radiologists
9 see patients in a clinical setting?

10 A No.

11 Q Do radiologists examine patients? Do radiologists
12 examine a patient and then try to determine whether their
13 complaints and physical findings on examination correlate with
14 what they see on MRIs or x-rays or anything like that?

15 A No, sir.

16 Q Okay. What do radiologists do? How do they work
17 in this day and age?

18 A Well, radiologists are purely diagnosticians. They
19 are typically in a dark room. And they get an MRI scan and
20 they get a little slip that says, perhaps, a 30-year-old man
21 with low back pain and right leg pain. And then he puts up
22 the film and reads the film. And then goes to the next film
23 and to the next film and to the next film. And that's what he
24 or she does.

25 Q And in fact, in today's day and age in medicine,

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1 they don't even throw the actual films up on the screen. It's
2 all digitized. They just get it over the computer. Right?

3 A That is correct, sir.

4 Q And they just type in their results or dictate their
5 results after looking on a computer and then go to the next
6 patient and the next patient and the next patient. Right?

7 A Exactly, sir.

8 Q And they never meet any of these patients?

9 A No, sir.

10 Q Ever perform any physical examinations on these
11 patients?

12 A No.

13 Q Do they ever get histories from these patients?

14 A No.

15 Q All right. So is it, in your experience, unusual to
16 see different radiologists, for example, looking at the same
17 MRI scan and have impressions that are different?

18 A Not unusual, sir.

19 Q Thank you.

20 THE COURT: Any follow-up?

21 MR. ROGERS: Four follow-ups. Very brief.

22 THE COURT: All right.

23 RECROSS-EXAMINATION

24 BY MR. ROGERS:

25 Q All right. Anything on the screen here?

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1 A Not right now, sir.

2 MR. ROGERS: 18. Page 2, I think. Okay. And can you
3 pull up an image? Go to assessment. Okay.

4 BY MR. ROGERS:

5 Q The Plaintiff showed you only part of this document,
6 contusion of the scalp. But the part that was removed was
7 with intact skin surface. Doesn't that tell you that this
8 bump to the head that the Plaintiff reported wasn't
9 sufficiently severe to break the skin.

10 A Well, it apparently did not break the skin. That is
11 correct, sir.

12 Q Another document the Plaintiff showed you in Exhibit
13 26, Page 8, you were asked whether the Plaintiff ever had a 10
14 of 10 pain. And this was Dr. Grover's record. The point of
15 discography is to reproduce the average pain. Correct?

16 A No, sir.

17 Q It's to reproduce the most extreme pain?

18 A It's -- the point of the discography is to reproduce
19 the patient's pain in terms of the distribution. And as I
20 pointed out, it's a provocative test. It most likely will
21 aggravate, exacerbate the patient's average pain because I'm
22 injecting dye into a disc that is painful. And therefore,
23 it's often perceived as worse, as his worst pain.

24 Q I recall that discussion. However, the point of it
25 was, the Plaintiff's average pain at that time wasn't a 10.

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1 It was a 7.

2 A His worst pain was a 10.

3 Q His average pain was a what?

4 A A 7.

5 Q Okay.

6 A And the worst pain was reproduced by a provocative
7 test, which is expected.

8 Q Now, on this gate theory of pain, you've been given
9 an example of someone smacking their thumb. Obviously, a
10 terribly painful event. But if that person had unremitting
11 back pain and hit their thumb, would their back pain go away
12 for six months?

13 A It depends on how -- well -- it depends how long the
14 painful stimulus is for the thumb. Is that's just a one
15 second stimulus, then obviously as soon as the thumb gets
16 better, the patient will feel the back pain again.

17 Q Now, on the question about this discogram, is it
18 your understanding like it is mine that the Plaintiff
19 continues to complain of neck symptoms?

20 A I have not seen the Plaintiff since I performed the
21 discography studies.

22 Q Do you have any understanding of his current
23 condition?

24 A Yes, but in order to make any -- or make any
25 statement, I would like to examine the patient, talk to the

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1 patient.

2 Q Okay. Well, let's say that because it is my
3 understanding that -- hypothetically -- the Plaintiff's neck
4 and arm symptoms continue. Okay? Were you aware that since
5 the surgery didn't resolve his pain, the Plaintiff has been
6 consulted by a shoulder surgeon?

7 A Again, I'm not aware of that, sir.

8 Q And naturally arm symptoms don't emanate only from
9 the cervical discs. They could emanate from the nerves that
10 come through the shoulder as well.

11 A It can. Shoulder pain can cause pain in the
12 arm.

13 Q Sure. And were you aware also that the Plaintiff
14 was worked up since the surgery for carpal tunnel syndrome?

15 A No, sir.

16 Q Which can also cause arm symptoms.

17 A It mainly causes -- excuse me -- hand symptoms where
18 the carpal tunnel is.

19 Q Wrist symptoms.

20 A It doesn't cause any pain in the upper arms.

21 Q And it's your testimony to the jury that even if the
22 surgery didn't work and even if the Plaintiff did consult a
23 shoulder surgeon, even if he did consult someone about carpal
24 tunnel syndrome, that you have no doubt about the validity of
25 that discogram you performed?

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1 A I have no doubt in the validity of the discogram,
2 sir.

3 Q Thank you.

4 MR. ROGERS: Thank you.

5 THE COURT: Any follow-up?

6 MR. EGLET: Just briefly, Your Honor.

7 FURTHER REDIRECT EXAMINATION

8 BY MR. EGLET:

9 Q Doctor, a contusion -- isn't a contusion a bruise?

10 A Yes, sir.

11 Q And a bruise by itself, it's nature, it doesn't
12 break the skin. Correct?

13 A It doesn't have to break the skin, sir. That's
14 correct.

15 MR. EGLET: Thank you.

16 THE COURT: Well, there's one remaining question from one
17 of the jurors, Doctor. I'd like to read it into the record
18 and ask you to answer it if you can, sir.

19 Body diagram. And I think it may require us to pull
20 up Exhibit Number 32.

21 The question reads, body diagram asks the patient to
22 put an X over the most intense pain. Is that an X on the
23 lower head?

24 MR. EGLET: Can we have left law control, Your Honor?
25 It's the pain diagram.

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1 THE WITNESS: It appears to be that there's an X looking
2 from the back in the left periscapular area, around the left
3 shoulder blade area, and in the left peri-spinus area in the
4 neck area. And potentially there's an X also in the occipital
5 area.

6 THE COURT: Any follow-up questions by Counsel, either
7 side?

8 MR. EGLET: No, Your Honor.

9 RECROSS-EXAMINATION

10 BY MR. ROGERS:

11 Q Are you just going by appearances, Doctor, or do you
12 know whether there's an X?

13 A Well, I can clearly see that there's an X over the
14 left periscapular area. And there's an X --

15 Q Explain to the jury --

16 MR. EGLET: Wait. Can he answer the finish the answer,
17 please.

18 THE COURT: Yes.

19 MR. ROGERS: Just explain it --

20 MR. EGLET: Let him finish his answer --

21 THE COURT: He should be entitled to finish the answer.

22 THE WITNESS: As I pointed out, there's one X in the left
23 periscapular area over the left shoulder blade, there's one X
24 higher above in the left side of the neck. And it appears
25 that there might be also an X, but I'm not entirely sure, in

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1 the occipital area.

2 THE COURT: Any follow-up?

3 MR. EGLET: No.

4 MR. ROGERS: No, Your Honor.

5 THE COURT: Going once. Going twice. I'll asked that
6 this be marked as Court's Exhibit next in order. Dr. Rosler,
7 you may also be excused. It's a good time to break, ladies
8 and gentlemen of the jury.

9 [Court Admonishes Jury]

10 [Bench Conference Not Transcribed]

11 [Proceedings Concluded at 5:03 p.m.]

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4
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6 LAURA HINTON, Transcriber
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9 Erin Goold

10 ERIN GOOLD, Transcriber
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16 Bonnie Furlong

17 BONNIE FURLONG, Transcriber
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19 Rebecca M. Breitenbach

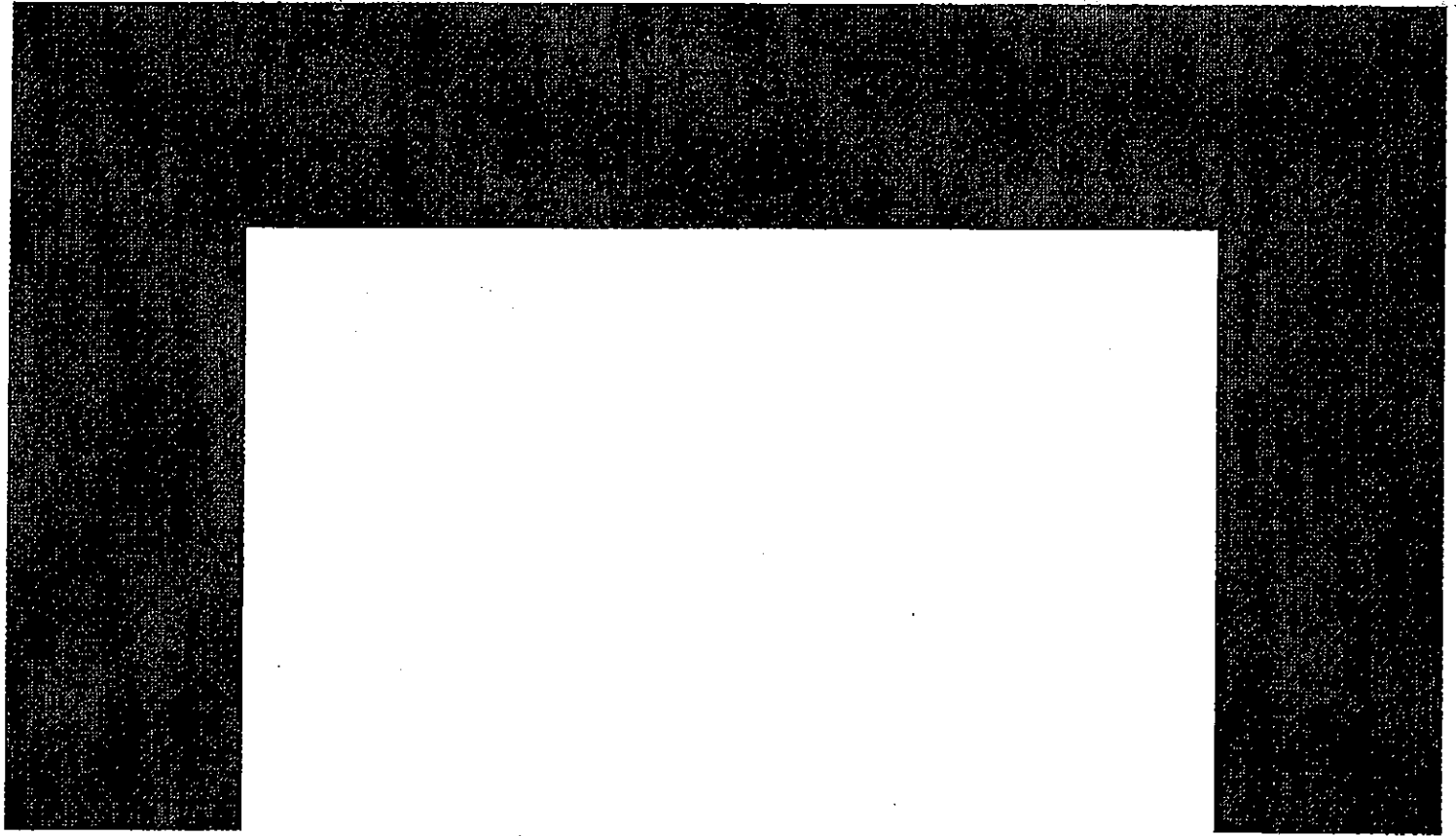
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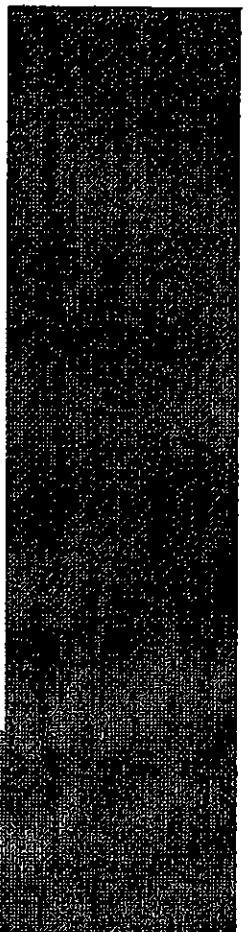
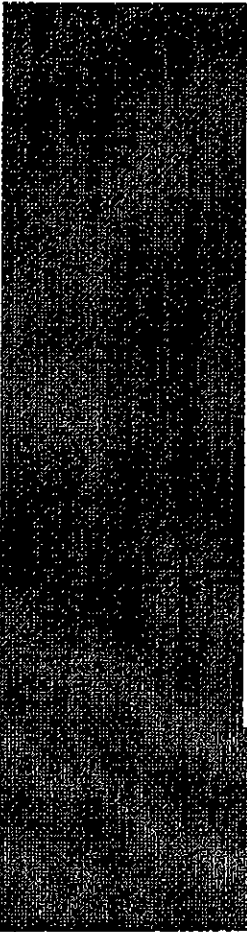
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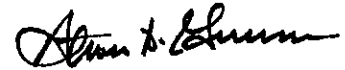


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**DISTRICT COURT
CLARK COUNTY, NEVADA**

WILLIAM JAY SIMAO, individually and
CHERYL ANN SIMAO, individually, and as
husband and wife,

Plaintiffs,

v.

JENNY RISH; JAMES RISH; LINDA RISH;
DOES I through V; and ROE CORPORATIONS I
through V, inclusive,

Defendants.

CASE NO.: A539455

DEPT. NO.: X

**PLAINTIFFS' OPPOSITION TO
DEFENDANT'S TRIAL BRIEF IN
SUPPORT OF ORAL MOTION FOR
MISTRIAL**

MAINOR EGLET

001664

PLAINTIFFS' OPPOSITION TO DEFENDANT'S TRIAL BRIEF
IN SUPPORT OF ORAL MOTION FOR MISTRIAL

COMES NOW, Plaintiffs, by and through his counsel of record, ROBERT T. EGLET, ESQ., DAVID T. WALL, ESQ., and ROBERT M. ADAMS, ESQ., of the firm of MAINOR EGLET, and hereby files PLAINTIFFS' OPPOSITION TO DEFENDANT'S TRIAL BRIEF IN SUPPORT OF ORAL MOTION FOR MISTRIAL.

This Opposition is made and based upon the pleadings and papers on file herein, the Points and Authorities attached hereto, and any oral argument which may be heard at the hearing of this matter.

DATED this 18th day of March, 2011.

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MAINOR EGLET

001665

MEMORANDUM OF POINTS AND AUTHORITIES

I.

ARGUMENT

A. Defendant's right to voir dire HAS NOT been unreasonably restricted.

Defendant claims that her right to voir dire has been unreasonably restricted because this Court has dismissed nine (9) prospective jurors for cause during Plaintiff's voir dire of the prospective jury panel. Defendant also alleges that based upon the removal of these nine (9) prospective jurors that she has been "unfairly and irrevocably prejudiced" thereby warranting a mistrial. Defendant's allegation of error is misplaced and must be disregarded.

As purported authority for her allegations, Defendant cites to *Leone v. Goodman*, 105 Nev. 221, 773 P.2d 342 (1989) and to *Whitlock v. Salmon*, 104 Nev. 24, 752 P.2d 210 (1988). However, neither of these cases stands for the proposition Defendant implies, i.e., that it was error to strike jurors without allowing defense counsel to first question the same. Instead both of these cases concern the issue of a trial judge exclusively conducting voir dire and disallowing participation by the parties' attorneys. See *Leone* 105 Nev. At 222 and *Whitlock* 104 Nev. at 24. Both of these cases were reversed on these grounds as the Nevada Supreme Court held that "[a]lthough a trial judge may reasonably restrict the right of supplemental attorney-conducted voir dire,... he may not prohibit the right altogether." See *Leone* and *Whitlock. supra*. These cases are inapposite to Defendant's argument, however, as the Nevada Supreme Court did not address the issue of whether excusing a prospective juror for cause prior to being questioned by both plaintiff's and defendant's counsel is improper.

Next, Defendant cites to criminal cases from Florida, Colorado, and Arizona in support of her position. Each of these cases, however, involve criminal conduct, three (3) of which involve the death penalty, and are highly distinguishable to this civil matter.

1 First, in *Sanders v. State*, 707 So.2d 664 (Fla. 1998), the Florida Supreme Court affirmed
2 the appellant's conviction for first-degree murder but vacated his death sentence, because, among
3 other issues, the trial court excused a juror for cause without allowing defense counsel to
4 question the juror. The basis for this reversal, however, was specifically limited to capital cases.

5 The *Sanders* Court first pointed out that Florida Rule of Criminal Procedure 3.300
6 provides both the State and the defense the right to participate in voir dire. *Id.* at 667-668. Such
7 a statute does not exist in Nevada's Revised Statutes, including NRS 16.030 which is relied upon
8 by the defense.

9 The *Sanders* Court further instructed:

10
11 Even though trial judges may question prospective jurors, their role in jury
12 selection must not impair counsel's right and duty to question the venire.
13 *Miller v. State*, 683 So. 2d 600 (Fla. 2d DCA 1996). Our holdings in
14 *Willacy*, *Hernandez*, and *O'Connell* set forth the general principle that
15 defense counsel must be afforded an opportunity to rehabilitate jurors who
16 have expressed objections to the death penalty or conscientious or religious
17 scruples against its infliction. **This is because the decision of whether a**
18 **person deserves to live or die must not be entrusted to a tribunal**
19 **organized to return a "verdict of death."** *Witherspoon v. Illinois*, 391
20 U.S. 510, 522, 20 L. Ed. 2d 776, 88 S. Ct. 1770 (1968). Accordingly, it was
21 error for the trial judge to refuse to allow defense counsel to question Juror
22 P.

23 *Id.* at 668. [Emphasis Added].

24 *Witherspoon, supra*,¹ relied upon by the Florida Supreme Court, is one of the seminal
25 cases concerning voir dire during a death penalty case and sets forth the importance of selecting
26 an impartial jury who is willing to follow the law when the life of a human being is at stake. The
27 *Witherspoon* Court held:

28 ¹ *Witherspoon* was overruled on other grounds unrelated to the subject matter of the instant Opposition. See *Brown v. Lambert*, 2004 U.S. Dist. LEXIS 30496 (W.D. Wash. Sept. 15, 2004); see also *Valle v. State*, 474 So. 2d 796, 1985 Fla. LEXIS 1460, 10 Fla. L. Weekly 381 (Fla. 1985)

1 It is, of course, settled that a State may not entrust the determination of
2 whether a man is innocent or guilty to a tribunal "organized to convict." *Fay*
3 *v. New York*, 332 U.S. 261. 294. See *Tumey v. Ohio*, 273 U.S. 510. It
4 requires but a short step from that principle to hold, as we do today, that a
5 State may not entrust the determination of whether a man should live or die
6 to a tribunal organized to return a verdict of death. Specifically, we hold
7 that a sentence of death cannot be carried out if the jury that imposed or
8 recommended it was chosen by excluding veniremen for cause simply
9 because they voiced general objections to the death penalty or expressed
10 conscientious or religious scruples against its infliction. No defendant can
11 constitutionally be put to death at the hands of a tribunal so selected.

12 *Id.* at 521-522.

13 Recognizing the importance of selecting an impartial jury in a death penalty case, and
14 applying its own statute, the Supreme Court of Florida held that it was reversible error to not
15 permit the defendant's counsel to question the excused juror.

16 Similarly, in *O'Connell v. State*, 480 So.2d 1284 (Fla. 1986), the Supreme Court of
17 Florida reversed a conviction of death after the trial court refused to allow a defendant to voir
18 dire two (2) prospective jurors who stated that they were opposed to the death penalty. *Id.* at
19 1287. The Court also cited to Florida Rule of Criminal Procedure 3.300 which spells out a
20 defendant's right to conduct voir dire of each prospective juror. *Id.* at 1286-1287. The Court
21 therefore reversed on this premise, holding that the trial court should have allowed defendant the
22 right to question the excused prospective jurors due to the right expressed in the criminal code.
23 *Id.* at 1287.

24 In *State v. Anderson*, 4 P.3d 369 (Ariz.2000), also a death penalty case, the high court
25 reversed a sentence of death because the trial judge committed error when it did not permit
26 defense counsel to question three (3) prospective jurors who were excused for cause after voicing
27 general objections to the death penalty in jury questionnaires *Id.* at 317. The refusal to permit
28

1 the questioning was a direct violation of Arizona Rule of Criminal Procedure 18.5, permitting
2 voir dire by a defendant.

3 Further, the Court also expressed that under *Witherspoon, supra.* as modified by
4 *Wainwright v. Witt*, 469 U.S. 412, 105 S. Ct. 844, 83 L. Ed. 2d 841 (1985):

5 The United States Supreme Court has held that the Sixth Amendment is
6 violated if the trial jury in a capital case is chosen by excluding for cause
7 persons who have general objections to the death penalty. *Witherspoon v.*
8 *Illinois*, 391 U.S. 510, 88 S. Ct. 1770, 20 L. Ed. 2d 776 (1968). A general
9 objection to the death penalty is not sufficient to create a presumption that a
prospective juror is unfit because of bias to sit on the panel. The Court's
language was quite clear:

10 It is, of course, settled that a State may not entrust the determination of
11 whether a man is innocent or guilty to a tribunal 'organized to convict.' It
12 requires but a short step from that principle to hold, as we do today, that a
13 State may not entrust the determination of whether a man should live or die
14 to a tribunal organized to return a verdict of death. Specifically, we hold
15 that a sentence of death cannot be carried out if the jury that imposed or
16 recommended it was chosen by excluding veniremen for cause simply
because they voiced general objections to the death penalty or expressed
conscientious or religious scruples against its infliction. No defendant can
constitutionally be put to death at the hands of a tribunal so selected. *Id.* at
521-23, 88 S. Ct. at 1776-77 (citations and footnotes omitted).

17 However, this rule is not applicable to prospective jurors who state
18 unequivocally that they could never impose the death penalty
19 regardless of the facts of the particular case. *Id.* at 514, 88 S. Ct. at 1772;
20 *see also Morgan v. Illinois*, 504 U.S. 719, 734 n.7, 112 S. Ct. 2222, 2232
21 n.7, 119 L. Ed. 2d 492 (1992) ("The process of voir dire is designed to cull
22 from the venire persons who demonstrate that they cannot be fair to either
23 side of the case. Clearly, the extremes must be eliminated -- i.e., those who,
24 in spite of the evidence, would automatically vote to convict or impose the
25 death penalty or automatically vote to acquit or impose a life sentence.").

26 ...a person's opposition to the death penalty need not be proved with
27 "unmistakable clarity," but a prospective juror may be excused if his
28 views "would prevent or substantially impair the performance of his
duties as a juror...." *Id.* at 424, 105 S. Ct. at 852 (quoting *Adams v. Texas*,
448 U.S. 38, 45, 100 S. Ct. 2521, 2528, 65 L. Ed. 2d 581 (1980)). Arizona
adopted an identical standard in *State v. Martinez-Villareal*, 145 Ariz. 441,

1 449, 702 P.2d 670, 678 (1985). In Arizona, "disqualification when a juror
2 states his inability to be impartial is not only permissible but imperative."
3 *State v. Wiley*, 144 Ariz. 525, 534, 698 P.2d 1244, 1253 (1985)(overruled
4 on other grounds by *State v. Superior Court*, 157 Ariz. 541, 760 P.2d 541
5 (1988)); see also *State v. Willoughby*, 181 Ariz. 530, 892 P.2d 1319
6 (1995)(excusing venire person who could not convict due to religious
7 opposition to the death penalty does not violate state constitutional
8 provision against disqualification based on religious beliefs).

9 In the present case, the trial judge's denial of questioning beyond the
10 prospective jurors' written answers forces us to determine from the
11 questionnaire answers alone whether their attitudes toward the death penalty
12 were so entrenched as to disqualify them from service. On this record, we
13 must conclude that it is possible that the three could have been rehabilitated
14 by oral voir dire that established their ability to set aside their beliefs and
15 follow the law.

16 *Id.* at 318-320. [Emphasis Added].

17 Notably, the Court recognized that voir dire by the parties is not required if a juror's
18 views "would prevent or substantially impair the performance of his duties as a juror." *Id.* at 319-
19 320. There, however, the Court determined that relying upon the record presented, it was
20 possible that the three (3) excused jurors could have been rehabilitated.

21 Lastly, in *People v. Lefebre*, 981 P.2d 650 (Colo. App. 1998), the trial court excused
22 three jurors who indicated on jury questionnaires they could not be fair and impartial. The Court
23 of Appeals of Colorado reversed the criminal conviction noting that under Colorado Rules of
24 Criminal Procedure 24(a)(2), an express right is granted for a defendant to voir dire a prospective
25 jury panel. *Id.* at 651-652. The Court held:

26 The mandatory language of the rule and the statute providing that counsel
27 be allowed to examine potential jurors expresses a strong policy from the
28 General Assembly and the Supreme Court that counsel for the parties not be
denied input in the jury selection process as to any potential juror. See
Crim. P. 24(b)(1)(X); 16-10-103(1)(j), C.R.S. 1998;

Id. at 652.

1 These cases relied upon by the defense involve specific criminal procedure statutes and
2 also describe the importance of empanelling a fair and impartial jury who will follow the law
3 when freedom and/or life is at stake. Thus, a defendant whose freedom and/or life is at stake is
4 sometimes permitted to conduct voir dire of a prospective juror even though that prospective
5 juror has demonstrated that he or she may not be able to follow the law. *See Witherspoon, supra*.
6 Because the instant case involves a civil matter, the cases relied upon by the defense should be
7 disregarded.
8

9 Rather than rely on the inapposite case law cited to by the defense, there is ample case
10 law, including cases from Nevada, which justifies the removal of the jurors who have
11 demonstrated that they cannot be fair and impartial.
12

13 The purpose of voir dire is to facilitate the identification and removal of potential jurors
14 "who, because of bias or prejudice, cannot serve as fair and impartial jurors." *Silver State v.*
15 *Shelley*, 105 Nev. 309, 774 P.2d 1044 (1989). The scope of voir dire "rests within the sound
16 discretion of the district court, whose decision will be given considerable deference by the
17 Nevada Supreme Court. *Johnson v. State*, 122 Nev. 1344, 1354-55, 148 P.3d 767, 774 (2006);
18 *Thomas v. Hardwick*, 231 P.3d 1111, 1115 (Nev. 2010).
19

20 As has been expressed by the Nevada Supreme Court, "[t]he test for evaluating whether a
21 juror should [be] removed for cause is 'whether a prospective juror's views would prevent or
22 substantially impair the performance of his duties as a juror in accordance with his instruction
23 and his oath.'" *Weber v. State*, 121 Nev. Adv. Rep. 57, 119 P.3d 107, 125 (2005), citing
24 *Leonard v. State*, 117 Nev. 53, 65, 17 P.3d 397, 405 (2001); See also *Wainwright v. Witt*, 496
25 U.S. 412 (1985).
26
27
28

1 The United States Supreme Court in *Wainwright* held that prospective jurors must be
2 excused if their views could substantially impair their ability to perform their function as jurors,
3 and the impairment need not be shown with unmistakable clarity. The Supreme Court of Nevada
4 has provided guidance for the District Court and trial counsel in determining whether a juror
5 should be removed for cause. The Court explained, "[i]t is not enough to be able to point to
6 detached language which, alone considered, would seem to meet the statute requirement, if, on
7 construing the whole declaration together, it is apparent that the juror is not able to express an
8 absolute belief that his opinion will not influence his verdict." *Thompson vs. State of Nevada*,
9 111 Nev. 439, 443, 894 P.2d 375, 377 (1995), citing *Bryant v. State*, 72 Nev. 330, 305 P.2d 360
10 (1956). This rule was recently affirmed by our Supreme Court, wherein the court stated:
11 "[d]etached language considered alone is not sufficient to establish that a juror can be fair when
12 the juror's declaration as a whole indicates that she could not state unequivocally that a
13 preconception would not influence her verdict." *Weber v. State*, 119 P.3d 107, 126, 121 Nev.
14 Adv. Rep. 57 (2005), citing *Thompson, supra*.

17 Any doubt should be weighed in favor of being excused in order to remove even the
18 possibility of bias or prejudice infecting the deliberations. See *Walls v. Kim*, 549 S.E.2d 797, 250
19 Ga.App. 259 (Ga. 2001).

21 The Nevada Supreme Court emphasized this point in *Thompson*, and found that,
22 "...[s]imply because the district court was able to point to detached language that prospective
23 juror eighty-nine could be impartial does not eradicate the fact that he previously demonstrated
24 partial beliefs, capped by an unequivocal statement that [the Defendant] was guilty." *Thompson*,
25 *supra* at 443. The Court further explained: "It may be true that on examination [the prospective
26 juror's] answers tended to contradict his previous statements, but we believe that his very self-
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1 contradictions do not increase his fitness as a juror." *Id.* citing *Bryant*, 72 Nev. at 334. The
2 *Thompson* court ultimately concluded that "... it was prejudicial error that [the] prospective
3 juror was not excused for cause.

4 Again, decisions concerning the scope of voir dire and the manner in which it is
5 conducted are reviewable only for abuse of discretion," *Hogan v. State*, 103 Nev. 21, 23, 732
6 P.2d 422, 423 (1987), and draw "considerable deference" on appeal. *Johnson v. State*, 122 Nev.
7 1344, 1355, 148 P.3d 767, 774 (2006). See e.g. *Lamb v. State*, 127 Nev. Adv. Op. 3 (March 3,
8 2011). Here, the record will reflect that all nine (9) jurors unequivocally demonstrated that they
9 could not be fair and impartial and were justifiably removed from the panel for cause. This
10 Court was well within its discretion to strike the subject panel members and a mistrial is not
11 warranted.
12

13 **B. This Court has not erred by allowing Plaintiff to conduct meaningful voir dire of**
14 **the prospective jury panel.**

15 Defendant's second basis for a mistrial, that this Court failed to properly restrict Plaintiff's
16 voir dire, is also misplaced and certainly does not warrant a mistrial.
17

18 The Nevada Supreme Court has specifically held that an attorney has a substantive right
19 to participate in voir dire. See *Whitlock v. Salmon*, 104 Nev. 24, 26, 752 P.2d 210 (1988). In
20 *Whitlock*, (also cited to by the defense) Appellants, Phyllis and J.T. Whitlock, brought an action
21 against Donald Salmon, M.D. for injuries received by Mrs. Whitlock during surgery for removal
22 of a brain tumor. *Id.* at 25. The Whitlocks' counsel specifically requested permission of the trial
23 judge to voir dire the jury. *Id.* However, voir dire was conducted exclusively by the judge. *Id.*
24 The Supreme Court found the trial judge's failure to permit counsel to voir dire the jury to be
25 reversible error. *Id.*
26
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1 NRS 16.030(6) provides:

2 The judge shall conduct the initial examination of the prospective jurors and the
3 parties or their attorneys are entitled to conduct supplemental examinations
which must not be unreasonably restricted.

4 [Emphasis Added]. The Court in *Whitlock* held that "the statute confers a substantive right to
5 reasonable participation in voir dire by counsel; and this court will not attempt to abridge or
6 modify a substantive right." *Id.* at 26. In so holding, the Court explained:

7
8 Usually, trial counsel are more familiar with the facts and nuances of a case and
9 the personalities involved than the trial judge. Therefore, they are often more able
10 to probe delicate areas in which prejudice may exist or pursue answers that reveal
11 a possibility of prejudice. Moreover, while we do not doubt the ability of trial
12 judges to conduct voir dire, there is concern that on occasion jurors may be less
13 candid when responding with personal disclosures to a presiding judicial officer.
14 Finally, many trial attorneys develop a sense of discernment from participation in
15 voir dire that often reveals favor or antagonism among prospective jurors. The
likelihood of perceiving such attitudes is greatly attenuated by a lack of dialogue
between counsel and the individuals who may ultimately judge the merits of the
case. In that regard, we expressly disapprove of any language or inferences in
Frame that tend to minify the importance of counsel's voir dire as a source of
enlightenment in the intelligent exercise of peremptory challenges.

16 *Id.* at 28.

17 The Supreme Court further explained the importance of trial counsel's substantive right
18 to participate in voir dire by emphasizing that this right was specifically safeguarded by the
19 legislature via a statutory enactment:
20

21 NRCP 47(a) contemplated a healthy respect on the part of trial judges for
22 appropriate supplemental participation by trial counsel in voir dire. Historically,
23 in most of Nevada's courts of general jurisdiction, counsel have been accorded
24 meaningful opportunities for involvement in the voir dire of prospective jurors.
The Legislature thus saw fit to enthrone the historical practice selectively enjoyed
by counsel in most trial procedures, in a substantive enactment that vouchsafes
the right to all counsel in every department of our district courts. We accordingly
25 view the statutory right thus bestowed as an acceptable solidification of the basic
intendment of N.R.C.P. 47(a).
26

27 *Whitlock*, supra, at 26.
28

1 In the instant matter, William Simao has suffered severe life-altering injuries as a result
2 of Defendant's carelessness and, as such, William will be requesting from the jury millions of
3 dollars to compensate him for his injuries. Moreover, William's wife, Cheryl Ann Simao, will
4 be requesting monetary damages for the losses she has sustained as a result of William's injuries.
5 Therefore, Plaintiffs' counsel is entitled to conduct voir dire of the jury panel which should not
6 be unreasonably restricted. "The voir dire examination of jurors . . . [is] to enable counsel to
7 exercise intelligently the peremptory challenges allowed by the law." *State v. Brown*, 53 N.C.
8 App. 82, 280 S.E. 2d 31, Cert Denied, 304 N.C. 197, 285 S.E. 2d 102 (1981). Therefore, the
9 purpose of voir dire is for counsel to gather information for peremptory as well as for cause
10 challenges. However, "[p]eremptory challenges are worthless if trial counsel is not afforded an
11 opportunity to gain the necessary information upon which to base such strikes." *Id.* at 27, citing
12 *United States v. Ible*, 630 F.2d 389, 395 (5th Cir. 1980).

13
14
15 Further, Defendant's reliance on *Lamb v. State*, 127 Nev. Adv. Op. 3 (March 3, 2011) is
16 not helpful to the defense's argument as the Court in *Lamb* simply points out that a trial judge
17 who limits voir dire questions "aimed more at indoctrination than acquisition of information"
18 does not abuse her discretion. The *Lamb* court speaks nothing of mistrial or any example of
19 what constitutes "indoctrination" versus "inquisition." Apparently, it is the Defendant's hope
20 that this Court simply accepts his argument on its face that "indoctrinating" questions are being
21 asked without demonstrating when or how the panel members have allegedly been indoctrinated.
22 The defense has completely failed to set forth how this case applies to the facts of the instant
23 matter and, therefore, it must be disregarded.²
24
25

26
27 ² Judges are not to be treated like pigs hunting for truffles buried in briefs. *Bishop v. Potter*, 2010 U.S. Dist. LEXIS
28 105845 (D. Nev. Oct. 1, 2010)

MAINOR EGLET

1 Lastly, Defendant claims that Plaintiff has "tainted" the jury pool by improperly advising
2 the pool on the burden of proof because Plaintiff has advised the jury that the parties are "equal."
3 As has been argued at length, Plaintiff is not advising the jury on the burden of proof when
4 asking questions designed around the parties starting positions in the minds of the prospective
5 jurors. Plaintiff is very familiar with the burden of proof and in no way, shape, or form, is trying
6 to shift that burden. Rather, as both parties are entitled to a fair and impartial jury who will
7 follow the law, it is imperative to know whether or not a potential juror has preconceived notions
8 which would place one party over the other prior to hearing any evidence. The notion that this is
9 improper is truly inconceivable given the fact that empaneling a fair and impartial jury is so
10 elementary to today's jurisprudence.

11
12 Defendant relies upon *Joynt v. California Hotel & Casino*, 108 Nev. 539 (1992) in support of her
13 "burden of proof" argument. *Joynt*, however, does not involve voir dire, or any matter involving
14 the selection of a fair and impartial jury. Instead, the case simply and correctly explains that a
15 plaintiff carries the burden of proof in a negligence action. *Id.* at 542. Aside from this, *Joynt*
16 offers nothing with regard to determining the propriety of advising the jury panel that it should
17 not give an advantage, or feel any affinity toward one party or the other prior to hearing
18 evidence. The illustration that the parties are to be placed evenly on the scales before the
19 introduction of evidence and that the empaneled jury is to then weigh the evidence and decide
20 whether or not the scales have been tipped by the Plaintiff is designed to convey the importance
21 of impartiality and expose potential jurors who might be unable to be impartial. Defendants
22 argument, that this sort of an example misconstrues the burden of proof, is unfathomable because
23 if Defendant were correct and she does in fact start ahead of the Plaintiff, it would mean that
24 Plaintiff would first be required to overcome the burden of rising to the same level on the scale
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1 as the Defendant and then overcome the burden of tipping the scale in Plaintiff's favor. This
2 would change the standard of proof from a preponderance of the evidence (more likely than not)
3 to something greater. Such a scenario would be patently unfair and contrary to well-settled
4 Nevada law.

5 **II.**

6 **CONCLUSION**

7
8 Based upon the foregoing, Defendant's Motion for a Mistrial must be summarily
9 **DENIED.**

10 DATED this 18th day of March, 2011.

11 **MAINOR EGLET**

12 

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In the Supreme Court of Nevada

Case Nos. 58504, 59208 and 59423

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Aug 14 2012 04:08 p.m.
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Clerk of Supreme Court

JENNY RISH,

Appellant,

vs.

WILLIAM JAY SIMAO, individually, and
CHERYL ANN SIMAO, individually and as
husband and wife,

Respondents.

APPEAL

from the Eighth Judicial District Court, Clark County
The Honorable JESSIE WALSH, District Judge
District Court Case No. A539455

**APPELLANT'S APPENDIX
VOLUME 7
PAGES 1428-1677**

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TABLE OF CONTENTS TO APPENDIX

Tab	Document	Date	Vol.	Pages
01	Complaint	04/13/07	1	01-08
02	Summons (Jenny Rish)	08/10/07	1	09-11
03	Summons (James Rish)	08/28/07	1	12-15
04	Summons (Linda Rish)	08/28/07	1	16-19
05	Notice of Association of Counsel	09/27/07	1	20-22
06	Defendant Jenny Rish's Answer to Plaintiff's Complaint	03/21/08	1	23-26
07	Demand for Jury Trial	03/21/08	1	27-29
08	Scheduling Order	06/11/08	1	30-33
09	Order Setting Civil Jury Trial	08/18/08	1	34-38
10	Stipulation and Order to Extend Discovery	05/06/09	1	39-43
11	Notice of Entry of Order to Extend Discovery	05/08/09	1	44-50
12	Amended Scheduling Order	06/10/09	1	51-54
13	Order Setting Civil Jury Trial	08/28/09	1	55-59
14	Stipulation and Order to Continue Trial Date	03/31/10	1	60-62
15	Notice of Entry of Order to Continue Trial Date	04/02/10	1	63-67
16	Notice of Association of Counsel	04/02/10	1	68-71
17	Order Setting Civil Jury Trial	12/15/10	1	72-75
18	Stipulation and Order to Continue Trial Date	12/22/10	1	76-78
19	Notice of Entry of Order to Continue Trial Date	01/04/11	1	79-83
20	Defendant Jenny Rish's Motion in Limine to Limit the Testimony of Plaintiff's Treating Physicians	01/06/11	1	84-91
21	Defendants' Motion in Limine to Preclude Plaintiffs' Medical Providers and Experts from Testifying Regarding New or Undisclosed Medical Treatment and Opinions	01/06/11	1	92-101
22	Defendant Jenny Rish's Motion to Exclude the Report and Opinions Plaintiff's Accident Reconstruction Expert, David Ingebretsen	01/06/11	1	102-114

23	Plaintiff's Omnibus Motion in Limine	01/07/11	1	115-173
24	Defendant Jenny Rish's Opposition to Plaintiffs' Omnibus Motion in Limine	02/04/11	1	174-211
25	Plaintiffs' Opposition to Defendant Jenny Rish's Motion in Limine Enforcing the Abolition of the Treating Physician Rule	02/04/11	1	212-217
26	Plaintiffs' Opposition to Defendant's Motion in Limine to Preclude Plaintiffs' Medical Providers and Experts from Testifying Regarding New or Undisclosed Medical Treatment and Opinions	02/04/11	1	218-223
27	Plaintiffs' Opposition to Defendant Jenny Rish's Motion to Exclude the Report and Opinions of Plaintiff's Accident Reconstruction Expert, David Ingebretsen	02/04/11	1	224-244
28	Defendant Jenny Rish's Reply in Support of Motion to Exclude the Report and Opinions of Plaintiff's Accident Reconstruction Expert, David Ingebretsen	02/08/11	1	245-250
29	Defendant Jenny Rish's Reply in Support of Motion in Limine to Limit the Testimony of Plaintiff's Treating Physicians	02/08/11	2	251-256
30	Defendant Jenny Rish's Reply in Support of Motion in Limine to Preclude Plaintiffs' Medical Providers and Experts from Testifying Regarding New or Undisclosed Medical Treatment and Opinions	02/08/11	2	257-262
31	Plaintiffs' Reply to Defendants' Opposition to Plaintiffs' Omnibus Motion in Limine	02/11/11	2	263-306
32	Plaintiff's Motion to Exclude Sub Rosa Video	02/14/11	2	307-313
33	Transcript of Hearings on Motion	02/15/11	2	314-390
34	Plaintiff's Motion in Limine to (1) Preclude Defendant from Raising a "Minor" or "Low Impact" Defense; (2) Limit the Trial Testimony of Defendant's Expert David Fish M.D. and; (3) Exclude Evidence of Property Damage	02/17/11	2	391-441
35	Defendant Jenny Rish's Opposition to Plaintiff's Motion to Exclude Sub Rosa Video	02/18/11	2	442-454
36	Transcript of Hearing	02/22/11	3	455-505
37	Order Regarding Plaintiff's Motion to Allow the Plaintiff's to Present a Jury Questionnaire Prior to Voir Dire	02/25/11	3	506-508

38	Defendant Jenny Rish's Opposition to Plaintiff's Motion in Limine to Preclude Defendant from Raising a "Minor" or "Low Impact" Defense; Limit the trial Testimony of Defendant's Expert David Fish M.D. and; Exclude Evidence or Property Damage	02/25/11	3	509-517
39	Plaintiffs' Reply to Defendants' Opposition to Plaintiffs' Motion to Exclude Sub Rosa Video	02/27/11	3	518-522
40	Transcript of Hearing	03/01/11	3	523-550
41	Plaintiffs' Second Omnibus Motion in Limine	03/02/11	3	551-562
42	Defendant's Opposition to Plaintiffs' Second Omnibus Motion in Limine	03/04/11	3	563-567
43	Transcript of Hearing on Omnibus Motion in Limine	03/08/11	3	568-586
44	Notice of Entry of Order Re: EDCR 2.47	03/10/11	3	587-593
45	Order Regarding Plaintiffs' Omnibus Motion in Limine	03/11/11	3	594-597
46	Order Regarding Plaintiff's Motion in Limine to (1) Preclude Defendant from Raising a "Minor" or "Low Impact" Defense; (2) Limit the Trial Testimony of Defendant's Expert David Fish M.D. and; (3) Exclude Evidence of Property Damage	03/14/11	3	598-600
47	Notice of Association of Counsel	03/14/11	3	601-603
48	Trial Transcript	03/14/11	3	604-705
			4	706-753
49	Trial Transcript	03/15/11	4	754-935
50	Trial Transcript	03/16/11	5	936-1102
51	Trial Transcript	03/17/11	5	1103-1186
			6	1187-1256
52	Trial Transcript	03/18/11	6	1257-1408
53	Notice of Entry of Order Regarding Plaintiffs' Omnibus Motion in Limine	03/18/11	6	1409-1415
54	Trial Brief in Support of Oral Motion for Mistrial	03/18/11	6	1416-1419
55	Trial Brief on Percipient Testimony Regarding the Accident	03/18/11	6	1420-1427
56	Trial Transcript	03/21/11	7	1428-1520

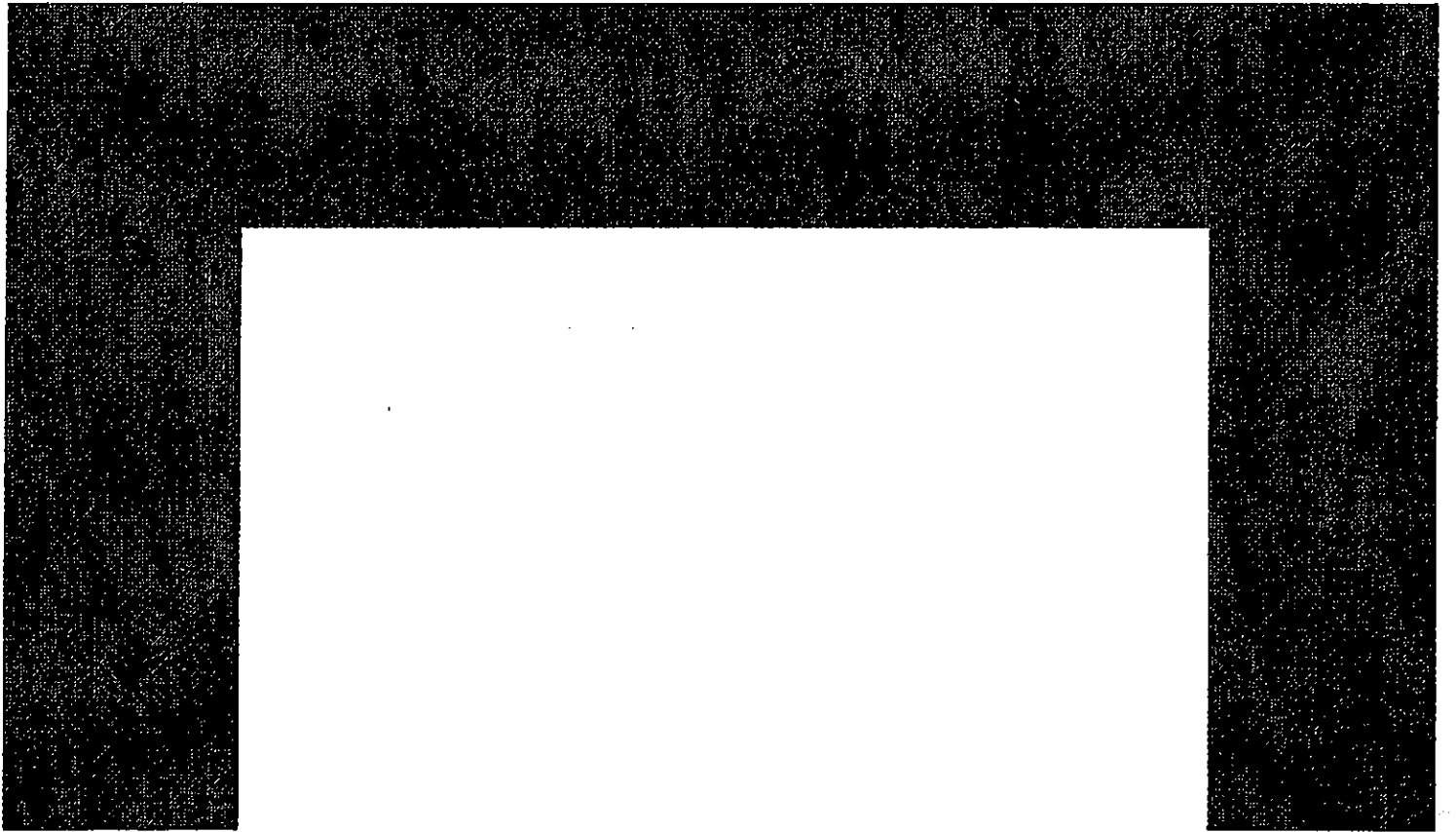
57	Trial Transcript	03/22/11	7	1521-1662
58	Plaintiffs' Opposition to Defendant's Trial Brief in Support of Oral Motion for Mistrial	03/22/11	7	1663-1677
59	Receipt of Copy of Plaintiffs' Opposition to Defendant's Trial Brief in Support of Oral Motion for Mistrial	03/22/11	8	1678-1680
60	Order Granting Motion to Exclude Traffic Accident Report and Investigating Officer's Conclusions	03/22/11	8	1681-1683
61	Order Regarding Plaintiffs' Second Omnibus Motion in Limine	03/22/11	8	1684-1687
62	Order Granting Motion to Exclude Life Care Expert, Kathleen Hartman, R.N.	03/22/11	8	1688-1690
63	Order Granting Motion to Exclude Witnesses from Testifying Regarding the Credibility or Veracity of Other Witnesses	03/22/11	8	1691-1693
64	Order Granting Motion to Exclude Graphic and Lurid Video of Surgery	03/22/11	8	1694-1696
65	Order Granting Motion to Exclude Duplicative and Cumulative Testimony	03/22/11	8	1697-1699
66	Order Granting Motion to Exclude Plaintiff's Accident Reconstructionist/Biomechanical Expert David Ingebretsen	03/22/11	8	1700-1702
67	Order Granting Motion to Exclude Argument of Case During Voir Dire	03/22/11	8	1703-1705
68	Order Granting Motion to Exclude Plaintiff's Economist, Stan Smith, for Lack of Foundation to Offer Expert Economist Opinion	03/22/11	8	1706-1708
69	Trial Transcript	03/23/11	8	1709-1856
70	Trial Transcript	03/24/11	8	1857-1928
			9	1929-2023
71	Plaintiffs' Amended Pre-Trial Memorandum	03/24/11	9	2024-2042
72	Trial Transcript	03/25/11	9	2043-2179
			10	2180-2212
73	Notice of Entry of Order Regarding Plaintiffs' Second Omnibus Motion in Limine	03/25/11	10	2213-2220
74	Trial Transcript	03/28/11	10	2221-2372

75	Trial Transcript	03/29/11	10	2373-2430
			11	2431-2549
76	Trial Brief Regarding Exclusion of Future Surgery for Failure to Disclose Computation of Future Damages Under NRCP 16.1(a)	03/29/11	11	2550-2555
77	Trial Transcript	03/30/11	11	2556-2681
			12	2682-2758
78	Trial Transcript	03/31/11	12	2759-2900
79	Stipulation and Order for Dismissal With Prejudice	03/31/11	12	2901-2904
80	Trial Transcript	04/01/11	13	2905-2936
81	Minutes of Hearing on Prove-up of Damages	04/01/11	13	2937-2938
82	Plaintiffs' Confidential Trial Brief	04/01/11	13	2939-3155
			14	3156-3223
83	Plaintiffs' First Supplement to Their Confidential Trial Brief to Exclude Unqualified Testimony of Defendant's Medical Expert, Dr. Fish	04/01/11	14	3224-3282
84	Plaintiffs' Second Supplement to Their Confidential Trial Brief to Permit Dr. Grover to testify with Regard to all Issues Raised During his Deposition	04/01/11	14	3283-3352
85	Plaintiffs' Third Supplement to Their Confidential Trial Brief; There is No Surprise to the Defense Regarding Evidence of a Spinal Stimulator	04/01/11	14	3353-3406
86	Plaintiffs' Fourth Supplement to Their Confidential Trial Brief Regarding Cross Examination of Dr. Wang	04/01/11	15	3407-3414
87	Plaintiffs' Fifth Supplement to Their Confidential Trial Brief to Permit Stan Smith, Ph.D., to Testify Regarding Evidence Made Known to Him During Trial	04/01/11	15	3415-3531
88	Stipulation and Order to Modify Briefing Schedule	04/21/11	15	3532-3535
89	Defendant's Response in Opposition to Plaintiff's Request for Attorney Fees	04/22/11	15	3536-3552
90	Defendant's Amended Response in Opposition to Plaintiffs' Request for Attorney Fees	04/22/11	15	3553-3569
91	Plaintiffs' Brief in Favor of an Award of Attorney's Fees Following Default Judgment	04/22/11	15	3570-3624

92	Stipulation and Order to Modify Briefing Schedule	04/22/11	15	3625-3627
93	Decision and Order Regarding Plaintiffs' Motion to Strike Defendant's Answer	04/22/11	16	3628-3662
94	Notice of Entry of Order to Modify Briefing Schedule	04/25/11	16	3663-3669
95	Notice of Entry of Order to Modify Briefing Schedule	04/26/11	16	3670-3674
96	Notice of Entry of Order Regarding Motion to Strike	04/26/11	16	3675-3714
97	Plaintiffs' Memorandum of Costs and Disbursements	04/26/11	16	3715-3807
98	Minutes of Hearing Regarding Status Check	04/28/11	16	3808-3809
99	Judgment	04/28/11	16	3810-3812
100	Defendant's Motion to Retax Costs	04/29/11	16	3813-3816
101	Notice of Entry of Judgment	05/03/11	16	3817-3822
102	Stipulation and Order to Stay Execution of Judgment	05/06/11	16	3823-3825
103	Notice of Entry of Order to Stay Execution of Judgment	05/09/11	16	3826-3830
104	Plaintiffs' Opposition to Defendant's Motion to Retax Costs	05/16/11	16	3831-3851
105	Defendant's Motion for New Trial	05/16/11	17	3852-4102
			18	4103-4144
106	Certificate of Service	05/17/11	18	4145-4147
107	Subpoena Duces Tecum (Dr. Rosler)	05/18/11	18	4148-4153
108	Plaintiffs' Motion for Attorneys' Fees	05/25/11	18	4154-4285
109	Defendant's Reply to Opposition to Motion to Retax Costs	05/26/11	18	4286-4290
110	Plaintiffs' Motion to Quash Defendant's Subpoena Duces Tecum to Jan-Jorg Rosler, M.D. at Nevada Spine Institute on Order Shortening Time	05/26/11	18	4291-4305
111	Notice of Appeal	05/31/11	19	4306-4354
112	Case Appeal Statement	05/31/11	19	4355-4359
113	Judgment	06/01/11	19	4360-4373
114	Defendant's Opposition to Motion to Quash	06/01/11	19	4374-4378
115	Minutes of Hearing Regarding Motion to Retax	06/02/11	19	4379-4380
116	Notice of Entry of Judgment	06/02/11	19	4381-4397

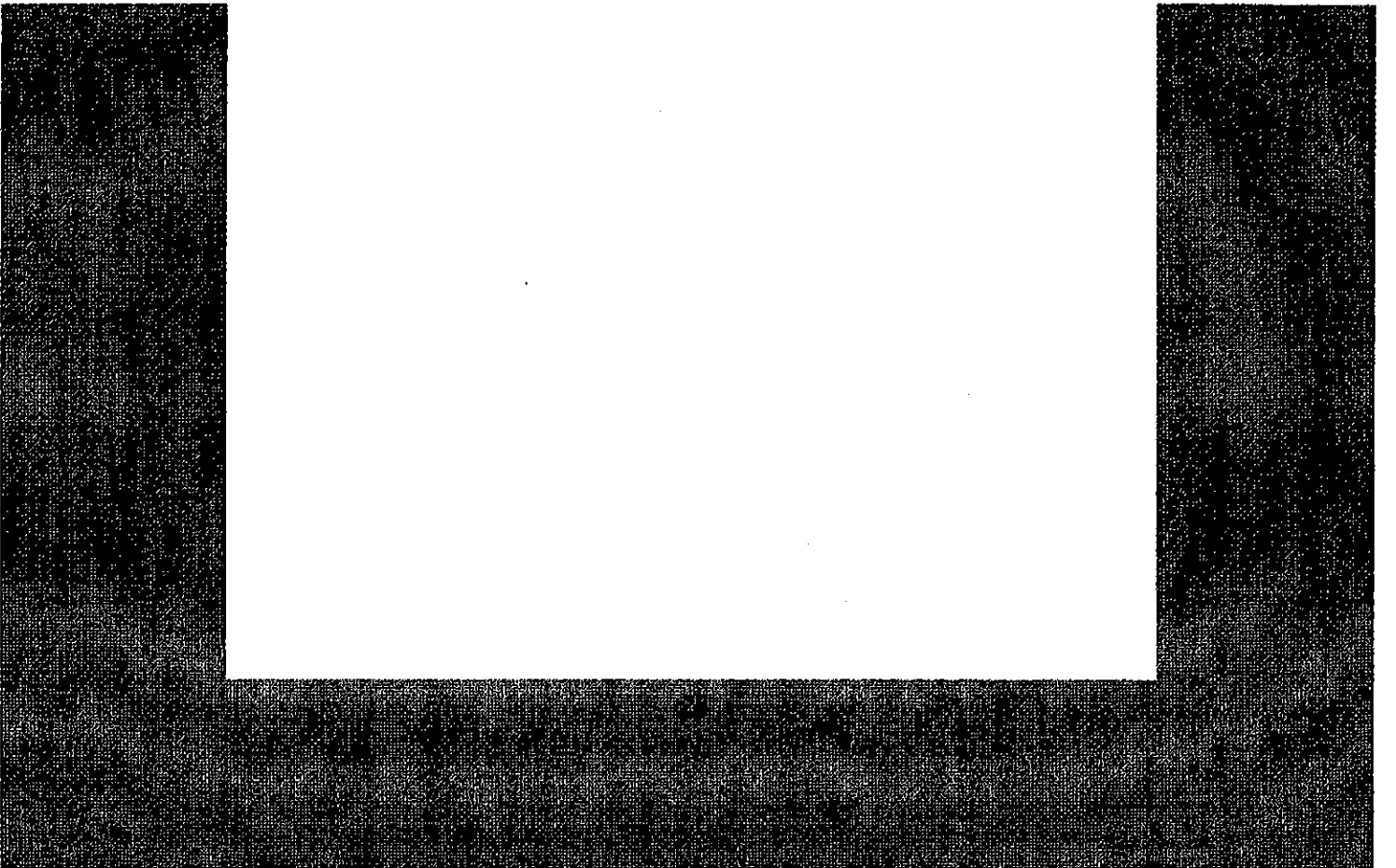
117	Plaintiffs' Reply to Defendant's Opposition to Motion to Quash Defendants' Subpoena Duces Tecum to Jans-Jorg Rosler, M.D. at Spine Institute on Order Shortening Time	06/06/11	19	4398-4405
118	Transcript of Hearing Regarding Motion to Quash	06/07/11	19	4406-4411
119	Defendant's Opposition to Motion for Attorney Fees	06/13/11	19	4412-4419
120	Order Denying Defendant's Motion to Retax Costs	06/16/11	19	4420-4422
121	Notice of Entry of Order Denying Motion to Retax Costs	06/16/11	19	4423-4429
122	Plaintiffs' Opposition to Defendant's Motion for New Trial	06/24/11	19	4430-4556
			20	4557-4690
123	Amended Notice of Appeal	06/27/11	20	4691-4711
124	Amended Case Appeal Statement	06/27/11	20	4712-4716
125	Defendant's Motion to Compel Production of Documents	07/06/11	20	4717-4721
126	Receipt of Appeal Bond	07/06/11	20	4722-4723
127	Defendant's Reply to Opposition to Motion for New Trial	07/14/11	20	4724-4740
128	Plaintiffs' Reply to Defendant's Opposition to Motion for Attorneys' Fees	07/14/11	20	4741-4748
129	Minutes of Hearings on Motions	07/21/11	20	4749-4751
130	Order Granting Plaintiffs' Motion to Quash Defendant's Subpoena Duces Tecum to Jans-Jorg Rosler, M.D. at Nevada Spine Institute on Order Shortening Time	07/25/11	20	4752-4754
131	Notice of Entry of Order Granting Motion to Quash	07/25/11	20	4755-4761
132	Plaintiffs' Opposition to Defendant's Motion to Compel Production of Documents	07/26/11	20	4762-4779
133	Minutes of Hearing on Motion to Compel	08/11/11	20	4780-4781
134	Order Denying Defendant's Motion for New Trial	08/24/11	20	4782-4784
135	Notice of Entry of Order Denying Defendant's Motion for New Trial	08/25/11	20	4785-4791
136	Order Denying Defendant's Motion to Compel Production of Documents	09/01/11	20	4792-4794
137	Notice of Entry of Order Denying Defendant's Motion to Compel Production of Documents	09/02/11	20	4795-4800
138	Second Amended Notice of Appeal	09/14/11	21	4801-4811

139	Second Amended Case Appeal Statement	09/14/11	21	4812-4816
140	Order Granting Plaintiffs' Motion for Attorney's Fees	09/14/11	21	4817-4819
141	Notice of Entry of Order Granting Plaintiffs' Motion for Attorney's Fees	09/15/11	21	4820-4825
142	Final Judgment	09/23/11	21	4826-4829
143	Notice of Entry of Final Judgment	09/30/11	21	4830-4836
144	Notice of Posting Supersedeas Bond	09/30/11	21	4837-4845
145	Request for Transcripts	10/03/11	21	4846-4848
146	Third Amended Notice of Appeal	10/10/11	21	4849-4864
147	Third Amended Case Appeal Statement	10/10/11	21	4865-4869
148	Portion of Jury Trial - Day 6 (Bench Conferences)	03/21/11	21	4870-4883
149	Portion of Jury Trial - Day 7 (Bench Conferences)	03/22/11	21	4884-4900
150	Portion of Jury Trial - Day 8 (Bench Conferences)	03/23/11	21	4901-4920
151	Portion of Jury Trial - Day 9 (Bench Conferences)	03/24/11	21	4921-4957
152	Portion of Jury Trial - Day 10 (Bench Conferences)	03/25/11	21	4958-4998
153	Portion of Jury Trial - Day 11 (Bench Conferences)	03/28/11	21	4999-5016
154	Portion of Jury Trial - Day 12 (Bench Conferences)	03/29/11	22	5017-5056
155	Portion of Jury Trial - Day 13 (Bench Conferences)	03/30/11	22	5057-5089
156	Portion of Jury Trial - Day 14 (Bench Conferences)	03/31/11	22	5090-5105



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Alvin L. Blum

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TRAN

DISTRICT COURT

CLARK COUNTY, NEVADA

WILLIAM SIMAO,

Plaintiff,

v.

JENNY RISH,

Defendant.

CASE NO. ~~A-539445~~

DEPT. X

A 53 9455

BEFORE THE HONORABLE JESSIE WALSH, DISTRICT COURT JUDGE

MONDAY, MARCH 21, 2011

REPORTER'S TRANSCRIPT

TRIAL BY JURY

DAY 1 - VOLUME I

APPEARANCES:

For the Plaintiff:

DAVID T. WALL, ESQ.
ROBERT M. ADAMS, ESQ.
ROBERT T. EGLET, ESQ.
Mainor Eglet, LLP

For the Defendant:

STEVEN M. ROGERS, ESQ.
Hutchison & Steffen, LLC

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CLERK OF THE COURT

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1 MONDAY, MARCH 21, 2011 AT 1:05 P.M.

2 [Within the Presence of the Jury]

3 THE CLERK: Please remain in order. Department X is now
4 in session. The Honorable Jessie Walsh, Judge, presiding.

5 THE COURT: Please be seated. Good afternoon, members of
6 the jury. Verbal response. That's a great start. Thank you.
7 Thank for returning each and every one. Will Counsel
8 stipulate to the presence of the jury?

9 MR. WALL: Yes, Your Honor.

10 MR. ROGERS: Yes, Your Honor.

11 THE COURT: Ladies and gentlemen of the jury, I would
12 like to briefly explain to you the proceedings you are about
13 to witness. You will, at the conclusion of the evidence,
14 determine the facts in this case, apply to those facts the law
15 which will be stated to you by the Court and on that basis,
16 reach a verdict consistent with the facts and the law.
17 Observe carefully each witness as he or she testifies and
18 consider carefully all of the evidence as it is presented to
19 you. For it is you who must determine the credibility of the
20 witnesses and wherein the truth lies.

21 If the Court sustains an objection to any evidence,
22 do not infer any bias of the Court based upon such rulings or
23 speculate about any feeling on the part of the Court for or
24 against either side in this case. If any objection to the
25 testimony of a witness is sustained, you must not guess as to

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1 what the answer might have been or draw any inferences from
2 the question objected to itself. Remember that questions and
3 arguments of Counsel are not evidence. Questions are important
4 on insofar as they give meaning to the answer of the witness.
5 Arguments of Counsel are only their opinion as to matters and
6 have no evidentiary weight.

7 During the course of the trial, matters may arise
8 which must be determined by the Court outside the presence of
9 the jury as a matter of law. Again, you are not to speculate
10 or be concerned in any way as to the reasons for such
11 occurrences. I assure you they will be as limited in
12 frequency and in duration as the law permits.

13 Your verdict in this case is to be based upon the
14 testimony of the witnesses and other evidence that is produced
15 in this courtroom and not on anything that occurs outside this
16 room. Accordingly, you are not to visit any site or location
17 that may be described by witnesses or to conduct experiments
18 or perform any research on any subject connected with this
19 case.

20 If during the examination of a witness some
21 questions occur to you which you would like to see answered,
22 please be patient. Your questions will probably be answered
23 before the examination has been concluded. If not, write your
24 questions on a slip of paper and give it to the bailiff. And
25 if it is a proper one under the law, I will see that it is

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1 answered.

2 You may individually take notes. And for that
3 purpose, you have been provided pencils and notepads.
4 However, in the event of a conflict between the notes of the
5 individual jurors during your deliberations, you are not to
6 rely upon the notes. You are to rely upon your own
7 recollection of the testimony and the evidence.

8 Ladies and gentlemen of the jury, you are admonished
9 that no juror may declare to his or her fellow jurors any fact
10 relating to the case as of his or her knowledge and if any
11 juror discovers during the trial or after the jury has retired
12 that he or she has personal knowledge of any fact in
13 controversy in the case, that juror shall disclose such a
14 situation to the Court outside the presence of the other
15 jurors.

16 One more reminder that Marshal Diamond is your only
17 point of contact during these proceedings. None of the rest
18 of us may have any direct contact with you.

19 Will Counsel stipulation that the reading of the
20 pleadings may be omitted?

21 MR. WALL: We'll waive, Your Honor.

22 THE COURT: Okay.

23 MR. ROGERS: Defense will too.

24 THE COURT: Then, ladies and gentlemen, this is the time
25 when the attorneys give you their opening statements. The law

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1 requires that the attorney for the Plaintiff goes first. Mr.
2 Wall are you prepared to proceed?

3 MR. WALL: I am. Thank you very much, Your Honor.

4 Good afternoon, ladies and gentlemen. No one is
5 allowed to needlessly endanger the public. If you needlessly
6 endanger the public and you hurt someone, you are responsible
7 for all of the harms and losses that follow. If you rear-end
8 another vehicle and you hurt someone, you are responsible for
9 all of the harms and losses that follow.

10 Now this case is about accountability and
11 responsibility. When we talk about responsibility, what we're
12 really talking about is who is to blame.

13 Let me tell you the story of this case. On the
14 morning of April 15th, 2005, the Defendant, Jenny Rish, left
15 Ogden, Utah, in a Chevy Suburban being driven by her
16 daughter-in-law, Linda Rish. For most of the day -- before I
17 get to this, let me tell you something. Thursday afternoon
18 when Mr. Rogers was questioning you, during the jury selection
19 process, I noticed something, realized something. When I
20 spoke to you a week ago today, I told you this occurred, I
21 believe, I guess, on the 215. Because a couple of you told
22 that to Mr. Rogers. That was my mistake.

23 For most of the day on April 15th, 2005, Defendant
24 Rish was a passenger in the Suburban that was headed toward
25 Las Vegas on I-15. Just outside of Las Vegas, the Suburban

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1 was stopped to get gas and Defendant Jenny Rish took over the
2 driving responsibility. And after taking over those duties,
3 she came upon heavy traffic before the Cheyenne exit
4 southbound on I-15. And in this heavy traffic at about 3:00
5 p.m., she was following behind the white van driven by
6 Mr. Simao. And after driving in this traffic for about --
7 approximately three minutes, the Defendant crashed that
8 Suburban into the rear of Mr. Simao's van. The crash caused
9 his head to hit a metal cage located behind the driver's seat.
10 This was a work van. And behind the front seats, there's a
11 cage and then equipment in the back. So the crash from behind
12 caused his head to hit the metal cage immediately behind the
13 driver's seat. After the impact, the Defendant, Jenny Rish,
14 immediately called 911.

15 Now, to get here, Mr. Simao sued Defendant Rish by
16 filing what we call a complaint. And in that complaint, he
17 alleged that she was negligent and careless in the operation
18 her vehicle that afternoon. And the complaint specifically
19 says,

20 "At the time of the collision herein complained
21 of and immediately prior thereto, Defendant Jenny
22 Rish was negligent and careless in the following
23 particulars. A, in failing to maintain a proper
24 lookout for other vehicles on the roadway, and more
25 particularly, the Plaintiff's vehicle. B, in

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1 operating the Defendant's vehicle without due
2 caution and with disregard for the rights of
3 Plaintiff. C, in failing to maintain a safe
4 distance behind William's vehicle. D, in failing to
5 keep her vehicle under proper control. And E, in
6 operating her vehicle without paying full time and
7 attention to its operation."

8 On behalf of the Defendant, her attorney answered
9 the complaint, which is how lawsuits begin, and denied the
10 allegations that were in the complaint. The answer says, and
11 it was Paragraph 12 of the complaint that I just showed you,
12 answering Paragraphs 12, 13, 14, 15 and beyond, the Defendant
13 denies the allegations contained therein. And through her
14 counsel, the Defendant blamed the crash on William. She
15 posited what's called an affirmative defense in her answers,
16 reasons why she shouldn't be held responsible. His damages,
17 if any, were caused in whole or in part by the Plaintiff's own
18 negligence, which was greater than the negligence if any of
19 this Defendant. And through her counsel, she also blamed
20 third parties for the crash. Plaintiff's damages, if any,
21 were caused by the acts or omissions of a third party over
22 whom this Defendant had no control. So who is blame?

23 In October of 2008, the Defendant answered
24 interrogatories under oath. It's a part of what happens in a
25 civil lawsuit. They are written questions sent from one side

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1 to the other that have to be answered in writing. And then
2 they're sworn to. So the answers are sworn. And unlike what
3 was in that answer, the one that I just showed you from her
4 counsel, Defendant Rish did not blame William for causing the
5 crash. She did not blame an unknown phantom third party for
6 causing the crash. The interrogatory said, "State how the
7 accident occurred, giving the speed, direction and location."
8 And her response was, "The parties were driving in bumper to
9 bumper traffic. Traffic slowed. Defendant Rish did not slow.
10 The accident followed." And as you're required to do for
11 interrogatories, she swore and verified that the contents of
12 those answers were true of her own knowledge.

13 In April of 2009, the Defendant gave deposition
14 testimony under oath. You'll learn that a deposition is
15 questioning of a witness. It's done under oath. And the
16 answers are preserved in writing. And you'll be instructed by
17 the Court that the oath and the testimony in a deposition is
18 to be taken as if basically it occurred here in court. It's
19 the same oath that you take before a deposition. And under
20 oath in that deposition, the Defendant testified that the
21 crash was her fault. She was asked, "Yes, it was your fault.
22 Correct?" Answer, "Yeah. I hit him." She was asked, "What
23 happened after the impact?" She said, "I called 911." "Did
24 somebody arrive at the scene?" "A fire truck, an ambulance,
25 and a policeman or highway patrol."

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1 So who is to blame? Even though she has testified
2 in her deposition that the crash was her fault, the defense
3 continues to blame others.

4 MR. ROGERS: Objection, Your Honor. This seems to have
5 no relevance to this case at all. The defense admitted
6 liability. And they seem to intend to demonize the attorneys.

7 THE COURT: Counsel, approach, please.

8 [Bench Conference Not Transcribed]

9 MR. WALL: Objection's overruled, Your Honor?

10 THE COURT: Yes.

11 MR. WALL: Thank you. Ladies and gentlemen, this is Bill
12 Simao. You've seen him in court so far. He was born in San
13 Francisco in 1963. He's lived in Las Vegas for about nine
14 years, since 2002, when he and his wife moved here from
15 Modesto, California. He has three children, Justin, William,
16 and Amanda. He's the owner of a cleaning service. A small
17 family business called Ameri-Clean. Do a lot of floor
18 cleaning work and carpet cleaning work. In fact, his son and
19 his daughter actually work in the small family business with
20 him. He enjoyed riding motorcycles. At least until April 15,
21 2005. And his wife, Cheryl Simao, who's been here in court.
22 Born also in San Francisco. They got married in 1984. So
23 they've been married for 26 years. Almost 27. She works as a
24 biller for a surgery -- a medical provider. And she has a
25 claim in this case as well. She has a claim for the loss of

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1 the companionship and support of her husband, now, in the
2 past, and in the future.

3 So as a result of this crash, Mr. Simao has had 139
4 medical visits so far. He's had 14 separate surgical
5 interventions so far. He'll be subject to lifelong medical
6 dependency. He losses [sic] in the millions of dollars,
7 including his medical bills to date, in the future, and loss
8 of enjoyment of life.

9 The constellation of injuries he suffered as a
10 result of this accident, for one, he had an exacerbation of
11 his migraine headaches. You will hear that he had migraines
12 even before this accident on occasion. After the accident, as
13 a result of the injuries in the accident, those became worse
14 and more frequent. He had muscle tension headaches, which
15 will be described to you, as a result of some of the muscle
16 and cervical issues, the neck issues, that he suffered in the
17 crash. He had a left elbow strain. He actually whacked his
18 left elbow in the crash, also against the cage. He had left
19 upper extremity radiculopathy. Now, you're going to learn a
20 lot of things in this case. That's going to be one of them.
21 What that means, your left upper extremity is your left arm.
22 Radiculopathy is pain that radiates from an injury here down
23 into your arm. It radiates, so it's called radiculopathy.

24 Most notably what he suffered is a neck injury. He
25 had disk disruption. Disruption of the disks in his neck, at

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1 two separate levels, which required an anterior cervical
2 discectomy. Now, you'll learn that basically what that is,
3 anterior means front. Cervical means neck. Discectomy means
4 the removal of two disks. Ectomy is removal. An
5 appendectomy, the removal of your appendix. Discectomy, the
6 removal of two disks.

7 All right. The spine. You're going to be learning
8 a lot about the spine. It's the information highway of the
9 body. It protects our spinal cord so the brain can direct
10 messages to the rest of the body. It allows us to turn, to
11 walk, to pick up things. It is unique. It is complex. It is
12 not solid or rigid. Because of the placement of all the bones
13 and the softer disks and the joints that are involved, it
14 gives us the ability to bend back and forth and twist.

15 Now, the spine is divided into separate areas. The
16 top area, the neck, is called the cervical spine. The central
17 portion is called the thoracic vertebrae. And the bottom, the
18 low back, is called the lumbar vertebrae. Below that is the
19 sacrum and then your tailbone, the coccyx, which actually
20 makes up the tailbone. So when you hear the doctor talk,
21 he'll either talk about a cervical region, a thoracic region
22 or a lumbar region. Especially when they talk about the
23 cervical, they're talking the neck.

24 And in addition to that, they actually number each
25 level. And they number the separate bones in the neck. So at

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1 the top would be C-1, C-2, C-3, C-4, C-5, C-6, C-7. There's
2 seven at the top. There's 12 thoracic and then there's five
3 lumbar. So when they talk about C-1 or C-2 or C-3, on medical
4 provider can reference that in a report and the rest of the
5 medical providers who see that will know exactly that he's
6 talking about. Now, the discs themselves, which are between
7 each layer of bone -- so if this is C-3 and this bone is C-4,
8 the disc in the middle they call C-3-4 because it sits between
9 the vertebrae C-3 and C-4.

10 Now, this is a disc. If you took one of the discs
11 and slid it out, this is sort of what it would look like. It
12 is soft. It is softer than bone. It gives us the ability to
13 move and bend and turn. It's made up of an outer substance
14 called an annulus fibrosis, which is sort of a tough membrane.
15 And the inner part is called the nucleus pulposus. It's a
16 softer, more like a jelly type material. You'll hear
17 sometimes the medical providers talk about it, the whole
18 thing, like it's a jelly donut. The outside is a little bit
19 tougher and the inside is a little mushier. Not a medical
20 term. My term. Mushier. All right? And that's what's in
21 each disc between each level of the bones. And so the spine,
22 with a disc in between each bone, that disc allows us to move
23 and bend. It acts as sort of a shock absorber for the bones
24 and allows us to move and do the things we need to do every
25 day.

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1 All right. When there's an injury to the spine --
2 see these things that come out at every level. They are nerve
3 roots emanating from the spinal cord, which is in the middle.
4 And those nerve roots that come out between each level send
5 nerves to distinct parts of the body. And when the spine is
6 injured in one spot, pain sometimes shoots down or radiates to
7 another part of the body. For instance, in the low back, you
8 see all of these go down this way. When someone has a low
9 back injury, you'll often see them with pain that radiates
10 down their legs to one leg or the other or to both. Sometimes
11 it's numbness that goes down. From the neck, you can see it
12 goes into this area. You'll get radiating pain into upper
13 extremities. Sometimes here. Sometimes back down the
14 shoulder into the arms down to the hands. Now, sometimes it's
15 pain that radiates. Sometimes it's numbness. Sometimes it's
16 nothing. Some days there's nothing. Some days there's more
17 pain. Some days there's more numbness. Some days there aren't
18 any.

19 This, if we took one of these and took a cut right
20 here and pulled the whole thing out, vertebrae, disc, bone,
21 and held it up, this is what it would look like. A picture in
22 the upper left hand corner, you see the disc sitting on top of
23 a vertebrae. You see the nerve roots that come out. You see
24 the spinal cord in the middle. It's actually floating in
25 fluid. It's not really attached to the bone. Those nerve

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1 roots come out and go to different parts of the body. Now, on
2 the bottom left, if you took this and cut it this way and
3 pulled it open and looked at it, you'd see what's on the
4 bottom left of that picture. You'd see each of the vertebrae
5 right here, the discs in between, and the spinal cord in the
6 center.

7 Now, one type of injury that can occur to the spine
8 is what's called a disc herniation or a disc protrusion. And
9 what's happens is that the disc actually bulges out slightly.
10 It may bulge out all the way around. A disc bulging, a disc
11 herniation, a disc protrusion, they're often used
12 interchangeably, those words. And what happens is that the
13 disc moves out in a way. And it can move in different
14 directions. Sometimes, it can even move toward the spinal
15 cord. Now, understand that when this happens because there's
16 nerves all the way through that area, that often you have
17 pain. You have radiating pain. You have pain actually in the
18 location as well as that pain which radiates.

19 Now, another thing that can actually happen is where
20 there's a tear in the disc. The disc, itself, actually tears.
21 And because there's nerves actually in the disc, itself, the
22 disc can tear and cause pain. And cause that same radiating
23 pain I talked about a moment ago.

24 All right. These are some of the treating provider
25 who have treated Mr. Simao. They will come in and testify as

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1 well as some of the other providers. The first one is
2 Dr. Patrick McNulty. Dr. McNulty is a fellowship trained,
3 board certified spine surgeon. Dr. Jas Grover is a fellowship
4 trained, board certified spine surgeon. Dr. Jorg Rosler is a
5 fellowship trained, board certified pain management
6 specialist. Someone who also treated Mr. Simao. And finally,
7 Dr. Sible, who is a fellowship trained, board certified pain
8 management specialist.

9 So April 15th, 2005 is the date the crash. And on
10 the date of the crash, once William got home, he waited for
11 his wife to come home and then went on to Southwest Medical
12 and went to urgent care. And this is what they noted. Post
13 motor vehicle accident. Complains of neck, back and shoulder
14 pain. The patient is a 41-year-old who was involved in a
15 motor vehicle collision at 3:30 p.m. His chief complaint is
16 left elbow, pain and tenderness in the back of his head. He
17 was the driver of a large van which was rear-ended at an
18 unknown speed, nearly stopped on the freeway. He had a
19 hyperflexion and extension movement of his neck which caused
20 him to strike the back of his head on a cage in the inside of
21 his work van. He denies loss of consciousness. On the
22 examination, they noticed his scalp is tender in the occipital
23 area. The occipital area sits right above the spine. Right
24 here on the back of your head, just at the top of the spine is
25 the occipital area. So he had pain to the touch there.

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1 They did x-rays of the his spine, his left elbow and
2 his left forearm, as well as his neck. Well, the C-spine.
3 That's his neck. And they were looking basically for
4 fractures. And when they do an x-ray, they're looking to see
5 if anything is fractured. The x-ray came back negative. They
6 told him to return to the clinic or seek primary care follow
7 up if you're not improving in the next week or ten days.

8 He returned on May 4th to Southwest Medical. And is
9 says, now having recurrent occipital pain. Occipital is the
10 area at the top of your neck. On May 4th, he presented for
11 follow up. He'd been in a motor vehicle accident where he was
12 rear ended on the highway. That caused his head to bang up
13 against the back of the wall of his cargo van that he was
14 driving. He does have a history of migraine headaches.
15 However, according to him, this feels different. He denies
16 that he experienced any loss of consciousness at the time of
17 the accident. They refer him for a CT scan which is similar
18 to an MRI. Gives them a better look. That's the occipital
19 region. At the top of the cervical spine. At the base of the
20 head. So they did that CT scan. Basically, they're looking
21 for some type of injury inside the skull. Some sort of
22 hemorrhage inside the skull. Maybe some aneurism. And they
23 found nothing.

24 He goes back on May 12th. Again, this is time he
25 has numbness to his upper lip and parts of the side of his

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1 face. He has a persistent pressure sensation in his occipital
2 head, at the top of his neck, after being involved in the
3 motor vehicle crash. He's had that for two weeks. A two-week
4 history of that pressure. He also now has blurred vision and
5 some facial numbness. He's referred for an MRI at that time.
6 And understand that to this point, every time he's gone to see
7 someone at a medical provider at Southwest Medical, he has not
8 seen a physician. He has seen a PA, a physician's assistant.
9 The do an MRI of his brain, which comes back negative. No
10 injury inside his skull.

11 He comes back on May 26th, 2005. He does have a
12 history of migraine headaches. He did experience a change in
13 his headache intensity and character after a motor vehicle
14 accident. He had cervical x-rays and a CT of his head, which
15 were all normal. He's had an MRI of the head and brain which
16 came back normal. All those were explained to Mr. Simao that
17 day, May 26th, 2005. And they tell him to come back in six
18 months for a checkup if he hasn't had any problems.

19 Understand what's happening at this point. He was
20 hurting since the motor vehicle accident. You saw how he
21 tried to find out what was wrong. Had some history of
22 migraines, but this was much, much different. The pressure.
23 The pain in the occipital region of his head. He took every
24 test they would give him because he knows something is wrong.
25 So by May 26th, 2005, five or six weeks after the accident,

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1 they tell him every test is negative. You're okay. He's been
2 told they can't find anything yet. And you'll hear that none
3 of the tests that they had run to this point would have
4 diagnosed the condition that he actually had. They tell him
5 essentially it'll go away. He trusts them. He believes them.
6 He goes home. They tell him, come back in six months. So he
7 does what they tell him to. He assumes that it will go away.
8 And instead, it gets progressively worse. The head pain. The
9 pressure at the back of his head. The neck pain. That's
10 what worried him the most. He has this neck pain. It's the
11 pressure inside his head that made it difficult for him. But
12 he had pain in his neck just as he did on the date of the
13 accident.

14 And even though they told him to come back in six
15 months, he couldn't wait that long. The pain was too great.
16 And by the way, he wasn't just sitting around this whole time.
17 He continued to work. He had a business to run, a family to
18 feed. And so he continued to work. But he couldn't make it
19 six months. He only made it four and a half. And on October
20 6th, 2005, he comes back to Southwest Medical. Again, sees a
21 PA. Check up. Neck and shoulder pain with headaches. He has
22 tension type headaches and he has migraine headaches. This is
23 a 42-year-old male with history of migraine headaches. Those
24 have become worse in the last few months. He's having it more
25 frequently. Nausea and vomiting. Occasionally, they start as

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1 tightness and pain in his left shoulder and then radiates up
2 into his neck. And later on, he will develop a migraine
3 headache. He's tried multiple various migraine headache
4 medications. Hasn't worked. They put him on some new
5 medications, including a muscle relaxant. And tell him to
6 follow up in six or eight weeks.

7 Six days later on October 12th, he returns. They do
8 x-rays of his neck and left shoulder -- or order them because
9 of his history of tension headaches associated with shoulder
10 discomfort. The x-rays actually take on October 18th, 2005,
11 x-ray of his neck and his left shoulder. Again, those would
12 not detect what he ended up with.

13 They tell him it's going to get better. But he
14 comes back on December 21st, 2005. He sees a Dr. Sy
15 [phonetic]. This is the first time he actually sees a doctor
16 instead of a physician's assistant. And the doctor notes,
17 neck and left shoulder pain. But he's been complaining of
18 neck and shoulder pain off and on for the past several months.
19 We are seven months now -- eight months post accident. And
20 it's gotten worse. He doesn't do any activities which may
21 worsen or exacerbate it.

22 And at that this point, Dr. Sy says, I think we
23 should recommend some supportive measures for his neck and
24 trapezial pain. Your trapezius is this muscle you can grab
25 sort right on top, on the top of your shoulders. Emanates

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1 from your neck.

2 So they recommend physical therapy for him. And on
3 his initial visit to physical therapy, January 16th, 2006,
4 it's reported that he initially sustained injury to his neck
5 and upper trap region when he was involved in a motor vehicle
6 accident on April 15th, 2005. His left hand goes numb. He
7 has pain at the back of his neck and his left upper trapezius.
8 Always the left. And increased frequency of his migraines.
9 They note that his left scapula, that's your shoulder blade,
10 is slightly depressed. And he has a tendency to lean his head
11 to the right. They note muscle guarding. And muscle tightness
12 is noted in that left upper trapezius. That's the beginning
13 of physical therapy. He goes just as he's directed to
14 physical therapy. Twice a week. Every week. Desert Valley
15 Therapy. He goes. One of the reports, from February 13th,
16 2005, from physical therapy shows pain more localized to his
17 left side. And a decrease in his headache frequency and
18 intensity. But continued numbness of his left hand. Unable
19 to play the guitar. So this is affecting his everyday life.

20 They give him what's called a tens unit, which is
21 sort of electric -- electronic nerve stimulator that you can
22 take home and use there. So he's still in the course of his
23 physical therapy. He continues to go twice a week, every
24 week.

25 We're up to March 6th, 2006. Twenty-five medical

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1 visits. On March 9th, 2006, he presents for follow up. Again
2 this is with a physician's assistant. He has been fairly
3 chronic neck pain with pain, burning, and numbness radiating
4 to his left shoulder and left upper extremities. You'll hear
5 that in the medical parlance, the word chronic. When they say
6 chronic pain, it means that it has lasted at least six months
7 if not more. He does complain of discomfort radiating to his
8 left shoulder with numbness with range of motion of his neck
9 and shoulder. He has tension headaches, migraine headaches,
10 cervicaljo [phonetic], which is a fancy word for neck pain,
11 with left upper extremity radiculopathy.

12 At this point, they decide, you know what, he hasn't
13 gotten any better. And due to the chronic nature, the
14 chronicity [sic] of his neck pain, with radiating symptoms,
15 maybe it's time to refer him to an orthopedic specialist.
16 They order an MRI, which is -- better than an x-ray, more like
17 a CT scan. It allows, with the technology now -- it's a
18 magnetic resonance imaging test -- to get much better pictures
19 of what's going on inside someone. And they do this in March
20 of 2006, March 22nd. And the result is two-fold. First,
21 there's a mild central broad based disc bulge. Remember we
22 talked about how a disc can bulge out from the area where it's
23 supposed to be. And that's at C-4/5. So between the C-4 bone
24 and the C-5 bone, the disc in the middle is the C-4/5. That
25 disc shows a slight bulge. There's also facet hypertrophy,

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1 which is actually sort of an enlarging of one of the bones on
2 the back -- or the joints in the back. These are facet joints
3 back here that help us move. This is a problem at the C-3/4
4 level. So now, we're one disc up and we're noting that
5 there's problems there too based on the MRI. And there may be
6 left C-4 nerve root contact. This nerve root that comes out,
7 if something is in contact with it, pinches it, you get
8 extreme pain and you get the radiating symptoms that William
9 suffered from. So the MRI shows there's at least a problem,
10 something to be aware of at C-3/4 and C-4/5. And he goes back
11 to Southwest Medical, sees a PA who has the results of the
12 MRI. And they say time to refer to an orthopedic specialist.
13 So they officially refer him to an orthopedic specialist.

14 So on April 18th, 2006, he has his first visit with
15 an orthopedic spine surgeon, Dr. Patrick McNulty. One year
16 and three days after the accident on medical visit number 30,
17 he has his first visit with the spine surgeon.

18 In that evaluation, the report of Dr. McNulty says,
19 the patient has a one-year history -- one year and three days
20 -- of posterior, that's the back, cervical, that's the neck,
21 pain with occipital radiation, that means radiation up to the
22 occipital area, and trapezial radiation, down to this muscle.
23 More so to the left with left upper extremity parathesis.
24 Okay. You know this is the left upper extremity. Parathesis
25 is the numbness that radiates down. It's described as

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1 aching, pins and needles, numbness, stabbing, pressure. He's
2 had medications. He's had physical therapy. The symptoms
3 started after the motor vehicle accident. His primary issue
4 is cervical pain. Pain in his neck. And then what
5 Dr. McNulty writes is interesting. Options were discussed
6 with Mr. Simao. In a simple sense, the patient does not feel
7 that the problem would mandate surgery. But at the same time
8 -- and I think it's supposed to be vocalizes -- he vocalizes
9 how his pain is getting worse and he needs to find out what is
10 wrong and fix it. The patient was given general comments on
11 the role of injections to help to define pain generators as
12 well as potentially help to decrease his overall pain. But
13 the chance of long term pain relief with injections only is
14 relatively low. And that the patient would most likely
15 require some type of surgical intervention to get definitive
16 long term pain relief. Understand that to this point, Mr.
17 Simao had seen some PAs. He'd gotten some medication. He'd
18 done some physical therapy. The idea of surgery was first
19 broached with him by Dr. McNulty at this point.

20 Dr. McNulty says, the patient will be referred to
21 pain management for bilateral C-3/4, C-4/5 for set blocks and
22 they're going to document if he gets any relief from it. This
23 is a procedure that an orthopedic surgeon would use in a
24 cervical neck injury to determine what happens next. And he
25 says, I will see the patient back after that's done.

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1 Now, by this point, as I mentioned, William has had
2 a course of physical therapy, now they're really taking notice
3 of the problem -- actually, McNulty needs to identify what
4 actually is generating the pain in William's neck. It's been
5 there for over a year and so he sends him to a pain management
6 doctor -- a specialist in this, but first he sees Douglas Yong
7 [phonetic], another PA, who says he has a history of
8 insidiously worsening neck and hand pain over the past year.
9 He's interested in any type of interventional treatments that
10 may be helpful in controlling his pain. His focus for over a
11 year was to find out why it hurt and how to fix it. He was
12 tender again over the left trapezius, they gave him little
13 trigger point injections -- little injections of pain relief
14 or steroid into his actual trapezius to try to break up the
15 tension of that muscle.

16 And he's referred then and he sees Dr. Ross Sible.
17 Dr. Ross Sible is a board-certified fellowship trained pain
18 management doctor. His specialty is pain management and
19 anesthesiology and he sees Mr. Simao on June 7th, 2006 and
20 does a surgical procedure called a cervical transforaminal
21 steroid injection. All right, what he does is he performs an
22 injection into my client's neck. It has two main purposes.
23 One is diagnostic. We're going to try to diagnose what the
24 problem is. The second purpose is therapeutic. We're going
25 to try to provide some therapy for this and try to help with

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1 the pain.

2 The MRI has shown them that there's potential
3 problems at C-3/4 and C-4/5, so they take this healthy size
4 needle into his neck. This is not like getting a flu shot or
5 having blood drawn at the doctor. This is a surgical
6 procedure, a very sophisticated. And so what they do,
7 cervical means neck; transforaminal -- this area back here,
8 see where the gap is, the hole? That's the foramen, so they
9 go across the foramen, transforaminal. It's a steroid
10 injection. It's got steroid in it, as well as pain relief,
11 and they inject an area near the nerve root where they think
12 the pain is coming from. Here it's C-3/4 and C-4/5 and they
13 inject it.

14 And it's got two main components. It's got some
15 pain medication, sometimes marcaine, sometimes lidocaine, it's
16 supposed to work quickly and wears off after awhile, like
17 Novocain. It works quickly, it numbs the area, but it wears
18 off after six or eight hours. And then the second part of
19 that injection is a steroid, not a Barry Bonds-type steroid.
20 This is a steroid which is sort of an anti-inflammatory. It's
21 supposed to help try to calm the inflamed nerve. And they
22 inject it in there and they see what the result is.

23 So they did -- on June 7th, 2006 Dr. Sible did a
24 cervical transforaminal steroid injection. And they do this
25 with what's called fluoroscopy. That's why -- one of the

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1 reasons why it's such a sophisticated procedure. They have
2 the patient lay on his stomach, they have fluoroscopy, which
3 is sort of like an X-ray, and they have it available so that
4 it can see the top and the side, they can see from multiple
5 angles, except it's hooked to basically a monitor, so as he
6 begins the injection into my client's neck he can see on this
7 screen where the needle is going. So it's like an X-ray that
8 is in motion and he can watch it on the monitor.

9 So the first thing that happens in this type of
10 procedure is that there's an anesthetic needle that goes in to
11 dull the pain, this is the nerve root -- this is from the back
12 of the spine, here's those bones that stick out, the nerve
13 roots that I talked about, that's the nerve that they're
14 trying to test. And so the needle goes very close to the
15 nerve and then comes the injection of a contrast solution,
16 it's dye. It makes it easier on the fluoroscopy scene to see
17 exactly where the nerve is and exactly where you're going.

18 Then the needle -- the syringe is changed and they
19 put in this medicated solution. Pain medicine and a steroid.
20 The pain medicine, because it acts quickly, tells them, if
21 after this procedure there's no pain in that area, they know
22 they probably have the right area. That pain medication in
23 that area has helped calm the nerve, if it does that's the
24 diagnostic part of it. It's helped them diagnose whether this
25 is the right nerve root that's causing pain. And then the

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1 steroid and the medication helps to try to at least calm the
2 pain for a longer period of time.

3 Now that steroid has an anti-inflammatory, like
4 Advil, ibuprofen is an anti-inflammatory, sometimes it works,
5 sometimes it doesn't, sometimes it works for awhile. It's not
6 really intended to work very long, especially in an injury
7 that's been there for over a year.

8 So according to Dr. Sible, when he did this is on
9 June 7th, 2006 it was meant to be both therapeutic and
10 diagnostic. It worked for awhile. Mr. Simao came back and
11 saw the PA, the physician's assistant Douglas Yong, on June
12 20th, 2006. He returns for a follow-up, he is status post-
13 left C-3, C-4 transforaminal epidural steroid injection,
14 states he's had a good overall response. He's noticed a
15 decrease in the severity and frequency of the headaches,
16 however he still has some pain in the left trapezial area.
17 They had done those little trigger point injections
18 previously, they tried those again, and the PA says I'll see
19 you back soon.

20 July 27th, 2006, so since that injection that you
21 saw was on June 20th -- or I'm sorry, June 7th, we're now
22 about a month-and-a-half, a little more than a
23 month-and-a-half after that injection. He comes back for
24 follow-up. His headache frequency has significantly reduced,
25 as is his neck pain. That steroid worked a little bit in that

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1 area. He's satisfied with the outcome. We'll see him back in
2 about three months or so on an as-needed basis as long as he
3 continues to do well.

4 He didn't make it three months. August 24th, 2006,
5 about two-and-a-half months after the initial injection, he
6 returns, sees the PA again. He returns to the clinic today
7 with a complaint of exacerbation or worsening of his left
8 trapezial pain. We had discussed in the past the result of
9 his epidural steroid injections were not stellar. He did have
10 a reduction in the frequency of his tension type headaches,
11 however the pain over the C-4 distribution on the left
12 continues to worsen and have more frequent exacerbations. C-4
13 distribution, remember we talked about from C-4 it will
14 distribute nerves to a certain area. That's what they're
15 talking about. It continues to worsen.

16 The PA says I've talked to Mr. Simao about trying a
17 left C-4 selective nerve root block to see if we can get this
18 to stop during the anesthetic period of the procedure. He's
19 in favor of moving forward with this. Depending on the
20 results, we can look at pulse radio frequency versus second
21 surgery consultation. So along with the PA, Mr. Simao is
22 doing whatever he can to try to find out why he has pain since
23 the motor vehicle accident.

24 All right. He goes back on October 3rd, 2006 and
25 has another injection. This one's called a cervical -- neck

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1 -- selective nerve root block. It's very, very similar to the
2 injection that we just saw in the animation, except it's a
3 little more selective. They use a little less of the
4 medication so it doesn't spread as far. It stays in a smaller
5 place, right around the particular nerve that they're trying
6 to isolate to see if that's the one that's causing the pain.
7 It's done here by a Dr. Adam Arita. And according to him, he
8 just thinks that Dr. Sible wasn't available on October 3rd,
9 and so he did the injection instead.

10 Now, there was some success with it. Because you're
11 using less medication, that initial pain medicine that you put
12 in -- like the -- like Novocain. It worked, but it only
13 worked for about eight hours or so. The fact that the pain
14 returned after eight hours means that that steroid that you're
15 putting in there really isn't having much effect, which is not
16 surprising since we are now over a year-and-a-half after the
17 original injury.

18 So he goes back, Mr. Simao does, after that
19 selective nerve root block, and talks to Dr. Arita again and
20 they try something else. They try another injection
21 procedure, a cervical selective nerve root block, same thing
22 he had up here, smaller amount, trying to be more selective,
23 with pulse radio frequency on the left side at C-4.

24 All right. Another injection you're going to learn
25 about. It's very similar to the one I just talked about.

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1 It's across, in the same area that we were before. They go in
2 there with the pain medication and the steroid, but now they
3 add a third quantity. It's basically, along the needle
4 there's sort of a wire that goes into the area and around the
5 nerve they use radio frequency and they pulse it. It actually
6 sort of warms the area around that nerve root. You know, if
7 normally we're, what, 98.6 degrees? This is about 106, 107
8 somewhere around there. They warm the area around the nerve
9 root.

10 I'm going to let the doctors explain to you why that
11 helps, but it essentially creates a nice, warm environment
12 around the nerve. Who doesn't like a nice, warm environment?
13 It makes for almost a happier nerve root, okay? And it lasts
14 for a period of time and it changes the way the nerve root
15 sends pain signals. So now they're trying something new and
16 expect -- and it's expected to hopefully help, but it's not a
17 cure. It's just a treatment for a finite period of time.

18 They do this and he comes back on January 10th,
19 2007. It was November 2006, so about two months. His pain is
20 still there, he says seven or eight out of ten. And what
21 you'll find is that doctors will ask you, on a scale of one to
22 ten, how is your pain today? Zero being no pain, ten being
23 the worst pain you've ever had in your life. So his pain is
24 seven to eight out of ten on average, but it's intermittent.
25 It's not constant.

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1 Patient believes that the pulsed radio frequency did
2 help and continues to be a benefit. Great, come back in three
3 months. Comes back in two months. When he comes back in two
4 months he tells them that it has worn off, as it is supposed
5 to do. I mean, it's not unusual that it wears off. It's
6 going to wear off. It's not a cure, it's just a temporary
7 treatment.

8 And so on March 22nd, 2007 they set up another one.
9 Patient wants to try repeating the procedure, that pulse radio
10 frequency, and will consider surgery if it doesn't work. So
11 five days later, on March 27th, 2007, he has that same
12 procedure, the one where we're warming the nerve as well as
13 putting in the pain medication. It works for a while.
14 Patient underwent a repeat left C-4 selective nerve root block
15 with the radio frequency. Pain has improved over his left
16 shoulder and trapezial area, his pain is three out of ten
17 overall, so it did work. He now has discrete pain around the
18 left medial scapular and paravertebral area, and they try to
19 treat that.

20 So what has happened here, and what you will hear
21 from some of the medical providers, is what they call the Gate
22 theory of pain. That is, this radio frequency, warming the
23 nerve, worked to help stop that, but he also has pain in other
24 areas, left medial scapular, C-2, which is even higher, that
25 he feels now because that injection with the -- that warmed

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1 the nerve didn't address those areas. He may not have even
2 been aware of those areas. The Gate theory of pain is
3 essentially that you will respond to whatever the greater pain
4 is.

5 Here's the example: if I have low back pain and it
6 bothers me every single day and then someone takes a hammer
7 and smacks my thumb, I'm not thinking about my back pain. My
8 back pain is not my primary focus anymore, it's my thumb. So
9 even though they took care for a while with warming the nerve
10 through that pulse radio frequency, a problem at C-4, there's
11 still pain in other areas that may have been masked by the
12 fact that his neck hurt so badly at the area that they did the
13 pulse radio frequency.

14 So they've assessed him and said well, it improved,
15 but he does have pain in other areas that we'll try to treat.
16 This time it lasts for about two-and-a-half months and he
17 comes back in June of 2007. We are over two years after the
18 accident. Dr. Arita does a third one, because it does work
19 for a little while. And the third one, on June 12th, 2007
20 also works, but about this time, after it's done, Mr. Simao
21 and Dr. Arita have a discussion. Essentially, "Look, do you
22 want to keep going through this surgical injection procedure
23 every two months or every month or every three months or is
24 there another option where you need to go back to the spine
25 surgeon, Dr. McNulty?"

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1 And on June 18th, in a follow-up with another one of
2 -- a PA who he actually had worked with before the accident
3 ever took place, Brit Hill [phonetic]. Patient was seen, he
4 still has neck pain, radiculopathy. Patient was seen by
5 Dr. McNulty already and sent for epidural steroid injections
6 and pain management medications. Patient has failed
7 conservative treatment and wants to see Dr. McNulty about
8 surgery.

9 So on September 6th, 2007, he goes back and sees Dr.
10 McNulty. Dr. McNulty report says the patient was seen by me
11 approximately a year-and-a-half ago, on April 18th, 2006,
12 where he had cervical thoracic pain with occipital radiation,
13 trapezial radiation, bilateral scapular radiation, some upper
14 extremity parathesias, numbness, and he was referred to pain
15 management. And it appears that pain management took him on a
16 course of various injections in order to avoid surgery.

17 I have no definitive diagnostic information as far
18 as clearly defining what's causing his pain. The patient has
19 failed measures of injections, as well as pulse radio
20 frequency. His pain has persisted. He decides to order a new
21 MRI of the cervical spine, at those levels -- and this is a
22 mistake, it should be C-4/5, because we're not talking about
23 the low back. He wants to do new epidural steroid injections
24 to further define what's causing the pain.

25 Now, Dr. McNulty at this point has gotten to review

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1 everything that's taken place so far and the results that have
2 and have not been achieved. He's still not sure of the exact
3 source of what's causing Bill's pain. I told you initially
4 how complex this area is, even for spine surgeons who deal
5 with it every day, and how many different things can overlap,
6 and before you go in and do surgery on someone's cervical
7 spine, a spine surgeon wants to be fairly clear about what
8 they're doing and why it should help.

9 So Dr. McNulty decides, "I'm going to try these
10 injections again, since it's been a while since they've been
11 done, and I'm going to do it myself." And so on November
12 16th, 2007 that very first one that we saw the animation of,
13 the injection near the spine with fluoroscopy, you send in the
14 dye first so you can isolate the nerve, see where the needle
15 is going, you add in some pain medication and some steroid.
16 And Dr. McNulty does that himself, both at C-3/4 and at C-4/5,
17 in the areas around those vertebrae and the disc.

18 And afterwards, on December 6th, 2007, he meets with
19 Mr. Simao and he says he had significant pain relief from the
20 left transforaminal epidural injection and this confirms those
21 levels of his cervical spine as being the pain generators.
22 Understand the relief was very short. It's that pain
23 medication that you put in there, like Novocain, but it worked
24 right away, which tells the spine surgeon that's an area
25 that's causing pain. It confirms those levels as pain

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1 generators.

2 So his plan -- Dr. McNulty's plan is an anterior
3 cervical reconstruction of two-level arthrodesis C-3 to C-5.
4 That is a fusion. That is a discectomy, where he's going to
5 go in and remove two discs, put something back in the space
6 where the discs used to be, and fuse it all together and screw
7 it together. That's his recommendation as of December 6th,
8 2007.

9 Now he hasn't taken that lightly, obviously, because
10 of the measures he's had William undergo up to that date, but
11 time didn't heal it, medications didn't heal it, physical
12 therapy didn't heal it, those injections worked for a little
13 while, but they didn't cure the problem, they didn't heal Mr.
14 Simao. The pulse radio frequency worked for awhile, but
15 hasn't solved the problem.

16 Now as you may or may not expect, someone to whom
17 this is communicated has some doubts about whether they want
18 someone to open up and fuse their cervical spine together.
19 And Mr. Simao had some reservations. So what he did is he
20 went out and got a second opinion from Dr. Jas Grover, who is
21 also like Dr. McNulty, a board-certified fellowship trained
22 spine surgeon. And he first saw Dr. Grover on March 28th of
23 2008.

24 And from Dr. Grover's report, the patient is a 44-
25 year-old right-hand dominant gentleman who was the restrained

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1 driver of an automobile that was involved in a rear-end type
2 collision two to three years ago, we are just short of three
3 years after the accident. He's been treated since that time
4 through a variety of modalities, including care -- physical
5 modalities of care, medical management, injection therapy,
6 he's been under the care of Dr. McNulty, who recommended
7 surgical treatment for him. He has tenderness back here, he
8 has discomfort with left cervical rotation, that hurts, and he
9 has this persistent left upper extremity symptomology. He has
10 these symptoms that have persisted for almost three years.

11 So Dr. Grover does what Dr. McNulty does. He says
12 look, on my own, I'm going to send him out for some pain
13 management and see what our results are and see if they're the
14 same as those that Dr. McNulty's -- Dr. McNulty and those to
15 whom he referred Mr. Simao found. So he recommends some of
16 those injections.

17 In April of 2008, exactly three years after the
18 accident, William meets with Dr. Jorg Rosler, who like
19 Dr. Sible, Dr. Arita is a board-certified fellowship trained
20 pain management doctor, the type that gives those injections
21 to try to isolate pain generators. And he notes that there's
22 neck pain radiating into his left upper extremity. This
23 gentleman relates his symptomology -- his symptoms, to a motor
24 vehicle accident about two to three years ago. There's pain
25 to the touch, there's some loss of that normal curve.

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1 Remember that diagram -- even with this, you can see that it's
2 not straight, there's a curve, what's called the lordosis of
3 the spine. He's lost some of that, which is noted by Dr.
4 Rosler.

5 And Dr. Rosler says, as recommended by Dr. Grover,
6 we're going to set him up for some left side C-4 and C-5
7 selective nerve root blocks for both diagnostic and
8 therapeutic purposes, similar to what he's gone through
9 before. They do a new MRI in April 3rd -- in April of 2008.
10 He goes back to Dr. Grover, who finds out that he actually
11 hasn't had the injection yet, because that takes place on May
12 10th, 2008. It's done by Dr. Rosler, it's on the left side,
13 it's those selective nerve root blocks, just as Dr. Arita did.
14 It's a little more selective; we're going to try to isolate
15 those two levels as the place where the pain is coming from.

16 And on May 10th, 2008 Dr. Rosler performs them with
17 fluoroscopy, the same way that the other doctors performed
18 theirs. And Bill had some relief. It was very short lived,
19 remember that pain medication wears off in a very short time,
20 but he did have some relief, which tells them this might be
21 the location. There was very little help from the
22 anti-inflammatory, that steroid. Before the injection he had
23 pain at a six out of ten. Immediately after his pain score
24 was one out of ten. So that temporary pain medicine worked
25 for a short period of time. He goes back to see Dr. Grover in

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1 June of 2008, still has pain, obviously the steroid didn't
2 have any effect, ongoing neck pain, sub-occipital headache,
3 potentially related to disc disruption. The patient is at his
4 wits end with his symptoms. I would recommend he proceed to
5 discography, to better understand his condition.

6 In August of 2008 he undergoes a procedure called
7 discography. This is the most invasive procedure so far.
8 It's a way -- the other injections just sort of tested the
9 general area of where the pain was coming from. This
10 discography is a test to see if the disc itself is injured,
11 compromised or even torn and maybe how to fix it. It's
12 another injecting procedure, but it's designed to give the
13 doctors a look basically at the disc itself to see if that's
14 where the problem is that is causing the pain.

15 So what happens in a discography, here's the discs,
16 here's the various vertebrae. It's an injection procedure
17 into the disc. The first thing they do is an anesthetize
18 track, they basically give you pain relief -- local pain
19 relief just along the place where the injection is going to
20 go, and they put in what is called a guide needle. It holds
21 other needles that you're going to put inside it in place, at
22 two separate levels.

23 The next thing they do is they take a needle and it
24 goes through this guide needle all the way into the center of
25 the disc, that nucleus pulposus, and it has dye in it, it has

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1 contrast in it, and it basically pressurizes the disc and they
2 do it at several different levels. For Mr. Simao they did it
3 at three different levels, C-3/4, because this would be C-3,
4 C-4, so that's C-3/4, they did it at 4/5 and 5/6, and they
5 inject right into the center of the disc and pressurize it.

6 Now, if you -- and the patient -- again, they're
7 doing this with fluoroscopy too, so they can see exactly where
8 the needle is going. The patient is sedated, he's out, and
9 they basically bring him out of it just enough to ask him
10 whether there's pain. If he just feels a little pressure when
11 they pressurize the disc, that's a normal disc. If he feels
12 pain, the same kind of pain he has on his worse day, then it's
13 what they call concordant pain. They have created the same
14 pain that he feels at his worst and it's because when they
15 inject things into the disc, maybe there's a tear, there's a
16 problem with the disc, and that's how they tell. They call
17 that a positive response to discography.

18 So again, the first thing that happens is the --
19 they anesthetize along the track level -- let me go back.
20 They give you a pain medication along the track that they're
21 going to go in and they have a guide needle that's anchored to
22 hold it in place at -- actually did three levels on William.
23 Then they send a needle through, all the way into the disc,
24 and they don't tell him what disc they are pressuring when
25 they ask him if it hurts. So the needle goes all the way in

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1 and all the way into the disc and they pressurize it.

2 So as a result of this procedure, August 8th, 2008,
3 he was positive at C-3/4. That disc, there was concordant
4 pain, ten out of ten. There was evidence that the disc was
5 disrupted. At the next level, C-4/5, it was positive at that
6 level. It showed a morphologically abnormal disc and there
7 was concordant pain. So they have established that there was
8 a problem with both of those discs themselves, that the discs
9 were injured or torn. And, in fact, the report shows that
10 there's a tear in each of those two discs, the one at C-4/5,
11 the lower one, was actually a little worse tear in the disc.
12 They also did it at the next level down, C-5/6 and it was
13 negative -- it was negative.

14 So now he's had the discography and here, there's a
15 -- at C-3/4 there's a grade four annular -- remember the
16 annulus is the outside of the jelly donut or the disc, fisher
17 -- a fisher is a tear, at the 4:00 position. The way they
18 look at it, that's where the tear is, sort of at 4:00. Now
19 there's a scale for how bad tears are. One is not too bad;
20 grade five is the worst. There's a grade four tear in this
21 disc. At the one below it, there's a grade five tear.

22 So he goes back to see Dr. Grover, he still has neck
23 pain, and here's a mistake in the records, which you see
24 sometimes, out of thousands and thousands of patients,
25 obviously it's not a discography of the lumbar spine, it's

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1 cervical. Discography of the cervical spine confirms
2 disruption at C-3/4 and C-4/5. I have counseled William today
3 at length as it relates to his condition, the risks, benefits,
4 limitations and alternatives of care. We've spent extended
5 period of time with he and his wife. He states that he's at
6 his wits end and I believe at this point he has approached the
7 point where he is considered to be a reasonable candidate for
8 an inter-body fusion, reconstruction and decompression at C-4
9 -- C-3/4 and C-4/5.

10 So if you've had basically parallel tracks here.
11 You've had Dr. McNulty who thought, you know what, we may need
12 surgery here, but I'm going to send him out, do pain
13 management, find out and when it comes back they say yep, you
14 need surgery. He gets a second independent opinion from Dr.
15 Grover, who sends him out to see Dr. Rosler, does injections,
16 does discography, comes back and comes to the exact same
17 conclusion that a fusion is necessary.

18 There's another MRI of his spine in November of
19 2008. By January of 2009 he goes back to see Dr. McNulty.
20 Mr. Simao now has confirmation from two separate spine
21 surgeons that confirmed what Dr. McNulty said originally, that
22 you may need major surgery, a fusion, you're a candidate.
23 Dr. McNulty has all of his results from before and when he
24 gets him back in January of 2009 -- remember, he hasn't seen
25 him since the end of 2007 Dr. McNulty. Dr. McNulty says okay,

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1 but before I do it I want to do one more injection to make
2 sure. And so he wants to confirm that the pain status is
3 still what he thought it was a little over a year earlier at
4 C-3/4 and C-4/5. And he does, on both sides left and right,
5 those epidural injections, the ones that we talked about
6 originally, you saw the animation of those, and he does them
7 on both sides at C-3/4 and C-4/5.

8 And he does them himself so that he can see for sure
9 that this is the right place. And Bill has 65 to 70 percent
10 pain relief right after the injection, for that first six,
11 eight hour period while the pain medication works and that
12 confirms for Dr. McNulty that we're in the right place and
13 everything is as it was a year-and-a-half earlier.

14 On March 24th, 2009 Dr. McNulty sees Mr. Simao.
15 This is the final procedure consideration visit for an
16 anterior front cervical neck reconstruction C-3 to C-5. The
17 patient was made aware of the nature of the problem, the
18 risks, the benefits, the options and consents to the
19 procedure, as well as indicated procedures. The patient knows
20 that there are no absolute guarantees and anything can happen.
21 The next day, on March 25th, 2009, he's admitted to UMC for an
22 anterior cervical discectomy, two levels at C-3/4 and C-4/5,
23 with anterior instrumentation.

24 Now, the surgery itself is performed by Dr. McNulty.
25 to remove two painful discs, C-3/4 and C-4/5. He's actually

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1 admitted to the hospital for this surgery because of the
2 nature of the surgery. And what happens -- and you're going
3 to see an animation of it in a moment -- essentially they
4 enter through the front -- in fact, let's start it. They
5 enter through the front, because as you can see it's so much
6 easier to get to the discs from this side than from this side.
7 There's an incision, and it's not quite as clean as this would
8 show.

9 They are going to retract it to open it. They
10 have to make sure once they go in that his esophagus, his
11 carotid artery are out of the way. And they go in. And
12 they remove portions of the damaged disc until it is all
13 gone. They make sure they've gotten all of it. They go to
14 the second level. They remove the actual esophagus.
15 Obviously for this procedure, he's completely sedated.
16 Make sure they got all of it.

17 Now, they cannot just leave it the way it is.
18 Sometimes they've got to fill in this area otherwise
19 everything would just fall down, crumble down. Sometimes
20 they use actual bone grafts to fill the areas in between
21 the discs. In this case they used a little cage. It's got
22 some metal in here, but it's also got some bone putty in it
23 so that eventually this will all grow together and fuse
24 into one piece. Since it doesn't fuse at first, they've
25 got to basically screw it into place. So they take a

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1 plate, a metal plate with screws in it and screw it in to
2 the pieces of bone that the vertebral bodies.

3 This is an actual X ray of my client. Here's the
4 metal plate that the screw is going in. In between is the
5 area of the cage so that eventually this would all fuse
6 together. Here's the plate, two screws on each side and
7 each three bone levels to try to hold it all in place.

8 Understand when this fuses together, since
9 there's no discs there anymore, there's no movement in
10 those areas. There's no cushioning. It is just solid bone
11 eventually these solid substance for those areas of the
12 neck. And there are restrictions that come with that.

13 So here's the post-operative report. Going in
14 his diagnosis, Dr. McNulty was symptomatic level disc
15 herniation at those two levels, a problem with both discs.
16 Post-operatively, what did he see? Exact same thing. They
17 do X rays always shortly after to make sure that everything
18 is holding and staying in place. He's discharged from UMC
19 after two days in the hospital.

20 He sees Dr. McNulty again about a month, maybe
21 three weeks after the surgery. Okay. He's two weeks
22 post-status reconstruction. Doing well. Already notices
23 significant improvement in his pain compared to before the
24 operation, follow up in six weeks.

25 They do continuous X rays to make sure the fusion

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1 is holding. He goes back to see Dr. McNulty in May of
2 2009. We're now two months after the surgery. And, by the
3 way, this is medical visit number 90 as a result of this
4 crash.

5 The patient is two months post fusion, doing
6 well. We can discontinue the neck collar that he's been
7 wearing for two months, and he can start physical therapy.
8 He can go back to work as tolerated and follow up with us
9 in four months. So far, so good.

10 He begins physical therapy. He goes
11 consistently. He comes back to see Dr. McNulty in July of
12 2009. So we are March to July, three months about post --
13 almost four months -- post surgery. Three and a half
14 months post fusion. He has had left upper-extremity
15 numbness down to the hand for approximately a week. We're
16 going to get a new MIR of the spine. Things are starting
17 to concern Dr. McNulty.

18 He comes back August 18th. He sees now a
19 neurologist by the name of Jesus Hernandez. His migraine
20 headaches have diminished to approximately once a month.
21 Now complains of neck pain that radiates down to the left
22 arm causing numbness into his fingers. He's undergoing
23 evaluation with orthopedic surgery for possible disc
24 disease.

25 You will hear, and as you saw from the note the

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1 day before the surgery, that success in such things is
2 never a guarantee. A certain percentage of patients the
3 surgery doesn't always work, and it doesn't always take
4 away the pain forever.

5 He sees Dr. McNulty again. He turns to Southwest
6 Medical and sees Dr. Hernandez again. He's now having
7 migraine headaches two to three times per week with neck
8 and shoulder pain and these trigger headaches. There's
9 tenderness even in the lower cervical region in his lower
10 neck below where the fusion was. He needs to be referred
11 back to pain management for possible intervention. Pain
12 management is the people who did all those injections over
13 the years.

14 In January of 2010 he still has a history of neck
15 pain on the left side. Sometimes the tightness in the neck
16 region, which has been in existence prior to his surgery,
17 triggers his migraine. He claims that the surgery resolved
18 his neck pain but not the migraine headaches. Some days it
19 hurts; some days it doesn't.

20 They put him back into physical therapy. And
21 just a week or two later when he's had physical therapy, he
22 has pain in his neck and down into his left upper extremity
23 just as he had before.

24 He has -- the arrow down is decrease. He has a
25 decrease in his cervical spine R-O-M, range of motion,

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1 obviously because he has a fusion, but he also has
2 additional problems. He'd a good candidate for physical
3 therapy, according to the physical therapist.

4 He comes back and sees Dr. McNulty March 23rd,
5 2010. We are about a year after the surgery, about five
6 years after the accident. Dr. McNulty says, "His patient
7 follows up and is still having primarily left-sided neck
8 pain with trapezial radiation" -- or, yeah -- "that
9 radiates down into the trapezius area just as it did before
10 the surgery."

11 He says, "I wouldn't recommend physical therapy
12 because he's done plenty of it. So I'll refer him back to
13 pain management."

14 He finishes up the course of what's prescribed
15 for him. Dr. McNulty sends him back to Dr. Sible
16 [phonetic], one of those pain management doctors. He does
17 a medial branch nerve block, another separate type of
18 injections near the area of the medial branches of nerves
19 as they come out from the cervical spine with a pain
20 medication to see if that can help isolate and still is a
21 problem.

22 In June of 2010, September of 2010, they do more
23 of those injections that they did at the very beginning,
24 those epidural blocks, some pain management, some pain
25 medication, some steroid involved, but it doesn't cure the

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1 problem.

2 September 27th, 2010, Mr. Simao presents to the
3 clinic for neck pain. He wants to get a referral to yet
4 another orthopedic surgeon to try to find out what in the
5 world is wrong with [indiscernible] and continues to hurt.

6 He comes in today for a follow up of neck pain.
7 Continue to follow up with pain management and put a new
8 referral in to orthopedics.

9 In October of 2010 he has initial visit with
10 another spine surgeon, Dr. Daniel Lee. He says this is a
11 47-year-old who is status post fusion with what appears to
12 me to be old left C4 radiculopathy. It occurred even
13 before the surgery.

14 Dr. Sible who did those injections, thought he
15 was symptomatic. He may be so. I would recommend left
16 C3-4 trans foramina selective nerve root blocks, more of
17 those injections to try to isolate the pain.

18 As another one of those procedures, medical visit
19 No. 134, in November of 2010. He sees Dr. Lee again in
20 January of this year, the end of January of this year.
21 "He's post fusion. He did get some significant relief with
22 that selective nerve root block injection. We'll see him
23 back again. Most of his pain is in the trapezius, but I
24 think it's referred pain from his neck."

25 There's a new MRI. It's about his fourth or

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1 fifth of his neck since the incident. He sees Dr. Lee
2 again February 24th, a month ago. MRI was re-reviewed. It
3 shows no significant stenosis. Stenosis is actually a
4 narrowing of the place where the spinal cord is. You can
5 see pain management. There's no surgical indications at
6 this time.

7 Essentially Dr. Lee is telling you that he's
8 going to need pain management, something, injections,
9 something because of what has been done, they haven't
10 gotten everything. They haven't cured him as a result of
11 what happened in this accident.

12 So he has had, with all those injections, 14
13 separate invasive surgical procedures. The nerve-root
14 blocks, the epidural injections, the discography, more
15 injections, a cervical fusion, more nerve blocks, more
16 steroid injections.

17 Now, through all of that medical history that's
18 taken place over 199 visits in almost six years,
19 Defendant's response is it will be -- I expect the evidence
20 to establish that they will say that he had pre-existing
21 degenerative disc disease in his spine. And he had a
22 problem that was there even before the accident happened.
23 So it's not our problem.

24 Everyone knows degenerative disc disease, not
25 necessarily a disease like the mumps or like cancer,

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1 degenerative disc disease is basically age-related changes.
2 As we all get older our spine tends to degenerate somewhat.
3 It happens because we've been on the planet and using it
4 for 40, 50 years. That's what it means. They're
5 age-related changes.

6 Now, most people who have degenerative changes in
7 their spine have no symptoms. They are asymptomatic. They
8 have no symptoms. And that's what my client was before
9 this accident took place, no neck pain symptoms before
10 April 15th, 2005. And the medical evidence in this case
11 will show that the accident, the Defendant, caused severe
12 neck injuries, caused this degeneration to become
13 symptomatic in his neck. And that the need for all --
14 well, underscore the need for all of the medical treatments
15 and the invasive procedures, the need for the surgeries and
16 future medical treatments, medications and pain that he's
17 going to endure for the rest of his life.

18 The defense has hired a medical expert by the
19 name of Dr. Wong. He will agree that none of the medical
20 records show that William had any symptoms of neck pain
21 before this accident. The other expert -- another expert
22 hired by the defense in this case, Dr. Fish also from
23 California, and he will say that he seen no medical records
24 that show that William had any symptoms of neck pain prior
25 to the April 15th, 2005 crash. So the response that

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1 somehow this disc disease, this degeneration, these
2 age-related changes in his spine caused what he has now is
3 simply not true.

4 Another response. His headaches weren't caused
5 by the crash because he had a history of migraine headaches
6 and was taking medication for migraine headaches.

7 MR. ROGERS: Objection. Your Honor, Counsel is
8 not only getting into argument, he's actually misstating
9 the defenses.

10 THE COURT: Counsel, approach, please.

11 [Bench Conference Not Transcribed]

12 THE COURT: The objection is overruled for the
13 record. Please proceed.

14 MR. WALL: Thank you very much, Your Honor.

15 Migraines before the crash and was taking
16 medication for it prior to the crash.

17 The evidence will show that he did have a history
18 of migraines prior to the crash. He's not claiming that
19 the crash caused his migraine headaches. That's not a
20 claim that we're making. The medical evidence will show
21 that his migraine headaches where made worse by the crash,
22 and that is a claim.

23 May 4th, 2005. He complains of occipital head
24 pain that he feels that's inside his head a deep pressure.
25 He does have a history of migraine headaches; however,

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1 these feel different to him. This is May 4th, 2005, within
2 weeks after the crash.

3 May 12th, 2005, head pressure. Blurred vision.
4 Facial numbness for two weeks post motor vehicle accident
5 head trauma.

6 May 26th. He has a history of migraine
7 headaches. He did experience a change in his headache
8 intensity after the crash.

9 July 27th, 2006, about a year and a half after
10 the accident, he has a history of chronic recurrent
11 migraine headaches. However, approximately a year ago he
12 was involved in a rear-end motor vehicle collision and
13 since then he had noticed increasing frequency of his
14 migraines.

15 And the medical evidence is also going to show
16 that in addition to migraines, a special type of headache,
17 the crash caused muscle-tension headaches.

18 October, 2005, he has a history since the
19 accident of both migraine and tension-type headaches.

20 March, 2006. Episodic tension headaches and
21 migraine headaches.

22 May, 2006, tension-type headaches, migraine
23 headaches.

24 June, 2006. Migraine headaches and tension-type
25 headaches.

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1 June 20th, 2006, same thing.

2 October, 2006. November, 2006. June of 2007.
3 December of 2009.

4 He has disc issues in the cervical spine that
5 sometimes act as migraine triggers for his migraine
6 headaches based on neck and shoulder pain.

7 March, 2010, tension headaches, migraine
8 headaches. June, 2010.

9 The evidence will show that this response is not
10 justified by the medical evidence.

11 Another response. He just sustained a
12 soft-tissue injury to his neck in the accident. Soft
13 tissue may be a muscle strain in the left shoulder that
14 would have resolved within a few weeks.

15 As you know by now, he had continuous complaints
16 of neck pain. His neck pain didn't resolve after a few
17 weeks. From the day of the crash he continued to
18 experience pain in his neck and the occipital region of his
19 head.

20 The day of the accident, neck, back and
21 left-shoulder pain. Tender to palpation to the touch in
22 the occipital area.

23 Three weeks after the crash now having recurrent
24 occipital pain. He complains of occipital-head pain,
25 tenderness over the occipital area.

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1 Five and a half months after the crash, neck
2 pain. Pain radiates from his shoulder up into his neck.

3 Six months later, X rays of his neck and left
4 shoulder because of the pain he's having. They do X rays
5 of his cervical spine because of the pain six months after
6 the crash, eight months after the crash.

7 Complaining of neck and shoulder pain off and on
8 for months. Nine months afterwards.

9 He sustains injury to his neck and upper
10 trapezius region when he was involved in a motor vehicle
11 accident.

12 Eleven months. This is the one you saw before.
13 Chronic neck pain. That means it's been going on for
14 longer than six months.

15 Twelve months, neck pain. And on and on and on.

16 The medical evidence will show that this response
17 is not justified by that evidence.

18 I told you that they hired Dr. Wong from UCLA as
19 an expert in this case. He examined Mr. Simao one time in
20 February of 2009. So that's about six weeks before the
21 surgery took place. He can't recall if the exam was as
22 short as 15 minutes or as long as an hour. And his
23 examination revealed that he had tenderness, pain in his
24 neck and left shoulder and it radiates into his left
25 shoulder indicative of some nerve problem. Remember at the

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1 very beginning it radiates.

2 Dr. Fish, Defendant's expert also from UCLA, not
3 an orthopedic spine surgeon, has never performed a fusion
4 surgery that refers patients to some spine surgeons in Las
5 Vegas. I'm not sure if he referred one to Dr. McNulty, but
6 he may. He examined Mr. Simao the same day as Dr. Wong.

7 Those two experts don't agree with the medical
8 records. They don't agree with one another. Dr. Wong says
9 William sustained a whiplash injury from the motor vehicle
10 collision. Dr. Fish says neck pain, but no whiplash
11 injury.

12 Dr. Wong says 25 percent of all the treatment
13 after May of 2005, that first five or six weeks, he gives
14 him all of that. And after that, 25 percent of it is
15 related to this crash. He doesn't know what the other 75
16 percent would be, but 25 percent of it is related to the
17 crash. Dr. Fish says none of that medical treatment is
18 related to the crash. Dr. Wong says that the MRI of Mr.
19 Simao showed degenerative changes in the spine. Dr. Fish
20 looked at the same MRIs and said they're normal. There's
21 no degeneration to be seen.

22 I told you at the outset that this case is not
23 only about responsibilities, who's to blame, but also
24 accountability.

25 You'll hear from Kathleen Hartman [phonetic]

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1 who's a registered nurse and a certified life-care planner.
2 She takes what's in the medical records and determines what
3 his future medical needs are going to be because of the
4 injuries.

5 MR. ROGERS: Objection, Your Honor. You entered
6 a foundational order on Ms. Hartman.

7 THE COURT: Counsel, approach, please.

8 [Bench Conference Not Transcribed]

9 THE COURT: Please proceed.

10 MR. WALL: As a certified life-care planner, what
11 Ms. Hartman will do is take what's in the medical records
12 and what's deemed to be possible future treatment for
13 Mr. Simao and establish essentially what the costs are for
14 those things, whether it might be future surgeries, whether
15 it might be physician care, pain counseling, pain
16 management, physical therapy, prescription medications. If
17 Mr. Simao requires those in the future, she'll tell you
18 exactly what they cost and what -- based on what's in the
19 medical records from the medical providers will be
20 necessary.

21 You'll also hear from Dr. Stan Smith who is an
22 economist from Chicago. He's going to calculate the
23 present value of William's future medical expenses. He's
24 not a doctor. But he'll take what the doctors communicated
25 to Ms. Hartman about what's going to be necessary, and she

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1 relates what that cost is. Because if he needs something
2 in 20 years or 30 years, there's economic formulas,
3 accounting formulas to determine what it would cost today
4 to make sure those things are paid for in the future. The
5 present value of money. There's a discount value. And I
6 can't explain to you exactly what the formula is, but he
7 explains what those things will cost to provide future
8 medical treatment to Mr. Simao for the rest of his life.

9 He's also going to calculate using that same
10 formula what the present value of his loss of enjoyment of
11 life is. The present value of the loss of household
12 services. There will be things that Mr. Simao cannot do in
13 the future. There's a cost attributed to that.

14 Also calculate the present value of the claim
15 that Cheryl Simao has for the loss of society and
16 relationship of her husband as a result of these injuries.

17 And you do that, all of that, based on a life
18 expectancy. At age 47 his average life expectancy is 31
19 more years. That takes into account -- that would put him
20 at 78. That takes into account the statistics prepared by
21 the government in establishing what an average age is -- it
22 won't make it to 78 and instead the law allows that you can
23 use this table of information from the government to
24 determine what a life expectancy would be for someone like
25 Mr. Simao.

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1 The evidence will establish that the past and
2 future medical expenses, for the loss of household
3 services, Cheryl Simao's loss of society and relationship
4 will be in excess of \$1 million.

5 The evidence will also establish that there's
6 almost six years of past loss of enjoyment of life and pain
7 and suffering, thirty-one years of future pain and
8 suffering and loss of suffering of life.

9 There is no -- as the Court will instruct you at
10 the end of case -- there is no formula to determine that.
11 That's up to you. So your responsibility using the burden
12 of proof that the Court will give you more likely than not
13 who's to blame for the crash. It's your responsibility to
14 determine more likely than not what are all of the harms
15 and losses caused by the Defendant's negligence to
16 Mr. Simao. And just more likely than not, it's your
17 responsibility only considering the harms and losses and
18 nothing else, it the full value of those harms and losses,
19 and that is what this trial is about.

20 Thank you very much, ladies and gentlemen.

21 THE COURT: Thank you, Mr. Wall.

22 Let's take a brief break before we hear from
23 defense.

24 I'm reminding you, ladies and gentlemen, of your
25 obligation not to discuss this case, not to form or express

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1 any opinion until this case is given to you. Not to do any
2 research on any subject connected with this case.

3 Actually, let's take about a 15-minute break.

4 Thank you.

5 [Recess]

6 [Outside the Presence of the Jury]

7 THE MARSHAL: Please remain in order.

8 THE COURT: Please remain seated. I understand there's
9 something outside the presence of the jury.

10 MR. ROGERS: Yes, Your Honor. Very briefly, there's two
11 things. Number one, we want to confirm for tomorrow that it's
12 going to be Doctors Arita and Rosler that are going to be
13 testifying for the plaintiff. That was initially the
14 plaintiff. We just wanted to make sure that that's still the
15 case.

16 THE COURT: Is that the case, Mr. Wall?

17 MR. WALL: I just mentioned that to trial counsel, that
18 is who we will be calling.

19 THE COURT: That is the case?

20 MR. WALL: Yes.

21 THE COURT: Okay.

22 MR. ROGERS: Number two, Your Honor, I believe, according
23 to the open-door or invited-error doctrine, we are now allowed
24 to comment upon the magnitude of the crash and I'll explain
25 why.

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1 The open door doctrine, in Taylor versus State, that's a
2 Nevada case, 1993. It also cites Lala versus People's Bank &
3 Trust of Cedar Rapids, that's the 420 N.W.2d 804, that's an
4 Iowa case, it's 1988. What the doctrine is, it says that even
5 when evidence is ordinarily inadmissible, rendered admissible
6 when the complaining party, who first raised, and during the
7 opening statement, counsel, he used the term crash; and as we
8 know from Webster's Dictionary, crash is, it's violently,
9 noisily. So he's stating to the jury that this impact was
10 violent and noisy. And because he's given the jury this
11 impression about the nature of the accident, he has opened the
12 door to us, in our opening statement, giving our version of
13 what the nature of the impact is, whether that -- whatever
14 adjective we should use. But, you know, counsel could have
15 said there was simply an impact. He chose to discuss the
16 nature of the impact, the violence of it, that the head of the
17 plaintiff struck the cage of the inside of the van. And so
18 because of that, he has opened the door to us being able to
19 argue our version of the events.

20 THE COURT: Well, Mr. Wall.

21 MR. WALL: Well, I won't -- I've got to be honest with
22 you, I was here, and I did speak, but I don't remember talking
23 about the nature of the impact or the violence of the impact,
24 which is what he just said that I said. So unless there's a
25 transcript that proves that I don't remember saying it, but

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1 said it, I would suggest that that's not correct and that
2 it's, in fact, absolutely incorrect. I never discussed that
3 it was a violent impact. I never discussed that it was a
4 noisy impact. I never even discussed that the impact was
5 violent enough, according to the medical providers, that
6 because of how violent it was, it must have caused A, B, and
7 C; none of the things that would open the door to a minor-
8 impact defense.

9 MR. ROGERS: Your Honor, he used the word crash like I
10 said. I'll cite the Webster's: That means, violently and
11 noisily. And when you use an adjective or a term you're
12 trying to describe for the jury what happened, and he used the
13 word crash, the jury gets an impression in their mind of some
14 big collision. They could -- he could have said that there
15 was an impact, but he had to use a term that, in their mind,
16 would think of it as a major accident. And I think we are
17 allowed to, thus, in our opening argument, give a term that
18 would show that it wasn't or, at least from our standpoint,
19 wouldn't be such a major collision.

20 THE COURT: The motion is denied. Are we ready for our
21 jury panel?

22 MR. ROGERS: We are, Your Honor.

23 [Jury In]

24 THE COURT: Please be seated, ladies and gentlemen.
25 Counsel, stipulate in the presence of the jury?

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1 MR. ROGERS: No, Your Honor.

2 MR. WALL: Yes, Your Honor.

3 THE COURT: Very well. Mr. Rogers, are you prepared to
4 proceed?

5 MR. ROGERS: I am. Thank you.

6 Good afternoon, everyone.

7 JURORS: Hi.

8 MR. ROGERS: All right. This is now Mrs. Rish's time to
9 describe what we anticipate the evidence will show. This case
10 is about -- was brought out in the plaintiff's opening
11 statement, a car accident that occurred in stop-and-go,
12 bumper-to-bumper traffic; both parties drove home.

13 The plaintiff claims a traumatic neck injury, but as
14 we study the records closer, you will see that he had no
15 complaints of neck pain for nearly six months following the
16 accident. He did have a history of pre-existing migraines and
17 tension type headaches, both of which can result in neck pain.

18 Following the car accident, he had extensive
19 diagnostic testing; plaintiff's counsel went through it at
20 length with you; MRIs, and CT scans, and so forth, none of it
21 shows evidence of a traumatic cervical disc injury.

22 And, finally -- oh, yes, very good. The discs, as
23 plaintiff's counsel pointed out, are these two right here.
24 Remember plaintiff's counsel talking about pain generators and
25 how this surgery was done because someone along the way

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1 determined that these two discs were pain generators. The
2 evidence will show that that is not so and that is why the
3 plaintiff's symptoms continue today. The discs that were
4 removed were not injured in this accident and they were not
5 pain generators.

6 Now, let's talk about the car accident and precious
7 little time was spent discussing that, so let's refocus it.
8 As I stated, bumper-to-bumper, stop-and-go. Mrs. Rish had
9 just arrived in town from Hill Air Force Base. She had
10 decided to drive her daughter-in-law and her grandchildren
11 down to her home in Gilbert, Arizona. Her daughter-in-law,
12 Linda, drove from Ogden, Utah, where Hill Air Force Space is,
13 to Las Vegas. And then just outside, they stopped at a
14 restaurant and got a bite to eat, and they got back in the
15 car, and Jenny Rish drove.

16 They got on the freeway and it was traffic time and
17 she pulled up behind the plaintiff. And several times over,
18 stopped, went, stopped, and went. She will testify that on
19 the final go, she was stopped behind the plaintiff, who moved
20 a few feet in front of her; she lifted her foot up off the
21 brake; she went forward; she saw the brake lights on his
22 vehicle; she applied her brakes, only just not quite hard
23 enough; and the accident following.

24 No one in this accident claimed loss of
25 consciousness. No one sustained cuts, or bruises, or

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1 abrasions. Both drivers pulled off to the side of the road
2 because of the traffic; paramedics arrived, but they were
3 refused by everyone; the plaintiff got out of his vehicle;
4 went back and spoke with Jenny Rish; and then both parties got
5 back in their vehicles; the plaintiff drove home; and Jenny
6 Rish, and her daughter-in-law, and her four grandchildren
7 continued on their drive, six hours to Gilbert, Arizona. And
8 until a lawsuit was filed, years later, that was the last the
9 Jenny Rish ever heard of this event.

10 I want to show you right now, because you've heard
11 enough from counsel describing what's coming, you will be
12 receiving evidence soon, as soon as we're done here. Jenny
13 Rish was examined under oath by plaintiff's counsel.

14 MR. WALL: May we approach, Your Honor.

15 THE COURT: Yes.

16 [Bench Conference Not Transcribed]

17 MR. WALL: For the record, the objection is sustained,
18 Your Honor?

19 THE COURT: Yes.

20 MR. ROGERS: For the record, we will wait, I suppose --

21 MR. WALL: I'm sorry, counsel.

22 MR. ROGERS: -- to hear from Jenny Rish.

23 THE COURT: I couldn't hear it either. I couldn't hear
24 what you were saying either, Mr. Rogers.

25 MR. ROGERS: Oh, I just said, you'll -- you must now wait

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1 to hear from Jenny Rish. But she will describe this accident
2 for you. You will what this is all about. All right. I'm
3 very much looking forward to her opportunity to do that.

4 One thing that will be brought up, and counsel
5 alluded to it, is that, at her deposition, she admitted that
6 she was at fault. She was asked, "Are you at fault for this
7 accident," and she said, "Well, yes, I rear-ended him." And
8 counsel pointed out that the answer to the complaint denies
9 liability. As you will see, if you study the entire
10 pleadings, pleadings are like a boiler plate contract.
11 They're designed to protect all rights. Jenny Rish testified
12 under oath, she never once shift from her responsibility.

13 All right. Now, what we do is, we turn to the
14 medical records right at the time of the accident. And you
15 will see, when you study these records, that they do not
16 support the plaintiff's claim of a traumatic neck injury. He
17 presents -- pardon me. At the scene, you'll recall, he denied
18 the paramedics. They actually came and he turned them away as
19 did everyone else. He did not go to an emergency room,
20 instead he drove his vehicle home. That evening, he went to
21 Southwest Medical Associates, actually, where his wife works.
22 And there, he complained of left elbow pain and headaches.

23 Now, the chief complaint was elbow pain. A full
24 exam still was performed, of the entire body. They examined
25 the head and they noted that he reported tenderness, but there

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1 was no deformity on the exam; no bumps noted. He complained
2 of tenderness at the neck, as well, but he had full range of
3 motion; no abnormal finding. He complained of tenderness at
4 the elbow, but there, again, no deformity. The neurological
5 exam was normal. The strength exam was normal. No cuts, or
6 bruises, or abrasions were noted. Still, the doctors ordered
7 X-rays, just to make sure. The elbow X-ray showed what:
8 Degenerative changes and no joint infusion; no swelling. The
9 neck X-ray showed alignment maintained, soft tissues, meaning
10 muscles, and tendons, and ligaments are normal. There was no
11 evidence of any abnormality on the neck X-rays.

12 And the plan, at that time, was to return in seven
13 to ten days if the symptoms resumed or if, otherwise, needed
14 and the plaintiff did not return in seven to ten days. He did
15 not return for three weeks. He did return to work in the
16 flooring trade, a labor intensive trade, certainly more so
17 than a desk job. When he returned three weeks later, he
18 presented, to a physician's assistant, who's name you heard in
19 plaintiff's opening. His name is Britt Hill. Britt Hill had
20 treated the plaintiff before the incident and he treated him
21 quite a bit after. On this visit, three weeks after the
22 accident, the chief complaint was headaches. There was no
23 mention anywhere of neck pain, three weeks after the incident.

24 Still, a full exam was done. On the head, no masses
25 or defects were found. On the neck, everything was normal

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1 again, just as before. The musculoskeletal exam, full range
2 of motion in all extremities, that's the arms and the legs.
3 Strength was normal. The neurological exam was normal.
4 Again, no mention of any bumps, or bruises, or abrasions. The
5 plan was to refer him out for a CT scan and continue his
6 normal chronic medications. Plaintiff counsel pointed out
7 earlier, that chronic is far longer than three weeks, so to
8 continue the medications you've always been taking.

9 They refer him out for the CT scan. It's done a
10 week later and it comes back normal. He follows up the next
11 day, he goes back to Southwest Medical Associates and what are
12 his complaints at that time: Headaches, numbness to upper lip
13 and nose. No mention of neck pain anywhere. And as to the
14 facial numbness and vision changes, we learned something
15 interesting and that is that the plaintiff had those exact
16 same problems before the car accident. Here in February 2003,
17 he's treated for headaches, facial numbness, cheek numbness,
18 teeth numbness. These symptoms are nothing new for him.

19 Back to May 12, 2005. At this point, remember,
20 we're right after that CT scan that came back as normal. They
21 did a full exam, this time the head was non-tender and, again,
22 there was no deformity. The neck, again, non-tender, full
23 range of motion. The neurologic exam was normal. The course
24 note reads, no signs of acute process. Acute, meaning
25 traumatic. Here we are three weeks out from the accident and

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1 no signs of acute process. The assessment at this point was,
2 tension headaches, again, nothing new. The plan was nothing
3 more than over-the-counter Tylenol.

4 Going back to the course note; the plaintiff, the
5 provider reported, was persistent in questioning about every
6 test or discussion that had taken place since his accident.
7 And he insisted on further evaluation, he's not satisfied with
8 the negative CT results. So the provider refers him out for a
9 brain MRI. What we learned from this is that the plaintiff is
10 not the type to shirk from insisting on medical help, that
11 there is no mention of anywhere of an insistence, or even a
12 mention, of neck problems. If there were neck problems,
13 wouldn't he have insisted on that, as well?

14 Then we go to the brain MRI, just like the CT scan;
15 grossly unremarkable, absolutely normal. He returns to
16 Southwest Medical three days after this normal MRI and what is
17 his problem this day: Headaches, again, no mention of neck
18 problems. The doctor notes, the CT and the MRI were normal,
19 and then in the plan, he states that he explained these normal
20 studies to the patient, and he was okay with that and did not
21 seek further treatment. He will continue current meds,
22 remember the chronic meds that he'd been taken from before the
23 accident, he will schedule a routine follow-up, as needed, in
24 the next six months.

25 Now, this brings us to one -- a month-and-a-half

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1 after the car accident. In that month-and-a-half, the
2 plaintiff has been examined four times. Every examination, a
3 normal finding. He had two X-rays, they were normal. He had
4 the CT scan, it was normal. He had the MRI of the head, that,
5 too, was normal. During this entire time, he was never taken
6 off work. He never even requested time off work. His only
7 complaint, since the date of the incident, has been headaches.
8 Aside from that single visit on the date of the incident,
9 there's never once been a mention of neck problems.

10 What we know for certain, at this point, is that
11 there is no evidence anywhere of a cervical disc injury; only
12 that the plaintiff returned to his normal medications. The
13 medical experts in this case will get on the stand and they
14 will explain medicine as doctors understand it. You've just
15 heard quite a treatise on medicine as personal injury lawyers
16 understand it. The doctors will clarify everything. They
17 will say, at this point, when the plaintiff was returned to
18 his previous medications, that if the plaintiff was injured at
19 all in this accident, this is when the condition resolved.
20 This is when he was back to whatever he had before.

21 In part, that is because what follows this visit, a
22 month-and-a-half after the accident, is a four month gap in
23 treatment. The plaintiff doesn't see anyone for four months.
24 During this time, however, he does continue to work in the
25 flooring trade.

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1 The questions that you will need to answer when this
2 case concludes, include: Does a person with a traumatic
3 injury to the discs in his neck not -- pardon -- he had not
4 complained of pain for nearly six months after the injury; the
5 next, does a person with a traumatic injury to his neck not
6 treat with anybody for it for nearly six months; and finally,
7 do they not ask for time off a labor job? Do they just
8 continue working without consulting any medical providers
9 about it?

10 The evidence will show that the answer to each one
11 of these questions is no, that that is not how a cervical -- a
12 traumatically induced cervical disc injury presents. Counsel
13 used the example of someone striking your thumb with a hammer,
14 you know it right then. That's not the way the plaintiff's
15 presentation played out at all.

16 This brings us to five-and-a-half months after the
17 accident. At this point, something did change, only it wasn't
18 neck pain, because he didn't present with neck pain. Again,
19 the exam was normal, supple meaning, no abnormal findings.
20 But what did occur here, after all this time of work and never
21 complaining of neck pain, is the plaintiff is assessed or
22 diagnosed with something new, a shoulder sprain. No one
23 before had ever diagnosed that and this is five-and-a-half
24 months after the accident. And, also, in this note, there's
25 no mention of the car accident.

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1 We turn, now, to the X-rays that were ordered
2 because of that shoulder complaint. The shoulder X-rays were
3 normal. There was a repeat X-ray of the neck, just like the
4 first time, it was normal. And then there's another gap in
5 treatment, this time for two months. We're within eight
6 months of the accident right now, a four month gap already,
7 and now a two-month gap. The plaintiff continues to work, but
8 he's not treating with any providers.

9 That brings us to December 21, 2005. At this point,
10 the plaintiff reports that he has neck pain that has gotten
11 worse for the past couple of weeks. This is eight months
12 after the accident. For the first time since the car
13 accident, there is some slight abnormality in the physical
14 exam and it's on the trapezius, this muscle that goes from
15 your neck to your shoulder. It's just a slight tension. In
16 this note, plaintiff counsel point out that this was one of,
17 if not the first M.D. that the plaintiff saw at Southwest
18 Medical. At this point, there's no mention of the car
19 accident anywhere in the record.

20 Eight months have passed, six-and-a-half months of
21 which are gaps in treatment, and all eight months in which the
22 plaintiff continued working in the flooring trade. And now we
23 move to January 16, 2006. Plaintiff cited this record to you,
24 this was the first time that the plaintiff presented to a
25 physical therapist after the accident. And he reported that

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1 he was struck from behind on the freeway, at best, and the
2 other vehicle was going 55 miles per hour.

3 The medical evidence provides no evidence whatsoever
4 of a traumatic cervical disc injury. The medical doctors will
5 clarify that for you when they're on the stand. I won't
6 attempt to explain to you anatomy and medicine, I will let the
7 doctors do that. And one way that we've gotten their
8 assistance in this case is, we've taken their depositions,
9 too, not just Jenny Rish, but the doctors' as well; sit them
10 down, have them under oath, and say, okay, explain what all
11 this means. And we are going to hear from various different
12 kinds of doctors in this case. One of them are doctors who
13 appear down here regularly in court, as often, if not more
14 than trial lawyers. Doctors McNulty, and Grover --

15 MR. EGLET: May we approach, Your Honor.

16 THE COURT: Yes.

17 MR. EGLET: We ask that that screen be taken down.

18 THE COURT: Take it down, please.

19 [Bench Conference Not Transcribed]

20 THE COURT: The jury will disregard the last slide
21 presented by counsel.

22 MR. ROGERS: Doctors McNulty, Grover, and Rosler, you
23 will learn, at least if they remain with the testimony that
24 they've given already, don't know the first thing about this
25 car accident and they didn't see the plaintiff for quite some

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Denver [303] 634-2295

1 time afterwards.

2 Now, there will be some doctors, you will see, who
3 were, also, treating providers of the plaintiff; doctors that
4 it was my first time to encounter them in this case: Britt
5 Hill, actually not an M.D., but a physician's assistant. As I
6 said before, he treated the plaintiff before and after the
7 accident, so he has a unique insight into this case. Before
8 the accident, he treated him for headaches; he treated him
9 for --

10 MR. EGLET: Your Honor, may we approach and that slide,
11 it needs to be taken down immediately.

12 THE COURT: It does.

13 [Bench Conference Not Transcribed]

14 THE COURT: Sustain the objection for the record.

15 Ladies and gentlemen, I'm instructing you to disregard
16 the last slide that was previously shown to you. There was a
17 pretrial ruling which reads, it is hereby ordered that
18 plaintiff's request to exclude and prior and subsequent
19 unrelated accidents, injuries, and medical conditions, and
20 prior and subsequent claims or lawsuits is granted in all
21 respects. And that specifically dealt with a 2003 motorcycle
22 accident.

23 MR. EGLET: Your Honor, counsel needs to review his --

24 THE COURT: We need to take a -- probably about a
25 ten-minute break, ladies and gentlemen. I'm reminding you of

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1 your duty not to discuss this case, not to form or express any
2 opinion, not to do any research on any subject.

3 [Recess]

4 [Outside the Presence of the Jury]

5 THE COURT: For what reason?

6 MR. EGLET: Your Honor, we, first of all, we viewed
7 Mr. Rogers' slides during the break and we want to make a full
8 record of what occurred in the first few minutes of his
9 opening statement. Which quite frankly, to be honest, Your
10 Honor, is what we projected, what we figured. We knew this
11 was going to happen, we knew it was coming. We actually
12 prepared these little books for each one of us with the
13 outlines of all the orders because we knew he was going to
14 systematically violate the Court's pretrial orders.

15 Within 10 minutes of his opening statement he
16 violated, clearly and unambiguously violated two of this
17 Court's pretrial orders. I don't know how you unring the bell
18 with this jury with the stuff that he's done. Now I
19 understand you admonished the jury, you've asked them to
20 disregard. As the Court knows, it's very hard to unring the
21 bell. I think at this point he has already tainted this
22 trial.

23 Then in the break, during the break, after you
24 sustained those two objections, admonished the jury, told him
25 to take the slides down, we went through some other slides.

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Denver [303] 634-2295

1 There were multiple other slides that had the same type of
2 problems in them. Most of them Mr. Rogers agreed with and
3 took those statements out of the slides, but again, if we
4 hadn't done that, there would have been three to four more
5 clear violations of these -- this Court's pretrial orders.

6 As Mr. Wall said at the bench, I think it's clear --
7 I think it's abundantly clear that Mr. Rogers is going to try
8 to mistry this case. I think it is abundantly clear that
9 that's what's going on.

10 I told the Court at the last bench conference that
11 that was two. If there were any additional ones, we were
12 going to start asking for monetary sanctions and other
13 potential sanctions in this case for this type of systematic
14 refusal to comply with pretrial court orders.

15 I expect his experts are going to do it as well. I
16 can assure this Court that they are going to violate a number
17 of the orders in their testimony, just like Mr. Rogers did up
18 there say oh, I -- I didn't realize that that was a, you know,
19 I didn't realize that was the Court's order. I was confused,
20 I guess.

21 So additionally, there are some other slides. Can I
22 have your young man over there put the slides --

23 MR. ROGERS: Yeah, Dan.

24 THE COURT: -- that we were talking about one at a time.

25 MR. ROGERS: Which ones -- now just so --

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Denver [303] 634-2295

1 MR. EGLET: Just put them up in order.

2 MR. ROGERS: -- that we can clear this up, I offered to
3 bring them over and said you guys look through them. Whatever
4 you object to, write it down and let's just bring it up to the
5 judge. There's no effort to hide anything going on here.

6 MR. EGLET: Well, let me point out that that's not
7 entirely true what happened, because he agreed that some of
8 the items on the slides were a violation of pretrial orders
9 and he had his tech assistant remove them.

10 MR. ROGERS: I disagree with that, but we'll get to that
11 later. So can you see these from your screen?

12 THE COURT: Yes.

13 MR. EGLET: That's not everything that was on the slide.

14 DAN: No, I know. They're -- which ones specifically
15 would you like to see?

16 MR. EGLET: I don't know.

17 DAN: Oh, okay.

18 MR. EGLET: You were supposed to keep track of them for
19 us.

20 DAN: I was.

21 MR. ROGERS: 168.

22 MR. WALL: Actually Adams did.

23 MR. EGLET: No, I saw him writing them down.

24 DAN: I took -- kept track of some, but not all of them,
25 because you didn't instruct me to do that.

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Denver [303] 634-2295

1 MR. ROGERS: Well, okay. Let me --

2 MR. EGLET: All right. Well, this is at the end of his.
3 Ask yourself -- this is argument, Your Honor. This is closing
4 argument stuff. This is not proper for opening statement. He
5 is not telling the jury these are what the facts of this or
6 the evidence will show in this case. He's asking them -- he's
7 -- this is argument. It's improper and we would ask that
8 these be not permitted, this slide not be permitted and not be
9 able to phrase as ask yourself, ask yourself this, ask
10 yourself that. It's argument.

11 THE COURT: Mr. Rogers?

12 MR. EGLET: It's --

13 MR. ROGERS: Well, the --

14 MR. EGLET: It's like say -- it's basically saying did he
15 prove, did he prove. Yeah, you say did he prove. That's
16 argument, Your Honor. That's argument. It is not this is
17 what the evidence will show.

18 MR. ROGERS: Well, counsel has already engaged in what I
19 objected to as argument by projecting what they believe the
20 defenses were going to be. Set aside the fact that they were
21 mistaken and focus on the fact that they were characterizing
22 our arguments, which is virtually, by definition, argument.

23 And what we are doing here is saying look, these are
24 the plaintiff's theories. And the question that you're going
25 to be charged with answering at the conclusion of this case is

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1 does the evidence support their theory of the case. And at
2 the conclusion of the case we'll say we believe the evidence
3 will not. And that's what the point of this slide is. It's
4 not to argue as you would in closing. It's saying these are
5 the plaintiff's claims, does the evidence prove it. Ask
6 yourself that as the case is presented.

7 MR. EGLET: If this was in -- slide was in closing
8 argument it would be fine, because it's argument, ask yourself
9 did he prove this, did he prove that, did he prove that, did
10 he prove this. This isn't what the evidence will prove.

11 When Mr. Wall was talking about defense counsel's
12 defenses, what he said was -- and it, contrary to what counsel
13 said, every one of them was right on the money of exactly what
14 his medical experts have said. So he's saying their evidence
15 that they will present from their medical experts are this,
16 Mr. Simao had preexisting degenerative changes or age related
17 changes in his spine, the -- prior to the accident.

18 The evidence at the trial will be that yes,
19 everybody his -- virtually everybody his age does. They
20 weren't causing any symptoms prior to the accident and after
21 the accident he had this constellation of symptoms and
22 injuries. That's what the evidence will present. That's the
23 difference.

24 That's not what this is doing. This is nothing but
25 pure, unadulterated argument, Your Honor.

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1 THE COURT: Well, I agree that this is argument, what's
2 contained on this slide. And I also think that when
3 plaintiff's counsel anticipates what the defendant's
4 affirmative defenses are, I don't see that there's anything
5 wrong with doing that in opening statement. So that's the
6 ruling. Are there any other slides we need to look at?

7 MR. EGLET: There are, Your Honor.

8 MR. ROGERS: So remove that --

9 MR. EGLET: The -- your Britt Hill, your physician's
10 assistant where you give her giving an opinion on medical
11 causation.

12 DAN: Give me one second.

13 [Pause]

14 DAN: That's the first of one, two --

15 MR. EGLET: You have one where it's the last bullet
16 point.

17 DAN: Okay.

18 MR. EGLET: Okay. Right here, the last bullet point on
19 this. Britt Hill, he is a physician's assistant. He is not a
20 medical doctor. He's not qualified under Nevada law, under
21 Morsicato and a whole line of cases in this jurisdiction that
22 says when you talk about medical causation, it is a medical
23 expert who must give the -- a medical doctor who must give the
24 opinion regarding causation.

25 This is clearly a causation testimony. There's no

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1 way that Britt Hill is going to be qualified to give that
2 opinion in this trial.

3 THE COURT: Britt Hill is a physician assistant?

4 MR. EGLET: He's a PA, yes, a physician's assistant.

5 THE COURT: Mr. Rogers?

6 MR. ROGERS: Right. This is actually the same problem
7 that we dealt with with Nancy Hartman [phonetic] when I
8 approached. Your Honor does have an order on that. On the
9 slide, she is projecting treatment that she has no expertise
10 to recommend or project.

11 In this case, we have Britt Hill saying -- if he
12 didn't say it's not related, he's saying, "I never even heard
13 of neck pain before 11 months after the accident." And he
14 might have added so no, I didn't think it was related. So I
15 can change that to say that his neck symptoms -- he never
16 complained of neck symptoms until 11 months after.

17 MR. EGLET: Well --

18 THE COURT: This one --

19 MR. EGLET: -- that would be an incorrect --

20 THE COURT: This --

21 MR. EGLET: -- statement of the facts, because the
22 medical records show he complained of neck problems prior to
23 that. But the point is I don't know -- I don't even
24 understand his argument with the life care planner, who's
25 simply saying this is what the cost of future medical care is

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1 based on what the doctors say that the plaintiff is going to
2 need. And that's all Mr. Wall said when he presented that
3 slide. That's all. And that's all the slide said.

4 What this says, this is a PA giving a medical
5 causation opinion in Nevada, which is not permitted.

6 THE COURT: I agree. The last sentence needs to be
7 removed.

8 MR. ROGERS: Okay.

9 MR. EGLET: Could we have the Dr. Sible slide where you
10 have this issue about smoking? I --

11 DAN: Sure.

12 MR. EGLET: Okay. This right here, they've got this
13 slide, Dr. Sible. And they say, last bullet point, smoking
14 can contribute to degeneration.

15 And in fact, this is the deposition testimony of
16 Dr. Sible on this area. That's just an absolute incorrect
17 statement. Okay?

18 "Question: The Southwest medical records
19 reflect that the plaintiff had a nicotine addiction,
20 that he was a smoker. Can smoker -- can smoking
21 cause greater degeneration than you find in patients
22 who aren't smokers?"

23 There's an objection to form and foundation. And
24 the witness says, Dr. Sible:

25 "I think that calls for more of an expert

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1 witness on this, not as it pertains to this patient.
2 I don't have any reason to believe that this
3 particular finding on here is caused by him
4 smoking."

5 So that's just an absolute misstatement of the
6 record. Dr. Sible didn't testify to that, didn't say smoking
7 can contribute to degeneration. That was the question that
8 was asked, but the answer was no, I can't say that with this
9 patient.

10 THE COURT: Mr. Rogers?

11 MR. ROGERS: Yes, I obviously don't have the Keebler tree
12 that Mr. Eglet's law firm has here. I can tell you that there
13 were other discussions in that deposition that I don't have in
14 front of me right now that did address smoking as a cause of
15 degeneration in the spinal disks. However, if you want me to
16 strike it, I'm --

17 MR. EGLET: Well --

18 MR. ROGERS: -- with you and want to get this thing
19 moving, and I'm ready to just get it done with.

20 MR. EGLET: Here's the point. I don't care if smoking
21 can potentially, maybe, hypothetically, one in a million
22 chance cause degeneration or an acceleration of degeneration
23 in a spine. Point is in this case did smoking, to a
24 reasonable degree of medical probability, accelerate the
25 degenerative process in his spine. Which I would find it very

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1 hard for them to argue since their own doctors, one of them
2 says there's not even any degeneration in the spine, period,
3 from his review of the MRIs. And the other guy says well,
4 there is degeneration, but doesn't relate it to smoking.

5 So there's no evidence to a reasonable degree of medical
6 probability that Mr. Simao's prior smoking is what caused his
7 degenerative condition. If you believe one of his experts, he
8 has no degenerative condition whatsoever.

9 THE COURT: Well, based on that, my understanding then,
10 this last sentence needs to be removed as well, Mr. Rogers.

11 MR. ROGERS: Okay. Dan. It's done.

12 [Counsel Confer]

13 MR. EGLET: Do you have any other ones written down?

14 DAN: Yes. It's Arita; correct, Dr. Arita?

15 MR. ROGERS: Arita. Oh, the exaggeration. But that was
16 -- you asked and that was taken out.

17 DAN: That was taken out. Then 68 and 69, I believe are
18 the last ones.

19 MR. EGLET: Can we see those.

20 DAN: But that was the ask-yourself stuff, and that's
21 out.

22 MR. EGLET: Oh, all right.

23 MR. WALL: What was 68? I thought I remembered 68.

24 MR. EGLET: Ask yourself. That was the ask yourself.

25 MR. ROGERS: That is 68.

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1 MR. WALL: Okay, 69.

2 MR. EGLET: All right.

3 MR. ROGERS: Well --

4 DAN: I'll just need a few minutes to make these edits.

5 MR. EGLET: That's fine.

6 MR. ROGERS: He said he'll need a couple minutes just to
7 make these revisions, then we can get --

8 THE COURT: Do you think we can finish closing today, or
9 are we going to have to finish it tomorrow?

10 MR. ROGERS: I think I'm -- I don't have that much
11 longer. All I have are -- I'm walking through the providers
12 now, Britt Hill, Sible, Arita. Am I pronouncing Sible right?
13 Wong and Fish, and then I close. I'm just saying these are
14 who these people are who are coming.

15 THE COURT: Do you think you can do it in 20 minutes?

16 MR. ROGERS: I believe so, very close to it.

17 THE COURT: Because I haven't made arrangements with Jury
18 Services for any overtime work for the court staff.

19 DAN: I'm done.

20 MR. WALL: All right.

21 MR. ROGERS: Let's go.

22 THE COURT: Bring our panel in then please.

23 [Pause]

24 THE COURT: Counsel approach please.

25 [Bench Conference Not Transcribed]

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1 [Jury In]

2 THE COURT: Please be seated, ladies and gentlemen.
3 Counsel stipulate to the presence of the jury?

4 MR. ROGERS: Yes, Your Honor.

5 MR. WALL: Yes, Your Honor.

6 THE COURT: Are you ready, Mr. Rogers?

7 MR. ROGERS: I am, yes.

8 We left off with this fellow, Britt Hill, physician's
9 assistant. As I said, he treated the plaintiff before and
10 after the accident. When he first met the plaintiff after the
11 accident -- remember this was after the three-week gap in
12 treatment. So accident is tax day, April 15th, this three-
13 week gap passes, we're about May 4th.

14 When he examines him on that day, there were no
15 signs of any trauma. The plaintiff complained only of
16 headaches to him. Throughout the entire course of the
17 plaintiff's treatment with Britt Hill there were no requests
18 for time off work and no time off given.

19 At a deposition we discussed with him well, here are
20 these MRI findings and he said well, those are typical for
21 people in their 40s. Asked can people have those findings on
22 their MRI and not have any symptoms at all? He said sure,
23 sure. Most everybody does have those conditions after a given
24 -- sort of like hair goes gray. It doesn't mean that you're
25 sick, it just means that's how you age. That was the

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1 condition of the plaintiff's spine.

2 Next we go to Dr. Sible. He was the first pain
3 management physician who the plaintiff visited. And Dr. Sible
4 it appears is no slouch. He did his residency in anesthesia
5 at Stanford. He did his fellowship in pain management at
6 Stanford. He's dual board certified in anesthesia and pain
7 management. He testified -- and remember this is one of the
8 treating providers. This is not an expert who the defense has
9 hired and is paying for. This is one of the plaintiff's
10 treating providers.

11 He said those MRIs don't show evidence of trauma.
12 And again, that the plaintiff's spine looks age appropriate,
13 that the plaintiff's symptoms can be the result of
14 degeneration or age. Said that the injections, all the
15 injections that plaintiff's counsel just walked you through
16 never isolated a pain generator. And you may remember a
17 discussion about a particular injection called discography.
18 In Dr. Sible's view, cervical discography is not reliable.

19 Also in Dr. Sible's opinion, surgeons should not do
20 their own spine injections and make surgical decisions based
21 on them. In this case, the plaintiff's surgeon did.
22 Dr. McNulty administered injections twice. Dr. Sible, one of
23 the other treating providers, says they shouldn't be doing
24 that.

25 He also said that the plaintiff's pain after the

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1 surgery was exactly the same as it was before, both in
2 severity and in location. This surgery did not work because
3 there was no injury caused to the cervical disks in this
4 accident.

5 Next is Dr. Arita. The plaintiff brought him up as
6 well. Again, appears to be a qualified doctor, went to
7 medical school, residency and internship at USC. Did a
8 fellowship in pain management and in cardiac anesthesia. He
9 testified that the plaintiff's complaints following this
10 accident were inconsistent with his examination findings.
11 Said, just like Dr. Sible and just like Britt Hill, the MRIs
12 do not show evidence of trauma. The MRIs are typical for
13 people the plaintiff's age, that people typically have the
14 same findings on MRI without symptoms or complaints. Again,
15 the injections did not isolate the pain generator; again,
16 surgeons should not perform their own injections.

17 He testified that the plaintiff's neck complaints
18 and symptoms are not likely caused by this car accident. He
19 also testified that he warned the plaintiff against surgery
20 and said you're not a good candidate, don't do this.

21 Plaintiff's counsel pointed out the UCLA medical
22 professors that the defense has brought in to examine all of
23 these records and to make sense of them, to give us their
24 opinions and conclusions about the meaning of it all.

25 First is Dr. Wong. He's a UCLA professor of

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1 orthopedics and neurosurgery. He's also a professor of
2 biomedical engineering. He's the chief of the spine service
3 there. He's a full-time spine surgeon. He works in the
4 trauma center. He teaches medical students, teaches people
5 how to perform these surgeries.

6 He's a keynote speaker all around the world on these
7 issues, most recently for the British Association of Spine
8 Surgeons. He was the recipient of the 2010 American Academy
9 of Orthopedic Surgeons achievement award. He's the chairman
10 of the National Association of Spine Surgeons spinal biologics
11 and research section. He is a scientist and a clinical
12 practitioner. He's reviewed this case, he's examined the
13 plaintiff. And his opinion, no injury was caused to the
14 plaintiff's cervical spine disks as a result of this
15 accident.

16 Dr. David Fish, also from UCLA. He is a pain
17 management physician there. He's licensed in both California
18 and Nevada. He was trained at Johns Hopkins. He worked in
19 the physician -- pardon me, as a physician in the military,
20 where he rose to the ranks of captain. He teaches pain
21 management to the fellows and the students at UCLA, teaches
22 them how to perform injections and how to administer nerve
23 testing.

24 He works, in addition to UCLA, at the L.A. Veterans
25 Hospital, where he does trauma. He's on boards of applied

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1 anatomy and pharmacology. He's reviewed this case and he has
2 examined the plaintiff, and in his opinion, the alleged
3 injuries were not caused by this accident.

4 All the doctors will admit that the plaintiff's
5 surgery was elective. They'll all admit that -- and this is
6 an obvious proposition -- that before you do surgery you
7 have to exhaust all less invasive measures. And you also
8 have to make sure that the area that you're going to operate
9 on is actually the pain generator. They'll also admit that
10 this surgery that the plaintiff had generally has a good
11 outcome.

12 Ladies and gentlemen, the plaintiff is still
13 complaining of pain. He evidently did not improve with
14 surgery. There's a pain diagram that the plaintiff filled out
15 before the surgery and after. This is the one, on the left,
16 that he filled out in that physical therapy visit where he
17 reported a 55 mile per hour impact. You can see right here,
18 the neck and the left arm, where he complained that he had
19 symptoms.

20 Remember in those eight months after the accident,
21 never saw that. Here it is now, nine months after the
22 accident; he's complaining of these symptoms. After surgery
23 it's the same [indiscernible]. That's because there was no
24 injury to those disks that the doctors removed in the surgery
25 as a result of this accident.

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1 At the conclusion of this case, nothing short of
2 proof that this car accident caused the neck injury that the
3 plaintiff alleges requiring the surgery that he had will
4 support his burden of proving that Mrs. Rish is responsible
5 for -- excuse me. At the conclusion of this case, the
6 plaintiff will not meet that burden of proof and we will ask
7 you to return a verdict in favor of Mrs. Rish.

8 Thank you.

9 THE COURT: Thank you, Mr. Rogers.

10 Ladies and gentlemen, I'm going to ask you to return
11 tomorrow promptly at 1:00 and excuse you for the evening,
12 reminding you of your obligation not to discuss this case with
13 anyone, not to form or express any opinion until this case is
14 given to you, not to do any research on any subject connected
15 with this case. Thank you. Have a nice evening. See you
16 tomorrow.

17 [Jury Out]

18 THE COURT: Who are the two witnesses we're going to hear
19 from tomorrow?

20 MR. WALL: It's Dr. Jorg Rosler and Dr. Arita.

21 THE COURT: And you think we'll be able to get through
22 both of them tomorrow afternoon?

23 MR. EGLET: Yeah, we should.

24 MR. WALL: I do.

25 THE COURT: Okay. Anything else we need to discuss

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1 before we adjourn?

2 MR. ROGERS: No, not that I can think of.

3 MR. WALL: No.

4 THE COURT: Okay. See you tomorrow at 1.

5 MR. EGLET: Okay, Your Honor.

6 [Proceedings Concluded at 4:45 p.m.]

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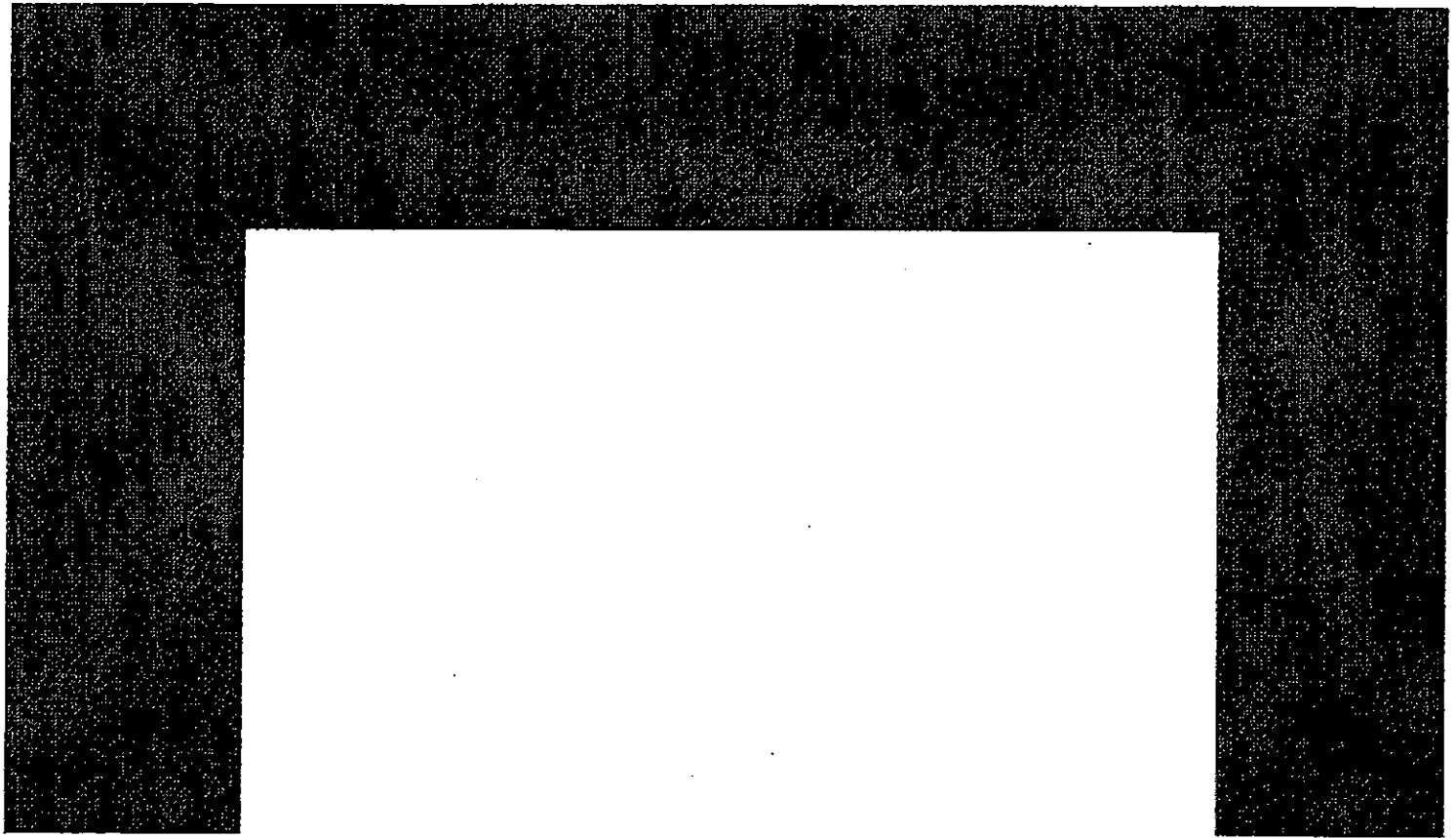
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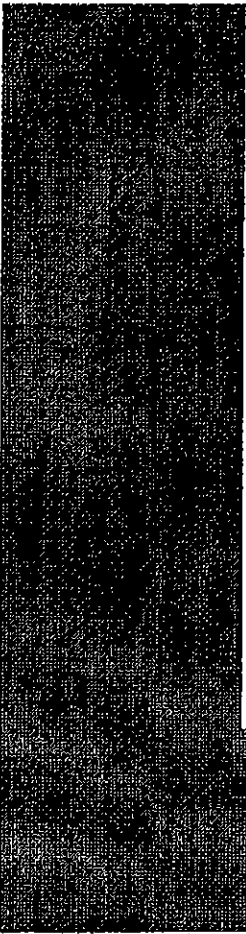
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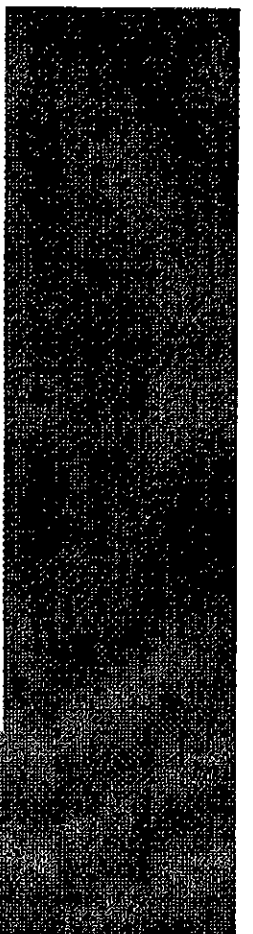
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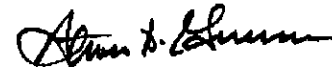
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DISTRICT COURT



CLARK COUNTY, NEVADA

CLERK OF THE COURT

CHERYL A. SIMAO and
WILLIAM J. SIMAO,

Plaintiffs,

CASE NO. A-539455

v.

DEPT. X

JAMES RISH, LINDA RISH
and JENNY RISH,

Defendants.

BEFORE THE HONORABLE JESSIE WALSH, DISTRICT COURT JUDGE

TUESDAY, MARCH 22, 2011

REPORTER'S TRANSCRIPT
TRIAL TO THE JURY
DAY 2 - VOLUME 1

APPEARANCES:

For the Plaintiffs: DAVID T. WALL, ESQ.
ROBERT M. ADAMS, ESQ.
ROBERT T. EGLET, ESQ.
Mainor EgletFor the Defendants BRYAN W. LEWIS, ESQ.
James and Linda Rish: Lewis and Associates, LLCFor the Defendant STEVEN M. ROGERS, ESQ.
Jenny Rish: Hutchison & Steffen, LLC

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TABLE OF CONTENTSPageMarch 22, 2011Trial to the JuryPlaintiffs' Witness(es):

Hans-Jorg Rosler, M.D..... 4

Defendants' Witness(es):

None

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EXHIBITS

Page

PLAINTIFFS':

Exhibit 64 40

DEFENDANTS':

None

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TUESDAY, MARCH 22, 2011 AT 1:01 P.M.

[Jury Present]

THE MARSHAL: Okay. Please come to order.

THE COURT: Please remain seated.

THE MARSHAL: Remain seated. Department 10 is back in session.

THE COURT: Good afternoon, members of the jury.

[Jurors Reply]

THE COURT: Counsels stipulate to the presence of the jury?

MR. LEWIS: Yes, Your Honor.

MR. ROGERS: Yes, Your Honor.

MR. WALL: Yes, Your Honor.

THE COURT: I think we're ready to proceed then.

Mr. Wall, who's the first witness?

MR. WALL: The first witness is Dr. Rosler, Your Honor.

THE COURT: We'll ask him to come forward to the jury, or witness box.

HANS-JORG ROSLER, PLAINTIFFS' WITNESS, SWORN

THE COURT: Whenever you're ready, Mr. Eglet.

MR. EGLET: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. EGLET:

Q Good afternoon, Dr. Rosler.

A Good afternoon.

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1 Q Dr. Rosler, would you please tell the jury the
2 specialty in medicine you practice?

3 A I'm a pain management anesthesiologist.

4 Q And can you describe your educational background for
5 us?

6 A Well, I was born in Germany, hence, my somewhat
7 strange accent. Came over here in 1997. Finished medical
8 school in Germany and proceeded then with my post-graduate
9 education in anesthesiology and pain management at the
10 University of Indiana, Indianapolis.

11 Q And is that where you did your internship?

12 A My internship was done at Michigan State Blodgett
13 Hospital.

14 Q All right. And you said you did your residency at
15 Indiana University --

16 A That is correct.

17 Q -- department of anesthesia. How long is an
18 internship following medical school?

19 A One year.

20 Q And how long is the residency?

21 A Three years.

22 Q Okay. And did you do a fellowship following your
23 residency?

24 A Yes sir.

25 Q And where did you do your fellowship?

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1 A At the University of Indiana.

2 Q And can you explain to the jury what a fellowship
3 is?

4 A A fellowship is a subspecialty training in a field
5 that is closely related to your main field. In
6 anesthesiology, you can train in critical care medicine. You
7 can train in pain medicine. In internal medicine, for
8 example, you can train in cardiology, in gastroenterology.
9 It's a subspecialty of your main specialty.

10 Q And what did you do your fellowship in?

11 A In pain medicine.

12 Q And are you board certified?

13 A That is correct, sir.

14 Q What does it mean for a doctor to be board
15 certified?

16 A Board certified means that you have achieved certain
17 standards that are set forth by a society or board of
18 specialty, and typically that to fulfill these standards that
19 comprises a training in your specialty as well as an
20 examination which can be a written examination and/or an oral
21 examination. Once you have successfully passed those
22 examinations, you are then admitted as a diplomat of the
23 respective board of your specialty.

24 Q And in what areas are you board certified, Doctor?

25 A I'm board certified in anesthesiology with the

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1 American Board of Anesthesiology, and in pain medicine with
2 the American Board of Pain Medicine.

3 Q Do you belong to any professional memberships?

4 A Yes I do. I belong to the largest body of
5 professional membership, that's the AMA - the American Medical
6 Association. And then I belong to the American Society of
7 Anesthesiology, the American Academy of Pain Medicine as well
8 as the North American Spine Society.

9 Q Do you belong to the International Spine
10 Intervention Society?

11 A Yes sir.

12 Q And what --

13 A The International Spine Intervention Society - or
14 ISIS - is a separate society.

15 Q And what is ISIS?

16 A ISIS is a society comprised of many members,
17 international members all around the globe which emphasizes in
18 the teaching of and the treatment of spinal pain, spinal
19 injections.

20 Q Okay. And could you detail for us the scope of your
21 practice as a pain management specialist?

22 A As a pain management specialist, I see patients who
23 complain of pain. And mainly in my practice, I see patients
24 who complain of symptoms of spinal pain, pain that's coming
25 from the vertebral column, the cervical spine, the thoracic

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1 spine, and the lumber spine. So my practice is rather focused
2 on spinal pain.

3 Q Okay. And do you have any hospital privileges?

4 A Yes, sir.

5 Q And where do you have hospital privileges?

6 A Well, let me see if I can get them all together, but
7 it's the Sunrise Hospital, University Medical Center, Valley
8 Hospital, Spring Valley Hospital, Mountain View Hospital,
9 Summerlin Hospital, Southern Hills Hospital, and St. Rose
10 Hospitals which is several - Rose de Lima, San Martin and
11 Siena. And North Vista Hospital.

12 Q And what does it mean to have hospital privileges?

13 A Hospital privileges means that you have fulfilled a
14 certain criteria set forth by each hospital to work as a
15 consultant physician in that hospital, to see patients in that
16 hospital, to admit patients in that hospital, to practice in
17 that hospital.

18 Q Okay. Doctor, have you been qualified as an expert
19 in the area of pain management and anesthesia in the courts of
20 Clark County, Nevada?

21 A Yes, sir.

22 Q Okay. Any other jurisdictions?

23 A Not to my knowledge.

24 Q Okay.

25 MR. EGLET: Your Honor, we would offer Dr. Rosler as an

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1 expert in anesthesia and pain management.

2 THE COURT: Any objection?

3 MR. LEWIS: No, Your Honor.

4 THE COURT: So ordered.

5 BY MR. EGLET:

6 Q Dr. Rosler, would you please describe for us what
7 the practice of pain management consists of?

8 A Well, the practice of pain medicine consists of the
9 diagnosis and the treatment of pain. That's a very global
10 definition.

11 Q Okay. And can you tell us specifically what you do
12 on a normal day with patients?

13 A Well, I --

14 Q What kind of clinical problems do you evaluate and
15 treat on a routine basis?

16 A Well, I see patients who complain of spinal pain,
17 neck pain, mid back and low back pain. I see these patients
18 in my clinic. I evaluate those patients. I come up with an
19 impression with a diagnosis and then, subsequently, with a
20 treatment plan in an attempt to improve the patient's
21 condition.

22 Q Okay. Now are you one of Mr. William Simao's
23 treating physicians?

24 A That's correct, sir.

25 Q Okay. In preparation for your testimony today, what

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1 documents have you reviewed and brought with you?

2 A I have reviewed the documents of our clinic, the
3 Nevada Spine Clinic.

4 Q And have you brought those documents with you?

5 A Yes, sir.

6 Q Okay. Now, Doctor, can a person have neck pain and
7 still have a normal range of motion?

8 A Yes, sir.

9 Q Okay. So if someone hypothetically stood in front
10 of this jury yesterday and said, well, Mr. Simao couldn't have
11 had neck pain because he had normal range of motion in his
12 neck during certain examinations, would that be accurate?

13 A I think that would not be necessarily an accurate
14 statement.

15 Q Why is that?

16 A Because patients do have, can have cervical
17 symptoms, neck pain, and can have full range of motion. That
18 doesn't preclude the fact that the patient is suffering from
19 pain.

20 Q Okay. Does a normal plain film of a cervical spine,
21 an x-ray performed within hours of a patient being involved in
22 a motor vehicle collision and presenting with neck pain rule
23 out an injury to the cervical spine?

24 A No.

25 Q Okay. And why not?

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1 A Well, first of all, the x-ray or the radiograph is
2 typically taken after an accident to see any gross
3 abnormalities, to see is there a fracture. In this case, if
4 there's a fracture of the cervical spine which would then
5 warrant immediate care. However, the x-ray does not show you
6 any underlying soft tissue injury. It can show you any bony
7 abnormalities, it can show you a fracture of the bone, a
8 dislocation, but it cannot show you any underlying soft tissue
9 abnormalities.

10 Q Okay. Now, does the initial diagnosis of a cervical
11 sprain or strain rule out the possibility that a disc or facet
12 injury occurred to the cervical spine?

13 A It does not.

14 Q And why not?

15 A Again, cervical strain and sprain pertains to the
16 soft tissue to the overlying muscles and ligaments, and often
17 the underlying injury can be also a result of the same impact
18 that resulted in a cervical strain or sprain.

19 Q So hypothetically, if someone stood in front of this
20 jury yesterday afternoon and told this jury that Mr. Simao
21 could not have had any injuries to his discs in his cervical
22 spine because his cervical x-rays were normal, would that be
23 an accurate statement?

24 A This would not be an accurate statement, sir.

25 Q All right. Doctor, when did you -- could you put up

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1 -- hang on a second.

2 MR. EGLET: The Court's indulgence?

3 THE COURT: Sure.

4 MR. EGLET: Your Honor, may we approach?

5 THE COURT: Yes.

6 [Bench Conference Not Transcribed]

7 MR. EGLET: Thank you, Your Honor.

8 Okay. Brendan, could you put up Exhibit 32, page 2
9 please?

10 BY MR. EGLET:

11 Q Doctor, can you see that screen in front of you?

12 A Yes I can.

13 Q If it's easier to refer to that screen or your
14 chart, whichever is easier, and if you need to circle
15 something with your finger on that screen you can.

16 Now, when did you initially evaluate Mr. Simao for
17 pain management consultation?

18 A I saw him initially on April 15th of 2008.

19 Q Okay. And who referred Mr. Simao to you?

20 A Dr. Grover.

21 Q And what specialty does Dr. Grover practice?

22 A Dr. Grover's a orthopedic spine surgeon.

23 Q And what was Mr. Simao's chief complaint at that
24 time?

25 A His chief complaint was at that time neck pain with

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1 radiating pain in his left upper extremity.

2 Q Left upper extremity means what?

3 A Left arm.

4 Q And some of you -- doctors say extremities, they're
5 talking about the arms and legs?

6 A Correct, sir.

7 Q Upper extremities are the arms, lower extremities
8 are the legs?

9 A Correct, sir.

10 Q Okay. Now what history did you obtain from Mr.
11 Simao at that time of your initial evaluations of him?

12 A As stated in my record, I evaluated and elicited
13 that the patient was presenting with these chief complaints of
14 neck pain, left upper extremity pain, and he stated that these
15 symptoms were a result of a motor vehicle accident two to
16 three years ago.

17 Q Okay. And did he note to you that he hit the back
18 of his head on a metal cage of the vehicle upon impact?

19 A Yes, sir.

20 Q And did he indicate that he had been suffering from
21 neck pain, interscapular pain and left parascapular pain
22 radiating into his left extremity as well as the osipit
23 [phonetic]?

24 A Occiput.

25 Q Occiput?

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1 A Yes, sir.

2 Q Okay. And he had been suffering from this pain
3 since the motor vehicle accident?

4 A Yes, sir.

5 Q Now what is interscapular and left parascapular
6 pain? Could you explain that to us?

7 A The scapula is the medical term for shoulder blade.
8 So interscapular pain means pain that is in between the
9 shoulder blades. Parascapular pain is pain that surrounds the
10 shoulder blade. So the patient was having pain in between the
11 shoulder blades and surrounding the left shoulder blade area.

12 Q What is the occiput? Where is that located?

13 A The occiput is the back of your head, the occipital
14 region - occiput.

15 Q Okay. Does it extend down to the top of the neck?

16 A Yes, sir.

17 Q Now, what evaluation and treatment did you document
18 that Mr. Simao received before your initial evaluation of him?

19 A The patient had undergone physical modalities
20 including physical therapy and had also undergone injection
21 therapy.

22 Q Okay. And would you please review for us --

23 MR. EGLET: Could you put up Exhibit 32, page 1 please,
24 Brendan?

25 ///

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1 BY MR. EGLET:

2 Q Could you review for us the pain diagram that was
3 filled out by Mr. Simao on April 15th, 2008?

4 A Yes, sir. On the pain diagram on the right side,
5 you'll see the posterior view or the view from the back, and
6 on the left side you see the front view. The patient was
7 marking on the back view pain in between the shoulder blades
8 radiating up into the back of his head, and then pain that was
9 coming down on the left side around the left shoulder blade
10 and into his left upper extremities.

11 Q Okay. And what does -- what is this scale on the
12 bottom like a numbered --

13 MR. EGLET: Can you shift this a little bit to the right,
14 Brendan? Reduce it a little bit maybe? A little bit more. I
15 think you're paper's off center. There you go.

16 BY MR. EGLET:

17 Q I see this scale on the bottom below the pain
18 diagram of one to ten with a circle around the seven. What is
19 that?

20 A It's the visual analog scale, VAS scale, which is
21 the easy to, for the patient to grade his com symptomatology,
22 the severity of the symptoms. And typically I say zero is the
23 no pain and ten is the worse pain you can imagine.

24 Q Okay. And so you have them grade it and then you
25 have the patient fill out, I guess, scribble on the front and

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1 back of the bodies there depicting where they're having their
2 problems?

3 A Yes, sir.

4 Q And what is the purpose for this document?

5 A Well, it gives us an estimate in what condition the
6 pain is in terms of his pain intensity which is very
7 important. Some patients, you can't necessarily tell by
8 looking at them in how much pain they are so you have to allow
9 them to explain in an easy way how severe their pain is.

10 Q Okay.

11 MR. EGLET: Now, could you go back to page 2 please,
12 Brendan?

13 BY MR. EGLET:

14 Q Now, Doctor, by way of review of the records
15 available to you in obtaining a history for Mr. Simao, did you
16 reach any conclusions as to whether he had, Mr. Simao had had
17 any previous clinically significant neck pain or upper
18 extremity symptoms that required evaluation or treatment
19 before this April 15th, 2005 motor vehicle crash?

20 A To my knowledge, there weren't any symptoms of neck
21 pain prior, and left arm pain prior to this motor vehicle
22 accident April 2005.

23 Q Now, under the paragraph on page 2 of your chart,
24 under the paragraph titled Past Medical History, in your
25 initial evaluation you do not have documented that Mr. Simao

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1 had a history of migraine headache syndrome. Did you
2 subsequently become aware that Mr. Simao had a history of
3 migraine headache syndrome that predated the April 15th, 2005
4 motor vehicle crash?

5 A Yes, sir.

6 Q Now does the fact that Mr. Simao has a medical
7 history of migraine headaches impact your clinical assessment,
8 differential diagnosis or plan of treatment for him?

9 A No, sir.

10 Q Okay. As an experienced pain management physician,
11 do you believe that occipital pain, axial neck pain and/or
12 upper extremity symptoms can trigger, exacerbate or aggravate
13 pre-existing migraine headaches?

14 A Absolutely, sir.

15 Q And why is that?

16 A Well, we all know, and perhaps one of our jurors is
17 suffering from migraines, that migraine type symptoms can be
18 aggravated by stress, by sometimes different smells, by lack
19 of sleep, by pain, of a pain that can trigger and exacerbate
20 and worsen the underlying migraine symptomatology.

21 Q Was Mr. Simao working at the time of your initial
22 evaluation of him?

23 A I believe so, sir.

24 Q And do you know what he did?

25 A I believe he was in the floor cleaning business.

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1 Q Okay. Does the fact that Mr. Simao remained
2 gainfully employed following this April 15th, 2005 motor
3 vehicle crash rule out the possibility that he sustained a
4 significant cervical spine injury as a result of that accident
5 with the development of chronic pain syndrome?

6 A No, it does not rule it out, sir.

7 Q And why not?

8 A Well, for one, people are, like we all have to
9 pursue a gainful employment to support our families, and the
10 fact that somebody has pain does not necessarily rule out that
11 he or she is not working due to the fact that one has to make
12 a living.

13 Q Okay. So if someone stood in front of this jury
14 yesterday afternoon and told them that the fact that Mr. Simao
15 returned to work after this motor vehicle accident so he must
16 not have had a disc injury, would that be accurate?

17 A No, sir.

18 Q Do you see patients in your practice who have
19 significant disc injuries who because of various reasons are
20 required to continue to work?

21 A I would say the majority of my patients with pain
22 pursue gainful employment and continue to be employed and
23 continue to work despite the pain.

24 MR. EGLET: Could you go to page 3 please, Brendan?

25 ///

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1 BY MR. EGLET:

2 Q Now, Doctor, what positive physical examination
3 findings did you document on your initial evaluation of Mr.
4 Simao?

5 A Well, first I did a general exam to just to rule out
6 that there's something underlying that might be a little more
7 pressing such as a cardiac problem, a heart problem or a lung
8 problem is always important that you cover your bases there
9 and make sure that the patient is okay in that respect. And
10 then I did a problem focused examine pertaining the cervical
11 spine, and there was, upon inspection, there was a loss of the
12 normal lordotic curvature of the spine. Lordosis or lordotic
13 curvature means there's a -- the normal cervical spine has a
14 curve and that curve --

15 MR. EGLET: May I approach, Your Honor?

16 THE COURT: Yes.

17 BY MR. EGLET:

18 Q Could you, using this spine, explain what you mean?

19 A As you can see the --

20 THE COURT: If you need to step down, Doctor --

21 THE WITNESS: Sure.

22 THE COURT: -- feel free to do so.

23 BY MR. EGLET:

24 A As you can see, this is the vertebral column, and
25 when you look at it from the side you see it's not straight.

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1 It's rather curved. It's an S shape. And so the cervical
2 spine, the thoracic - the mid back, thoracic spine, and the
3 lumbar spine - the lower back, it's all in an S shape. So in
4 this case with Mr. Simao, the curvature of the cervical spine
5 was reduced. He had a straightening of the cervical spine,
6 and that was evident on physical exam. So rather than having
7 an S shaped or rather than having a curve in the cervical
8 spine, the patient had a straight cervical spine.

9 Q In your experience, what causes that?

10 A That is typically caused by an injury to the soft
11 tissue underlying a spinal injury where you have a protected
12 reflex of the musculature where the musculature pulls the
13 spine in a more straight position.

14 Q Okay. What else did you find on your physical
15 examination at that time?

16 A Well, the patient had tenderness to palpation to --

17 Q What does that mean?

18 A When I palpate, I put pressure in the area of the
19 cervical spine in the, we call it paraspinous area that means
20 in the side of the cervical spine as well as in between the
21 cervical spine, in between the shoulder blades and across the
22 shoulder blades, there was tenderness elicited upon pushing so
23 to speak. We call it palpation.

24 Q All right.

25 MR. EGLET: Could you go to page 4 please, Brendan?

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1 BY MR. EGLET:

2 Q Doctor, did you perform provocative testing on
3 Mr. Simao's cervical spine at the time of your initial
4 evaluation?

5 A Yes, sir.

6 Q Okay. And what is provocative testing and what is
7 the purpose of provocative testing of the cervical spine?

8 A Provocative test, the purpose of provocative test is
9 to elicit or reproduce the patient's symptomatology under a
10 stress. In his case, in the patient's case, I performed an
11 axial compression test where I pushed down on the head of the
12 patient and asked the patient while I was doing this whether
13 this causes him to have any symptoms. And the patient was at
14 that time was reporting symptoms of all icky, exacerbation of
15 his normal symptoms, neck pain, pain in between the shoulder
16 blades, pain in his left shoulder blade area and left arm
17 pain. So the axial compression test was thereby positive, or
18 therefore positive. I also performed a spurling sign. A
19 spurling sign is a test of the nerves that come out of the
20 vertebral column. I had the patient look up to the ceiling
21 and turn the head as he looks up, turn the head to the side.
22 And what I do I narrow the canal where the nerve travels
23 through, and if this canal is already compromised by a disc,
24 if the canal is already more narrow, if there's already an
25 underlying spinal nerve irritation, that will exacerbate this

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1 symptomatology. That's the spurling sign. And both the axial
2 compression test and the spurling sign were positive in Mr.
3 Simao.

4 Q Okay. Now, Doctor, can a patient with neck pain and
5 upper extremity symptoms have a normal non-provocative -- a
6 normal non-provocative examination of the cervical spine with
7 a supple neck and without tenderness and still have positive
8 provocative physical examination findings in the cervical
9 spine like you found here?

10 A Yes, sir.

11 Q Okay. And so if Mr. Simao's previous medical
12 providers had documented his neck to be supple without
13 tenderness but did not document provocative testing of the
14 cervical spine, would that necessarily mean that he had a
15 normal examination of his cervical spine?

16 A Well, it does not. It's not a complete examination.
17 It's a -- I can make an analogy. If I try to evaluate the
18 patient's heart and I just feel for the peripheral pulse, I
19 cannot make any conclusion whether the patient may have a
20 murmur or not so I have to do some more testing or more
21 examinations. So this would not be a complete physical exam
22 to rule out an underlying cervical spine injury.

23 Q And if the physical examination is not complete or
24 is incomplete, it's inconclusive?

25 A Correct, sir.

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1 Q Okay. And does that mean that no meaning can be
2 drawn from this examination absent a provocative physical
3 examination testing?

4 A Yes. It's an inconclusive examination. It's not a
5 thorough examination.

6 Q Okay. And you, I think you described that you
7 performed provocative axial compression at the time of your
8 initial examination?

9 A Correct.

10 Q Okay. And you listed provocative spurling signs in
11 your initial examination of Mr. Simao?

12 A Correct, sir.

13 Q Okay. And have you explained to us what spurling
14 signs are?

15 A Yes, sir.

16 Q All right. What is the clinical significance of a
17 positive axial test and a positive left spurling sign in Mr.
18 Simao?

19 MR. EGLET: Could you highlight that please, Brendan, the
20 axial compression and the spurling signs?

21 BY MR. EGLET:

22 A As I have pointed out, with a positive spurling
23 sign, there is a -- a positive spurling sign is indicative of
24 the nerve root irritation. Nerve root is the spinal nerve
25 that comes off the spinal cord that goes, in our case, goes

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