

1 THURSDAY, MARCH 25, 2011 AT 12:03 P.M.

2 THE MARSHAL: Please remain seated and in order.
3 Department X is now in session. The Honorable Jessie Walsh,
4 Judge, presiding. Thank you.

5 THE COURT: Good afternoon. Thank you, members of the
6 jury for returning early today; we appreciate that. Will
7 Counsel stipulate to the presence of the jury?

8 MR. WALL: Yes, Your Honor.

9 MR. ROGERS: Yes, Your Honor.

10 THE COURT: All right. So, since it's a new, day let's
11 re-swear the Doctor, please. Please stand and raise your
12 right hand.

13 PATRICK SHAWN MCNULTY, PLAINTIFF'S WITNESS, SWORN

14 THE CLERK: Thank you. Please be seated and state and
15 spell your name for the record.

16 THE WITNESS: Patrick Shawn McNulty. Patrick,
17 P-A-T-R-I-C-K, Shawn, S-H-A-W-N, McNulty, M-C-N-U-L-T-Y.

18 THE COURT: Very well. Mr. Rogers?

19 MR. ROGERS: Yes.

20 THE COURT: Are you ready?

21 CROSS-EXAMINATION CONTINUED

22 BY MR. ROGERS:

23 Q Good afternoon, Doctor.

24 A Good afternoon.

25 Q All right. The neck condition that you diagnosed

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1 the Plaintiff with is something that can be caused by
2 something other than just a single traumatic event, correct?

3 A Yes.

4 Q It can be caused by something other than a car
5 accident?

6 A Yes.

7 Q And the conditions that you observed on the MRI, you
8 can't date them, if I understand you correctly?

9 A I cannot tell you when they actually occurred.

10 Q Okay. Now, you first saw the Plaintiff a year after
11 the accident --

12 A Yes.

13 Q -- in April of '06?

14 A Yes.

15 Q And you don't know anything about the car accident
16 other than what he told you, right?

17 A It was just simply he said he had a car accident and
18 that's when he -- his problems started.

19 Q Okay. But did you discuss with him whether he was
20 able to drive from the scene of the accident?

21 A No, I really didn't go into the other -- into the
22 other details. No, I did not discuss that.

23 Q Okay. Do you know anything about the folks in Jenny
24 Rish's car?

25 MR. EGLET: Objection; relevance.

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1 THE COURT: What's the relevance, Mr. Rogers?

2 MR. ROGERS: Well --

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

4 THE COURT: Yes.

5 [Begin Bench Conference]

6 MR. EGLET: We've already been down this road. Whether
7 anybody was injured or not in Jenny Rish's car or their
8 condition is not relevant. He's already tried this with, I
9 think, Dr. Rosler and the objection was sustained. It's the
10 same thing, Your Honor, it's not relevant.

11 MR. ROGERS: I'm not sure how it is not relevant. Is
12 this something that there's an order?

13 MR. EGLET: It doesn't matter whether it's order --

14 MR. WALL: What would be the relevance other than some
15 argument of minor impact.

16 MR. EGLET: Yeah, the fact --

17 MR. WALL: Whether Jenny Rish received --

18 MR. ROGERS: The relevance is that if one of them were
19 injured or were not, that would be relevant or probative to
20 whether the others were injured.

21 MR. EGLET: No, no it's not. No it's not. That's the
22 whole point.

23 THE COURT: Sustain the objection.

24 [End Bench Conference]

25 ///

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1 BY MR. ROGERS:

2 Q Your causation opinion then is not based on any
3 particularized facts about the acc. It's based on a history
4 that the patient gave you?

5 A Well, the simple answer is it's based on several
6 things, and the history is a very important part of it.

7 Q All right. Now, has anyone in the medical field
8 published on the reliability of determining cause based on the
9 patient's word?

10 A I would imagine so. I'm not aware of detailed
11 articles.

12 Q So you're not aware of any such publications that
13 have been subjected to peer review?

14 A Well, that would be -- the answer is no.

15 Q And you agree that peer review is something that
16 doctors rely on, that's what establishes -- well, reliability
17 in science?

18 A I would say that peer review in general definitely
19 helps to make that, but like any process, it's still subject
20 to some variability. A peer review is, I would say, the
21 accepted best venue to look at an article, read it, decide if
22 it's pertinent. If it comes from a good peer review journal
23 then that's more important.

24 Q Okay. Now, on the subject of peer review, you're a
25 member of NASS, right?

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1 A That and others, yes.

2 Q Okay. Yesterday there was a discussion with Dr.
3 Fish regarding discography. You agree that there are concerns
4 in the medical community about the reliability of provocative
5 cervical discography?

6 A Yes.

7 Q And you, yourself, don't do provocative cervical
8 discography?

9 A I myself have done and can do provocative cervical
10 discography, but I prefer not to use that as my first line of
11 diagnostic tests.

12 Q Okay. And in your view, an analgesic is a more
13 reliable indicator of a good surgical outcome than a
14 provocative discograph?

15 A Well, first of all, that -- are you saying analgesic
16 discogram or just --

17 Q Yes.

18 A analgesic?

19 Q Yes.

20 A Because technically I did not perform an analgesic
21 discogram in this gentleman.

22 Q No, no one did, that's understood.

23 A So technically I would agree very much so with the
24 simple statement that in general I much prefer using analgesic
25 structural blocks to determine the pain status of a particular

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1 structure than a provocative block.

2 Q Okay. So if Dr. Fish testified that cervical
3 discography isn't always reliable you wouldn't disagree with
4 that?

5 A I would not.

6 Q Now, another topic that was broached yesterday was
7 whether a doctor expects his patients to follow his advice.
8 Do you expect your patients to follow your advice?

9 A The simple answer is no.

10 Q Okay. And in this case you've testified that the
11 Plaintiff did not follow your advice, I think it was sometime
12 shortly after you first met him, in November I believe,
13 recommending surgery?

14 A Yes, he chose not to at that time.

15 Q And you further testified that by not following your
16 advice he may have developed a neuropathic pain?

17 A I think precisely what I said is because of the
18 extended delay in treatment between known event, starting of
19 symptoms and definitive surgery being delayed approximately
20 four years, that would put him at a higher risk for
21 neuropathic pain.

22 Q All right. When the Plaintiff first presented to
23 you, you weren't aware that there was a personal injury
24 lawsuit going on; is that right?

25 A I made this comment, there are no medical/legal

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1 issues, so again, I think I testified as to why I made that
2 comment.

3 Q And when Britt Hill, the physician's assistant at
4 Southwest Medical referred the Plaintiff to you, he didn't
5 mention anything about a trauma or a car accident?

6 A I had no conversation with Britt Hill.

7 Q Okay.

8 A I mean, there really isn't a venue for any patient
9 with Britt Hill --

10 Q When the Plaintiffs presented to you, this is
11 initial visit -- if you want, you can pull that up, it's
12 Exhibit 2, Page -- or 22, Page 5. You had a discussion with
13 him at that very first visit of a potential surgical
14 intervention.

15 A Okay. I'm ready.

16 Q Do you have the records in front of you?

17 A I've got my copy as well.

18 Q Okay. You may refer to either one.

19 A Okay. I'm ready.

20 Q Okay. Is that correct?

21 A Let's see, I basically -- if we go down to
22 recommendations and opinions, what I stated is that there
23 would be injections that could be done to help identify the
24 pain generators or define the problem, but then I also stated
25 I really didn't expect them to do much for long term. And

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1 then we go -- and then I discuss basically referring him for
2 injections.

3 Q Right. And in that paragraph that you're reading
4 from you wrote that he would most likely require some type of
5 surgical intervention.

6 A Yes.

7 Q Okay. And at that point you referred the Plaintiff
8 back to Southwest Medical Associates for spine injections?

9 A Yes.

10 Q And then you didn't see him again for roughly 16
11 months?

12 A I -- I know there was --

13 Q No need to count it out, the date that I have of you
14 return is September of 2007?

15 A Correct, yes.

16 Q Okay. Now, if the Plaintiff did not have neck pain
17 for a period of roughly four-and-a-half to five months
18 following the date of the incident does that, in your opinion,
19 decrease the likelihood in any way that the car accident
20 caused trauma?

21 A Yes.

22 Q When the Plaintiff returned to you in September
23 2007, you discussed ordering that epidural that you did
24 shortly thereafter. Do you remember that?

25 A I think -- I authorized with me doing it, yes.

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1 Q Okay. And the idea of getting that epidural done
2 was to identify the pain generator and then make a future
3 treatment decision based on it, right?

4 A Yes.

5 Q Now, are you aware that before the epidural was
6 performed, that the Plaintiff was sent back to Southwest
7 Medical Associates for an operative clearance?

8 A Before my epidural?

9 Q Yes.

10 A I wasn't aware of that, no.

11 Q Okay. Can you pull up -- it's Exhibit 18, Page 112
12 and it's down on the bottom of the page in that section
13 entitled, "Addendum" right below -- there you go. And on this
14 date it reads that the Plaintiff presented for preoperative
15 screening.

16 A Can you show me the -- I'm sorry, is that the date
17 that's correct, 10/9/07?

18 Q Yes.

19 A Okay.

20 Q And that was before you did the epidural injection,
21 right?

22 A Well, let's see. Yes.

23 Q So he was cleared for this surgery before the
24 injection was done that would have determined where the pain
25 was coming from?

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1 A Yes.

2 Q Okay.

3 A To be quite honest, I don't know why he was. He's a
4 healthy guy normally I wouldn't send him for that. These are
5 just simple injections, I don't really consider these surgery.
6 They're procedures, but they're not really any major surgery.

7 Q And then you did the epidural, if you would, Exhibit
8 25, Page 18. And I want to focus on your pre- and post-
9 operative diagnosis.

10 A Okay.

11 Q I want you to go to the end of the top page where it
12 says pre-operative diagnosis and post-operative diagnosis and
13 the diagnoses, when you performed that epidural, were
14 degenerative conditions at C-3/4 and C-4/5.

15 A Yes.

16 Q All right. Not traumatic, but degenerative?

17 A Correct.

18 Q All right. Now, after you performed the injections
19 you recommended surgery and then the Plaintiff left your
20 treatment and went to Dr. Grover for awhile. Do you remember
21 that?

22 A Yes.

23 Q And then he returned to you roughly a year later in
24 November of 2008?

25 A Yes.

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1 Q Or at the end of 2008. And then just to get the
2 chronology straight, you performed another epidural and then
3 the surgery was done in March of 2009?

4 A Yes.

5 Q And this surgery was an elective procedure, correct?

6 A Yes.

7 Q There were no complications in the surgery?

8 A No.

9 Q And in the follow up that you had with the Plaintiff
10 following the surgery, you reported that he was improved and
11 that he could go back to his regular routine?

12 A Yes.

13 Q Now, I want to discuss the arm symptoms that the
14 Plaintiff has complained of. In your opinion, those symptoms
15 weren't coming from the discs; is that correct?

16 A I think we need to be a little more specific.

17 Q We're talking about -- and if you could go to that
18 first pain diagram, I believe it's Exhibit 22, Page 3.

19 A And part of being more specific is at what time?

20 Q Sure. Now, this is his initial presentation to you,
21 so April of 2006.

22 A Uh-huh.

23 Q These arm symptoms --

24 A Yes.

25 Q -- those weren't coming from the cervical spine; is

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1 that right?

2 A Well, to be quite honest, the simple answer is I
3 don't know, but as we discussed throughout the lineage of
4 chart notes, I basically made the point that as far as his
5 imaging, the mechanical compression that potentially could be
6 symptomatic did not follow that pattern.

7 Q Right. That was the C-4 nerve root and that
8 wouldn't have caused the pain down the arms that you see
9 there?

10 A Typically -- in and of itself, as far as a
11 compressive methodology. There's other scenarios that could
12 be explaining it, but as far as the concept of something
13 mechanically pinching a nerve, the imaging showed that that
14 was the C-4 nerve at the left C-3/4 nerve foramen of the exit
15 hole and that would not be consistent with that pain diagram.

16 Q Okay. And that condition at C-4, that was either
17 congenital or degenerative; is that right? Meaning it was
18 there from birth or it was degenerative process, like facet
19 tropism?

20 A Well, they can call it tropism, I mean, I would
21 simply state it was a bone spur coming off of a set joint.

22 Q Okay.

23 A And then typical bone spurs are considered a time-
24 related or degenerative condition.

25 Q Okay. Like arthritis?

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1 A Arthritis, you can have juvenile arthritis, so
2 that's arthritis in kids, but in general I say time-related or
3 degenerative.

4 Q Okay. But that condition wasn't being caused -- the
5 condition seen on the pain diagram wasn't being caused --

6 A As far as the mechanical pinching from a bone spur,
7 potentially affecting the C-4 nerve root, again that would not
8 explain that left arm pain diagram.

9 Q Right. Now, after the surgery you referred the
10 Plaintiff to a shoulder surgeon.

11 A I'm sorry?

12 Q You referred the Plaintiff to a shoulder surgeon, is
13 that Dr. Taylor?

14 A No, he's not a shoulder, he's a upper extremity,
15 actually he's elbow down.

16 Q Okay. And was he the one then who did the carpal
17 tunnel workup?

18 A That was me actually.

19 Q Okay.

20 A I -- I mean, is it okay if I briefly summarize or --

21 Q Well, yeah, as I understand it, an EMG, a nerve
22 conduction study was done and there was some positive
23 findings?

24 A Right. The simple scenario was he still had these
25 arm symptoms, which had gotten better, then come back,

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1 repeated the imaging, it didn't show an obvious structural
2 cause to explain it and I thought to briefly recall, because
3 there's a -- always a potential that maybe another disc could
4 be causing troubles, that's why I particularly mention in my
5 chart notes C-6, which would be potentially attributed to the
6 C-5/6 disc, which is the level that's below the fusion. So I
7 got the appropriate studies; ruled that out.

8 So I said okay, well what's going on? So then I
9 ordered the EMG nerve conduction studies and that came back
10 showing issues with the median nerve and the ulnar nerve. And
11 then once I saw those studies I said well, if there's a
12 potential procedure or something needs to be done about that,
13 then see Dr. Taylor because that's his subspecialty.

14 Q Okay. This surgery that you performed, there was a
15 discussion about the success rates of it, but I wasn't clear
16 on what the success rate is. In this case you have the two-
17 level cervical fusion, what is the success rate?

18 A Well, the simple answer is it depends. In general,
19 if someone is having a two-level cervical fusion and is within
20 a reasonable time frame, and the patient doesn't have any
21 major contributing issues and failed reasonably conservative
22 measures, I would say that success rate is probably about 85
23 to 90 percent.

24 Q Okay. Now, let's turn to the discussion at -- near
25 the conclusion of your testimony the other day about the

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1 spinal cord stimulator. There are no recommendations in your
2 records for such a future treatment; is that right?

3 A Yes.

4 Q Yes, that's correct?

5 A Yes, that's correct.

6 Q And I believe your testimony was that you last saw
7 the Plaintiff, when was it in March 2010?

8 A Let me just look. While, I'm looking, I mean,
9 briefly, I last saw the Plaintiff and sent him to pain
10 management to consider having some medial branch blocks to see
11 if potentially he had set pain that was coming from the levels
12 below his fusion and then I never saw him after that. Back --
13 let me see just briefly -- just so I can be clear with it. So
14 it appears, by my note, the last time I saw him was March
15 23rd, 2010.

16 Q Okay. Now isn't it fair to say that before you
17 would recommend a spinal cord stimulator on a patient that
18 there are tests that you would want to perform?

19 A Yes.

20 Q You would want to rule out any unrelated causes of
21 problems like this carpal tunnel issue?

22 A Yes.

23 Q You'd want to rule out whether the hardware that was
24 installed in the cervical fusion that you did might be causing
25 pain?

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1 A Yes.

2 MR. ROGERS: Your Honor, I have a question I'd like to
3 ask, but I'd like to approach.

4 THE COURT: Very well.

5 [Begin Bench Conference]

6 MR. ROGERS: A standard part of the pre-surgical
7 clearance for a spinal cord stimulator is a psychological
8 clearance. I'm not sure if you'll allow me to ask that
9 question?

10 MR. EGLET: That is not a standard. That is an option,
11 depending on the patient, and there has been no indication in
12 any of the records that he -- if they were going to do a
13 psychological clearance before a spinal cord stimulator,
14 they'd do a psychological clearance before they did the
15 cervical surgery on this gentleman. There was no request for
16 psychological clearance because there's no issues of
17 psychology or secondary gain or issues like that in this case.

18 So it is not -- it is incorrect to say it is
19 standard procedure to have a psychological clearance before
20 spinal cord stimulator. That is up to the surgeon and is only
21 if he sees indication that he might -- he thinks there might
22 be issues of secondary gain or somatoform disorder or some --
23 or something to that issue, which there has been none in this
24 case and this Court has ruled as not appropriate. So it's not
25 an appropriate question.

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1 MR. WALL: Right. And they did it way back when, before
2 his first injection, and he cleared everything and then got
3 moved on to treatment.

4 MR. ROGERS: Oh, no, no, they -- that's not accurate
5 actually.

6 THE COURT: Did --

7 MR. ROGERS: He didn't --

8 THE COURT: -- you name any witnesses? Did you name any
9 psychiatrists --

10 MR. ROGERS: No.

11 THE COURT: -- psychologists or anybody like that --

12 MR. ROGERS: No, and that's not --

13 THE COURT: -- during the discovery process?

14 MR. ROGERS: No, and that's not actually the purpose of
15 this question. The question is this, the Plaintiff has
16 presented a claim for a spinal cord stimulator and the point
17 of these questions isn't to say that the Plaintiff has a
18 secondary gain or a malingering problem, but rather that there
19 are criteria that must be met before the Plaintiff is actually
20 considered a candidate for the procedure that the Plaintiff
21 now wishes to board for damages. I want to get a list of all
22 of those criteria.

23 MR. EGLET: A psychological clearance is not a criteria
24 that the Plaintiff must meet. Psychological issues have been
25 specifically excluded in a motion in limine in this case.

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1 There are no psychological issues in this case.

2 The only reason to do this is to suggest, just like
3 he suggest he threw out his doctors by saying that there's no
4 injury, there's nothing, that this is all -- you know, the
5 only suggest -- any of that, is that oh, this just must be in
6 Mr. Simao's head. So the only reason to ask that question is
7 just to make that suggestion. It is -- there is no foundation
8 that a psychological clearance is a requirements for a spinal
9 cord stimulator and that is not the case. That is absolutely
10 case.

11 MR. ROGERS: The question would really bring the
12 foundation, that's the reason I approached. You know, I don't
13 want to get in any trouble here. I just want to know whether
14 I can ask him about all the foundation.

15 THE COURT: Seems like an attempt to get around a
16 previous pretrial ruling, to me. I'll sustain the objection.

17 MR. EGLET: Thank you, Your Honor.

18 [End Bench Conference]

19 BY MR. ROGERS:

20 Q Okay. These criteria that we've been discussing
21 that would be -- need to be met before you could recommend
22 this future procedure, they haven't been met; is that right?

23 A I think we just briefly -- what did you talk about,
24 we talked about hardware and --

25 Q Things like ruling out potential unrelated causes

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1 and all that stuff.

2 A If it's okay, I'll just make the simple statement --
3 I just want to make sure nothing else is wrong. So I would
4 hypothetically repeat the MRI, repeat the CT, take the x-rays,
5 talk to the patient, examine the patient, and all that would
6 be a pertinent part to getting to the point of deciding that
7 the patient has a high likelihood of neuropathic pain and
8 considering a spinal cord stimulator trial.

9 Q Okay. Because it's possible that it isn't
10 neuropathic pain, it could be related to the hardware, for
11 example?

12 MR. EGLET: Objection, Your Honor, speculation,
13 possibility.

14 THE COURT: Sustained. Ask you to rephrase the question.

15 MR. ROGERS: Sure.

16 BY MR. ROGERS:

17 Q The point of these ruling out tests that you've just
18 describe to the jury is that you need to rule out whether
19 there is an alternate problem that wouldn't be necessarily
20 repaired by a stimulator?

21 A Correct. Yes.

22 Q Now, Doctor, yesterday there was a discussion about
23 the testimony history of a doctor. I don't broach this topic
24 with you to be insensitive, but I want to touch on it since
25 that issue has been raised. You testified under oath, whether

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1 it be in trial or in deposition, somewhere around 100 times;
2 is that right?

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

4 THE COURT: Sure.

5 THE WITNESS: So I'm to wait?

6 THE COURT: Yes, please.

7 [Begin Bench Conference]

8 MR. EGLET: If he has a deposition of prior testimony of
9 this Doctor that he wants to impeach with him, or show that
10 he's testified inconsistently with, that's fine, but just to
11 throw out there this -- what he's asking for is an opinion out
12 of a treating physician that oh, well sometimes doctors
13 testify differently at different depositions, you know,
14 without having any foundation for it, without having an
15 example of another deposition where that has occurred is
16 improper. There's no foundation for that.

17 MR. WALL: Excuse me, trial doctors, like in the opening,
18 this is medical buildup.

19 MR. EGLET: You know -- yeah, this is medical buildup.
20 It's -- this is like a trial doctor, like the slide he put up
21 there.

22 MR. WALL: You sustained the objection during the opening
23 of referring to him as a trial doctor, because it really
24 reflects medical buildup, which was kept out.

25 MR. EGLET: Okay. And there's no foundation for this --

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1 I mean, I'm not sure exactly where he's going. I think I have
2 a good idea, but just to throw out there, you testified in
3 hundreds of other cases and blah, blah, blah, what does that
4 have to do? If he's got a deposition where he wants to show
5 that the Doctor testified inconsistently in some other case,
6 that's fine, but just to throw this out there without any
7 foundation for it, without having the Doctor to have a
8 deposition to be able to confirm one way or the other when
9 that happened, that's inappropriate. He -- you know, we had --
10 -- we have ten specific prior depositions on different -- Dr.
11 Fish is totally different.

12 THE COURT: Mr. Rogers, do you have any deposition
13 testimony?

14 MR. ROGERS: Not unrelated to this case. The reason I
15 bring it up is, you'll recall yesterday, what happened was
16 Plaintiff brought forward, in a very in guess emphatic way, a
17 long list of depositions in which Dr. Fish testified and he
18 read through each one of them and made quite a display of a
19 long history and I objected and the objection was overruled.
20 There had been no foundation laid that any of them would be
21 used for impeachment. The point was to get across that this
22 is a guy who's testified many times.

23 And then after reciting about nine or ten cases in
24 which Dr. Fish had testified, the Plaintiff proceeded to use
25 only two for impeachment and that was --

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1 MR. EGLET: Well, I'm not finished with my cross-
2 examination. I'll be using all of them, Counsel.

3 THE COURT: We ran out of time, I thought.

4 MR. EGLET: Yeah, I'll be using all of them, Counsel.
5 But the point is, it's -- first of all, to suggest that there
6 was no foundation that we were going to use these depositions
7 as impeachment is absolutely incorrect. On the day of Dr.
8 Fish's deposition, Mr. Wall attached every one of these
9 depositions as an exhibit and specifically said on the record
10 that these will be used for impeachment purposes. So they
11 were on notice from day one and they haven't done that with
12 this Doctor.

13 And also, this is a treating physician, not an
14 expert, like Dr. Fish. It's a different situation and there's
15 no foundation. He can't just say well, you know, what about
16 -- have you had cases in the past? There's no foundation for
17 it. It's just -- he's shooting -- excuse me, you know, he's
18 shooting at ducks in the dark. There's nothing --

19 MR. WALL: My question is, where is he going?

20 MR. EGLET: Yeah, where is he going with this?

21 MR. WALL: After he says, you testified a lot, what is --

22 MR. EGLET: Yeah, what's your offer of proof here?

23 MR. ROGERS: I'll wait until my turn.

24 THE COURT: Well, what I recall is -- I wasn't at the
25 deposition, of course, but what I recall is that you objected

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1 when Mr. Eglet proceeded to ask that those depositions be
2 marked. I think we had a sidebar and I think at the sidebar,
3 if memory serves me, you disclosed that your intent was to use
4 the deposition transcript testimony to impeach the witness.

5 MR. EGLET: Correct.

6 THE COURT: That's what I recall. Is that what you
7 recall?

8 MR. EGLET: Yes. Yes, and that's how they were disclosed
9 at the time of the deposition. That's exactly what -- they
10 have been on notice of this. They have not identified,
11 presented any deposition transcripts other than the deposition
12 in this case of Dr. McNulty. So they don't get to start
13 acting -- asking about hypothetical depositions or how many
14 times his -- you know, in other depositions where he's been
15 deposed where he hypothetically may have said something
16 different. He's asking this doctor to speculate without
17 refreshing his memory, we don't have the deposition here, it's
18 entirely improper.

19 MR. ROGERS: Just to make my record on this, actually
20 there is notice, because Dr. McNulty attached his testimony
21 to --

22 THE COURT: There's no what? I'm sorry.

23 MR. ROGERS: Notice, because --

24 THE COURT: There's no notice?

25 MR. ROGERS: There is notice and foundation, because Dr.

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1 McNulty attached his testimony history to his deposition.

2 MR. EGLET: They have to provide the depositions. They
3 have to put us on notice that these are the -- the rule is
4 clear. Any depositions you intend to use for impeachment
5 purpose must be identified and produced to the other side.
6 The fact that Dr. McNulty complied with the rule and set forth
7 these are the cases he's given deposition testimony, in fact,
8 does not relieve them of their burden of identifying what
9 depositions they intend to use for impeachment purposes. They
10 did not do that.

11 MR. WALL: My question is, where's he going next? Is he
12 just going to throw out there, you testify a lot? Where's he
13 going next?

14 MR. EGLET: Yeah, you've testified a lot. That becomes
15 the issue of a trial doctor, which -- and that's medical
16 buildup. So there's two bases for the objection.

17 THE COURT: Sustain the objection.

18 [End Bench Conference]

19 BY MR. ROGERS:

20 Q Okay, Doctor, let's move next then, how much do you
21 charge per hour for your medical legal work?

22 A I think it's 1250.

23 Q Meaning 1,250?

24 A \$1,250 per hour.

25 MR. ROGERS: All right. Let me look through my notes

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1 here. I may be done. I am. Thank you.

2 THE COURT: Okay. Redirect?

3 MR. EGLET: Thank you, Your Honor.

4 REDIRECT EXAMINATION

5 BY MR. EGLET:

6 Q Doctor, Mr. Rogers asked you at the beginning of
7 your cross-examination today about whether, when you give a
8 causation opinion, it is based on what the patient has told
9 you. In other words, the patient history. And I believe you
10 testified that you -- your testimony was well, it's based on a
11 number of things and the patient's history is one of the
12 important factors, correct?

13 A Yes.

14 Q What other things is it based upon?

15 A Well, it's based on patient history, as we stated,
16 but as well as diagnostic information, such as MRIs, CAT
17 scans, MRI -- I'm sorry, plain x-rays, examining the patient.

18 Q Okay. So it's not just the patient history, it's
19 the whole picture put together --

20 A Yes.

21 Q -- is that a fair statement?

22 A Yes.

23 Q Okay. Now, you also testified that -- on cross that
24 you preferred not to use provocative cervical discography, but
25 you have done it in the past, correct?

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1 A Yes.

2 Q There are cases where it is appropriate?

3 A Yes.

4 Q Okay. Did you find any fault in -- or -- in Dr.

5 Grover ordering and Dr. Rosler performing a cervical

6 discography in this particular case?

7 A No.

8 Q Okay. Did you review the discography report?

9 A Yes.

10 Q Did it appear from the report that the discography

11 was performed properly?

12 A Yes.

13 Q Did it appear from the report that there was any

14 complications from the discography?

15 A No.

16 Q Okay. Did it appear from the report that the

17 discography was positive at -- for disc disruption at C-3/4

18 and C-4/5?

19 A I would simply answer that, it was positive for

20 concordant pain at C-3/4 and C-4/5.

21 Q Which is a positive discography, correct?

22 A Correct.

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

24 THE COURT: It is. Sustained.

25 ///

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1 BY MR. EGLET:

2 Q Is that a positive discography?

3 A Yes.

4 Q Okay. Now, Counsel asked you the question, well
5 this surgery is -- elective. Do you recall that question?

6 A Yes.

7 Q Okay. Isn't all surgery of this type, where it's --
8 well, strike that.

9 When you have a patient like Mr. Simao who is
10 complaining of significant pain from -- which has been
11 confirmed to be from particular discs through the diagnostic
12 studies you perform in their neck, whether they have surgery
13 or not, is that always the decision of the patient?

14 A Yes.

15 Q Okay. Is it basically whether they can continue to
16 live with the pain or whether they can't continue to live with
17 the pain?

18 A Yes.

19 Q Okay. So in all of these disc type injuries that
20 we're talking about, unless you have a severe cord compression
21 where you may have a risk of para- -- quadriplegic or
22 paraplegic issues, it's an elective procedure?

23 A Well, just to be complete there's also a scenario of
24 someone who has a severe traumatic injury where everything is
25 unstable, but that patient not -- may not be quadriplegic, but

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1 again it's -- yes, it's the same basic scenario there, risk
2 for quadriplegia.

3 Q So is it a fair statement that whenever a patient is
4 -- has surgery on a painful disc, that the surgery is
5 elective?

6 A In this type of particular scenario where it's
7 discography and not a severe traumatic, unstable injury, yes.

8 Q Okay. Does that make -- the fact that it's elective
9 -- I mean, sometimes I think when people hear the word well,
10 it's elective surgery, when I think of elective surgery the
11 first thing I think of is plastic surgery, you know, somebody
12 getting their nose fixed or breast implants or liposuction.
13 We're not talking about that type of elective surgery are we?

14 A No.

15 Q Okay. And the fact that it's an elective surgery,
16 that doesn't make it any less appropriate, does it?

17 A No.

18 Q Okay.

19 MR. EGLET: Now, could you bring up that pain diagram,
20 please, that they brought up earlier that you filled out at
21 Dr. McNulty's -- I think it was the April '06 visit.

22 MR. ROGERS: It was Page 3, Exhibit 22.

23 BY MR. EGLET:

24 Q Okay. Now, Mr. Rogers talked to you about this pain
25 diagram on cross-examination and he talked to you about the

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1 fact that the -- where Mr. Simao documented on the pain
2 diagram the pain going all the way down in his left upper
3 extremity that that would not be consistent with a C-3/4 or
4 C-3/5 nerve impingement-type situation; is that correct?

5 A Well, technically we just talked about C-3/4.

6 Q Well, C-3/4, that would not be consistent with that;
7 is that correct?

8 A Correct.

9 Q What about C-4/5?

10 A No.

11 Q Now, has anybody in this case, including yourself,
12 diagnosed Mr. Simao, with respect to his disc injuries, with a
13 structural nerve impingement from one of these discs?

14 A No.

15 Q Okay. Are there other things from a disc injury
16 which can cause radicular symptoms?

17 A Yes.

18 Q And what are those other things?

19 A Well, there's an entity known as radiculitis, which
20 means the nerve is irritated, like appendicitis, your appendix
21 is inflamed and irritated, it's the same basic term. And the
22 scenario is that you have local inflammatory caustic
23 substances being generated from the disc that are locally
24 causing an inflammation and irritation of nerves going by it.

25 Q Okay. And that can cause radiculitis?

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1 A Yes.

2 Q Okay. Now, Dr. Rosler the other day talked about
3 the fact that with disc disruption when there's a tear to the
4 disk, that there can be chemicals leaked from the discs which
5 can irritate the nerves; is that correct? Do you agree with
6 that?

7 A Yes.

8 Q Okay. And that he indicated that that is kind of
9 the classic difference sometimes between the radicular
10 symptoms that you see from a frank herniated or protruded disk
11 that's pinching a nerve as opposed to disc disruption, where
12 you get to the chemical leak irritating the nerve.

13 A Yes.

14 Q Okay. And when you get that chemical when it
15 irritates the nerves, does that radiculitis necessarily follow
16 a particular dermatome pattern?

17 A It can be more variable.

18 Q And what do you mean by it can be more variable?

19 A Well, it's not in classic presentation, like
20 classically a C-5/6 disc herniation affects C-6, but the other
21 important thing to keep in mind is that when they say, "Oh, C-
22 6 is radiating down to the thumb," that technically only
23 applies to 85 percent of the people even without the issue of
24 chemical radiculitis versus compressive radiculopathy, just
25 because people aren't all wired the same. A C-5/6 disc

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1 herniation affecting a C-6 nerve root can actually vary in
2 different people.

3 Q Okay. So it can vary, it's not always the same.

4 A Yeah.

5 Q And with respect to -- back to this disc tears, the
6 annular tears, where we have the leak- -- the chemical leaking
7 and irritation, can those be more diffused, in other words,
8 spread out and not follow a particular nerve pattern?

9 A Yes.

10 Q Okay. And the pain diagram you see here, assuming
11 he has a tear, tears in those disk [sic] and they're having
12 this chemical leaks and this irritation, could that explain
13 the pain -- the radiculitis symptoms that he's documented here
14 on this pain diagram?

15 A Yes.

16 Q Okay. Now, with this type of ridiculer or -- you
17 call it -- I guess you differentiate that as radiculitis
18 versus ridiculer pain; is that correct?

19 A I use the term radiculopathy versus radiculitis.

20 Q Radiculopathy. And radiculopathy is when you have a
21 specific impingement or compression on a nerve and that's
22 causing radiculopathy?

23 A Yes.

24 Q And radiculitis is when you have more of this
25 chemical irritation where you can have this diffused pattern;

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1 is that right?

2 A Yes.

3 Q Okay. With the radiculitis issue, when you have a
4 torn disc and this chemical nerve irritation, can that
5 radiculitis wax and wane?

6 A Yes.

7 Q What does that mean to wax and wane?

8 A Well, the very nature of pain, it can be variable
9 day-to-day. A human being is not a rock solid static
10 individual, so -- but even in the form of radiculitis, which
11 is more of an inflammatory thing, there can be variation in
12 the amount of inflammatory substances that can more easily
13 explain and have a more variable pattern.

14 Q Okay. And with that chemical radiculitis --
15 chemical irritation radiculitis we're talking about, does that
16 type of radiculitis sometimes take time to present itself as
17 opposed to occurring right on the day of the trauma?

18 A Well, in general inflammation can be a gradual
19 process where there can be a gradual buildup of substances.
20 So if you have a known event that starts inflammation, it's
21 just -- I guess the best analogy is a fire. You know, right
22 away you don't have a lot of smoke, but as it keeps burning
23 there's more smoke. So it's a gradual process that can
24 buildup as it goes on.

25 Q Okay. Now, Counsel talked to you about the success

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1 rate of cervical spine fusions and you -- your initial answer
2 was well, it depends, there's a lot of different factors, but
3 generally if you don't have any, you know, other issues
4 involved, that generally it's about 85 to 90 percent success
5 rate in your hands; is that correct?

6 A Yes.

7 Q So it's fair to say that then there is a 10 to 15
8 percent where it's not successful, right?

9 A Yes.

10 Q Where the patient doesn't get better?

11 A Yes.

12 Q Continues to have pain?

13 A Yes.

14 Q Does that -- the fact that it's -- there is a 10 to
15 15 percent probability that if this surgery is performed that
16 the patient might not get better, does that mean that the
17 surgery shouldn't be done?

18 A No.

19 Q Why?

20 A Well, there is nothing in medicine that's 100
21 percent, so if we use that as the main indication to do
22 anything, hardly anything would get done.

23 Q Now, Counsel talked to you about the fact that when
24 you look at these changes that you identified in the C-3/4 and
25 C-4/5 level of Mr. Simao's MRI that you can't, by looking at

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1 the MRI, you can't date precisely when those conditions
2 occurred; is that correct?

3 A Right.

4 Q But we do know, and you testified earlier, that
5 there's no document of any kind which indicate that Mr. Simao
6 had any neck complaints before the April 2005 motor vehicle
7 accident, correct?

8 A Yes.

9 MR. ROGERS: Your Honor, this is still leading.

10 MR. EGLET: I'll --

11 THE COURT: Sustained.

12 MR. EGLET: I'll rephrase.

13 BY MR. EGLET:

14 Q Is there any documents or information or evidence
15 you're aware of that Mr. Simao ever had any complaints in his
16 neck, complaints in his occipital region before the April 2005
17 motor vehicle accident?

18 A No.

19 Q Okay. So you can't date when these conditions
20 appeared on the MRI by looking at the MRI, but based on the
21 patient's history, are you able to identify and date when the
22 complaints started, the pain started?

23 A Yes.

24 Q Okay. And in this case, did the complaints and the
25 pain start after the April 15th, 2005 motor vehicle accident?

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1 A Yes.

2 Q And can you have these -- and you testified -- I
3 know the document Mr. Rogers put up, your pre-operative and
4 post-operative assessment before you did your epidurals said
5 degenerative -- I don't know if it said degenerative disease
6 or degenerative changes at C-3/4, C-4/5, do you remember that?

7 A Yes.

8 Q Okay. And you testified the other day that
9 degenerative changes means what?

10 A Well, degenerative changes primarily mean age-
11 related changes because I can't really qualify if they're
12 symptomatic, pertinent until I do further diagnostics in this
13 case, such as I did.

14 Q Okay. And do a lot of people have age-related or
15 degenerative changes in their spine who walk around every day
16 with absolutely no complaints or no problems?

17 A Yes.

18 Q In fact, people who are over the age of 40, what --
19 if you were to randomly do MRIs on say a 100 people who were
20 age 40 or 45, statistically, how many of those people are
21 going to show age-related changes in their spines at various
22 levels?

23 A Well, assuming obviously we're talking about the
24 cervical spine, the literature varies, but I would say at that
25 age group a reasonable range would be approximately 30 to 40

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1 percent.

2 Q Okay. And those are people that aren't complaining
3 of any pain?

4 A Correct.

5 Q Okay. Now, can these type of age-related changes
6 that we're talking about, where you're not having any pain and
7 you are subjected to a traumatic event like a motor vehicle
8 accident, can that traumatic event cause these age-related
9 changes to become symptomatic?

10 MR. ROGERS: Objection, foundation, Your Honor.

11 THE COURT: Overruled.

12 THE WITNESS: I would simply answer that those findings,
13 which are presumably age-related asymptomatic, and then the
14 scenario that that same MRI is now being applied to a person
15 who's had a known traumatic event with symptoms starting, then
16 that would state then it becomes possible that those findings
17 can correlate with the patient's symptoms.

18 BY MR. EGLET:

19 Q So while you can't date the findings of the MRI, you
20 can state in this case when Mr. Simao's symptoms began,
21 correct?

22 MR. ROGERS: Leading again, Your Honor.

23 THE COURT: Sustained.

24 BY MR. EGLET:

25 Q Okay. You just testified you can't date the

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1 findings in the MRI. Can you date the -- can you state the
2 date the symptoms began with Mr. Simao?

3 A Yes.

4 Q And that was when?

5 A After his accident in April of 2005.

6 Q Now, Mister -- I want to talk about the spinal cord
7 stimulator. Mr. Rogers pointed out the fact that you had not
8 personally examined Mr. Simao since March of last year; is
9 that correct?

10 A Yes.

11 Q Okay. But since that time, in March of last year,
12 has Mr. Simao been followed in your office by one of your --
13 one of the orthopedic spine surgeons who works with you?

14 A Yes.

15 Q Who is that?

16 A Daniel Lee.

17 Q Okay. And so Dr. Lee has been following Mr. Simao's
18 treatment?

19 A Yes.

20 Q And has been seeing Mr. Simao?

21 A Yes.

22 Q In fact, did Mister -- did Dr. Lee see Mr. Simao
23 just a few weeks ago?

24 MR. ROGERS: Your Honor --

25 THE COURT: Counsel, approach please.

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1 [Begin Bench Conference]

2 MR. ROGERS: The last record of treatment that I'm aware
3 of was --

4 THE COURT: I'm sorry?

5 MR. ROGERS: I'm sorry. The last record of treatment
6 that I'm aware of was in February.

7 MR. EGLET: This is March, this is a few weeks ago,
8 February, I would say --

9 MR. ROGERS: Is that where you're going --

10 MR. EGLET: Yeah.

11 MR. ROGERS: -- or is there a new record?

12 MR. EGLET: No, there's not a new record. I don't think
13 so. I don't know. I mean, I know that Dan Lee seen him in
14 February.

15 MR. ROGERS: I think it was February 11, if I remember
16 right.

17 MR. EGLET: I don't remember the date, but --

18 MR. ROGERS: I just don't want them to get into records
19 that haven't been disclosed.

20 MR. WALL: What does it say, 17 on there?

21 THE COURT: Huh?

22 MR. WALL: Seventeen on it.

23 MR. EGLET: Looks like February 24th.

24 THE COURT: February 24th is what it shows to be on the
25 screen. Sustained. Sustained.

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1 [End Bench Conference]

2 BY MR. EGLET:

3 Q Okay. Doctor, what is the date of --

4 MR. EGLET: Bring that up.

5 BY MR. EGLET:

6 Q What is the date of Dr. Lee's last visit with Mr.
7 Simao?

8 A 2/24/2011.

9 Q Okay. So last month, okay. And have you reviewed
10 Dr. Lee's treatment records of Mr. Simao since he's been
11 following him?

12 A Yes.

13 Q Okay. And would last visit with Dr. Lee, did he
14 recommend additional pain management for Mr. Simao?

15 A Yes.

16 Q Now, did you testify two days ago that a spinal cord
17 stimulator is part of pain management --

18 A Yes.

19 Q -- it's a pain management device?

20 A Yes.

21 Q Okay. So my question is that based on your
22 treatment, the records you've reviewed, your examinations, as
23 well as the follow up treatment that your -- I think he's your
24 junior partner, Dr. Lee, is -- has performed and has done, is
25 it still your opinion that it is more likely than not that Mr.

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1 Simao will benefit from a spinal cord stimulator?

2 A Yes.

3 Q Okay. And is that a conclusion to a reasonable
4 degree of medical probability?

5 A Yes.

6 Q Now, I want to talk to you like Mr. Rogers did about
7 a few things that were said yesterday by Dr. Fish --

8 MR. EGLET: You can take that down now.

9 BY MR. EGLET:

10 Q -- in his testimony yesterday.

11 Dr. Fish is a pain management physician out of
12 California, you understand that?

13 A What's his -- is he --

14 Q He's a pain management physician out of California.

15 A Is he rehab, physiatry, anesthesia --

16 Q He's not an anesthesiologist. He's a rehabilitation
17 specialist, physiatrist --

18 A Physiatrist.

19 Q -- and also pain management.

20 A Because that's important for me, because those are
21 -- they tend to be different types of specialists.

22 Q He's not a trained anesthesiologist, he's not a
23 board certified anesthesiologist. Dr. Fish testified
24 yesterday that the April 15th, 2005 motor vehicle accident did
25 not cause Mr. Simao to sustain disc injuries at C-3/4, 4/5.

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1 Do you agree with that?

2 A No.

3 Q Why not?

4 A Well, I would say the simple answer is because of
5 everything I've said up to this point.

6 Q In fact, Dr. Fish testified yesterday that Mister --
7 that he doesn't believe that Mr. Simao had any injuries in the
8 April 2005 motor vehicle accident. Do you agree with that?

9 A No.

10 MR. ROGERS: I'm not actually sure that that's an
11 accurate representation of his testimony --

12 MR. EGLET: Yeah, that's what he said.

13 MR. ROGERS: -- Your Honor.

14 THE COURT: Counsel, approach please.

15 [Begin Bench Conference]

16 THE COURT: I'm trying to recall exactly how you posed
17 that question.

18 MR. WALL: He said -- he was asked well, was the
19 Plaintiff hurt in any way by the motor vehicle accident and
20 said -- he said it's hard to say if he was even truly injured
21 by the motor vehicle accident.

22 MR. EGLET: That was his testimony and that was his
23 testimony in his deposition too. Mr. Rogers asked him, was
24 the Plaintiff -- was [indiscernible] -- was the Plaintiff
25 injured in any way in this accident and he says, it's hard for

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1 me to believe that he was truly injured in any way.

2 That was his testimony. I didn't make it up.

3 THE COURT: Dr. Fish said you mean?

4 MR. EGLET: Dr. Fish said it.

5 THE COURT: Yeah, he said something pretty much like
6 that.

7 MR. ROGERS: I --

8 THE COURT: You don't recall that?

9 MR. ROGERS: I don't.

10 THE COURT: Yeah, he did.

11 [End Bench Conference]

12 THE COURT: Yeah, let's take a 10 minute break.

13 [Court Admonishes Jury]

14 [Jury Out]

15 [Recess]

16 [Begin Bench Conference]

17 THE COURT: We have a note from one our jurors. I'm not
18 sure -- I think Marshall Diamond said it was Ms. Prince. I
19 don't really see how we can give the schedule.

20 MR. EGLET: Fine with me. But whatever the Court's
21 schedule --

22 MR. ROGERS: It's possible for me

23 MR. EGLET: That's your call. What did you say?

24 THE COURT: It is possible for me.

25 MR. EGLET: It's certainly possible for us. I mean, I

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1 don't what the Court's schedule is. I know another judge has
2 your courtroom on --

3 THE COURT: On Fridays.

4 MR. EGLET: -- on certain days. But, you know, we
5 certainly can do it.

6 THE COURT: The problem is, we have criminal calendar on
7 Mondays and Wednesdays, quite often runs right up until --

8 MR. EGLET: Right. What about Tuesdays and Thursdays?

9 THE COURT: Thursday morning I might have some
10 flexibility. I have to check and see what I've got
11 calendared. Tuesday it's a motion calendar. It's usually
12 pretty full.

13 MR. EGLET: Okay.

14 MR. ROGERS: Your call.

15 MR. EGLET: It's your call, Judge.

16 THE COURT: All right. Thank you.

17 MR. ROGERS: You know [indiscernible] discussion this
18 thing we were just discussing Dr. Fish's schedule. And he's
19 told me that he can be available tomorrow -- or, I mean,
20 Monday.

21 THE COURT: Tomorrow?

22 MR. ROGERS: Monday.

23 MR. EGLET: Why don't you tell him to come tomorrow. Sit
24 here.

25 MR. ROGERS: He's doing something. It was -- I thought it

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1 was at Berkley, until 12:30, which is the first flight he said
2 he could get. So he can get here at 2:00 on Monday. And
3 we've tried to get a little earlier so he could here at 1:00.
4 He said he just won't be able to finish whatever that task is.
5 It was a class or something that he has to do.

6 MR. EGLET: Judge, you know, here's --

7 THE COURT: I guess he's got to come Tuesday. He's got
8 to come before we hear from Dr. Yong.

9 MR. ROGERS: Yong is Tuesday.

10 MR. EGLET: Yong is Tuesday.

11 MR. ROGERS: Take him out of order.

12 MR. EGLET: Here's the issues, Judge, Okay. Again, we
13 made this accommodation for them. Their witness has put us in
14 a situation. We've got Dr. Arita scheduled for Tuesday --

15 MR. ROGERS: Monday.

16 MR. EGLET: -- Monday afternoon after we expect to him to
17 come. We want him here at 1:00 so we can -- I can finish --
18 I'm going to cut my cross-examination down. I think it's
19 going to be a lot shorter. We expect we can get him done in
20 an hour. And then we've got Arita to put on. What we don't
21 want is, and it's totally unfair for us, is for us to put
22 Arita on for an hour and then have him sit out in the hall
23 while we pay him for them to have their expert come in out of
24 order and inconvenience us. It's their witness out of order.
25 He's needs to be here at 1:00 on Monday.

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1 MR. ROGERS: That's not going to make [indiscernible].
2 We wouldn't break up Arita. It would be one or the other goes
3 first. And if Arita goes first, then --

4 MR. EGLET: Then you're going to risk -- this is what
5 you're going to -- well, first of all, no. We want him
6 finished. We talked about this yesterday. We want him
7 finished before we put Arita on the stand. That's our case in
8 chief. We should be able to pick the order of the witnesses.
9 We should be able to finish this witness before we put our
10 witness on the stand. But here's the other risk. If we put
11 Arita on first, and he goes longer than expected like all the
12 witnesses have --

13 THE COURT: Uh-huh.

14 MR. EGLET: -- then we're not -- again, we're not going
15 to have time to finish him on Monday and we're going to be in
16 the same situation.

17 THE COURT: Uh-huh.

18 MR. EGLET: If they can't move to Tuesday, he's got to be
19 here Monday at 1:00.

20 MR. ROGERS: If we put -- I don't know that we can do
21 that. Your Honor asked us to make him available Monday or
22 Tuesday. He made himself available on Monday. And it seems
23 that if --

24 MR. EGLET: Court starts at 1:00 on Monday.

25 THE COURT: He doesn't [indiscernible] the Court's

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1 schedule.

2 MR. ROGERS: I know. Now --

3 THE COURT: Come on. He wasted enough time yesterday.
4 You know, if he had simply answered the questions, we might
5 have gotten through his testimony. He was --

6 MR. ROGERS: Yeah. I -- believe me, I told him.
7 Afterwards, I said, "Look, you've got to just answer the
8 questions and get out." The fact of the matter is that while
9 I think it was made to appear that he's been in court a lot, I
10 don't believe he has. I think he's a nervous wreck up there.
11 I was surprised. And so that aside, if he already moved a lot
12 of his clinic, and he did, to get here, he's gone to great
13 lengths to do what the Plaintiff wants. And it seems to me
14 that the problem that they brought up yesterday was they need
15 him on before Yong, not before -- Arita wasn't -- I didn't
16 even know Arita was coming Monday until now.

17 THE COURT: You know, here's the thing, and I have to
18 tell you, I find really frustrating as a judge with some of
19 these expert witnesses. They want to dictate when they're
20 going to show up in the courtroom. We don't have that luxury
21 to allow them to dictate when they're going to show up. And
22 it sounds like the witness is one of those people. So Court's
23 seen people like that before. I'm sure Counsel has seen
24 people like that before.

25 MR. EGLET: Yeah.

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1 MR. ROGERS: Okay. Well, where does that leave us?

2 THE COURT: Well, I guess Fish needs to be here at 1:00.
3 That's the time we start court on Monday. Your Honor

4 MR. ROGERS: And if he can't -- can we move him to
5 Tuesday? Switch him out with Yong. Cause then at least he's
6 done before Yong. That seemed to be the Plaintiff's main
7 concern.

8 MR. EGLET: And when's Yong?

9 MR. ROGERS: I don't know. I don't know that Yong can
10 move. But I'm trying to juggle these two experts right now
11 and --

12 MR. EGLET: Look.

13 MR. ROGERS: -- I don't know how it's going to play.

14 MR. EGLET: They need to have -- we have -- we Arita --
15 I'm already finishing Dr. McNulty, putting another of our
16 treating physicians on before we get to cross Fish. Now they
17 want us to put yet another treating physician on before we
18 cross Fish. I did bring up Arita yesterday. He needs to be
19 here on Monday before Arita testifies. Monday is the day he
20 says he can come. He doesn't get to dictate what time on
21 Monday he comes.

22 THE COURT: No, he does not.

23 MR. EGLET: Court starts at 1:00 on Monday. That's when
24 he needs to be here.

25 MR. ROGERS: But what I -- what I'm not clear on --

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1 MR. EGLET: And this is a waste of time.

2 MR. ROGERS: -- and -- I mean, I get your -- I get
3 your --

4 MR. EGLET: We're not going to get done today at the rate
5 we're going. I promised --

6 THE COURT: Yeah.

7 MR. EGLET: -- Dr. Grover that we would finish him today.
8 Okay? All right. We got to get going.

9 THE COURT: Yeah. We do. We do. We can discuss this
10 later.

11 MR. ROGERS: Okay.

12 [End Bench Conference]

13 [Jury In]

14 [Within the Presence of the Jury]

15 THE COURT: Please be seated, ladies and gentlemen. Will
16 Counsel stipulate to the presence of the jury?

17 MR. EGLET: Yes.

18 MR. ROGERS: Yes, Your Honor.

19 THE COURT: Very well. Mr. Eglet.

20 MR. EGLET: Thank you, Your Honor.

21 BY MR. EGLET:

22 Q Okay, Dr. McNulty, let's see if we can get this
23 finished up. The question that was pending before we took the
24 break is that Dr. Fish had testified that he didn't believe
25 that Mr. Simao was truly injured in any in this motor vehicle

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1 accident of April 2005. Do you agree?

2 A No.

3 Q And for all the reasons you've already stated?

4 A Yes.

5 Q Dr. Fish also testified yesterday that no treatment
6 received by Mr. Simao after May 5th, 2005 was related to the
7 April 2005 motor vehicle crash. Do you agree with that?

8 A No.

9 Q For all the reasons you've already stated?

10 A Yes.

11 Q Dr. Fish also testified yesterday that the gate
12 theory of pain could not explain Mr. Simao's initial clinical
13 presentation because all disc injuries are occur with
14 immediate onset of symptoms and are obvious and felt by the
15 patient right away. Do you agree with that?

16 A Do we have a spectrum there? In general, I would
17 say no.

18 Q No, he just says any disc injury.

19 A No.

20 Q Okay. Why not?

21 A Well, the simple reason is when someone gets
22 initially hurt and their necks hurts, there can be all kinds
23 of reasons it hurts. So you can have all kinds of things
24 going on. Typically, when I will talk to a patient and take a
25 history and reasonable causation history is the patient does

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1 have the pain starts usually within a day or two. So in my
2 practice, that's what I think is a reasonable time frame. But
3 again, you always have to put that in the context of what else
4 is going on. Sometimes the patient can have a -- a great
5 example is in trauma. Cause I take trauma calls at UMC. It
6 is very common for someone to come in with multiple injuries
7 and because you have things that hurt more than others, or
8 they're more important, more severe, it may -- you may miss
9 initially up to 20 percent of injuries. So you have -- always
10 put that in perspective of what's on with the patient. So Mr.
11 Simao's situation, I believe he had headaches, all kinds of
12 things going on. I believe he was seen relatively soon.
13 Right?

14 Q Yeah.

15 A So that's a very strong history, I think, it was,
16 what, within a few hours?

17 Q Yes.

18 A Yes. And he said his neck hurt. And he was
19 diagnosed with a cervical sprain. That's all consistent.

20 Q Dr. Fish testified yesterday that he had never seen
21 a patient with a cervical disc injury of any kind. He
22 diagnosed with that injury more than one and a half months
23 from the date of the injury -- from the actual date of the
24 accident. In your practice, do you ever see patients with
25 cervical disk injuries that present to you more than one and a

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1 half months from the time of their injury and whom you
2 subsequently cervical disc injury?

3 A Yes.

4 Q Is that a rather typical presentation in your
5 practice?

6 A Yes.

7 Q Okay. Dr. Fish testified yesterday here that if
8 Mr. Simao did not present to his treating providers within 48
9 to 78 hours with neck pain, upper extremity pain, upper
10 extremity weakness, severe upper extremity parasthesia, and/or
11 bowel and bladder dysfunction that he could not have had a
12 cervical disc injury. Do you agree with that?

13 A No.

14 Q Why not?

15 A Well, again, I don't know, Dr. Fish. But the simple
16 statement is disc injury is a broad spectrum.

17 Q Can you explain that?

18 A Well, I am a spine surgeon and I see traumatic
19 injuries. And I see the full spectrum. I see the full
20 spectrum where people come into the trauma center that
21 literally their head has almost been ripped off and they are
22 paralyzed to the point they can't even breath. So in my
23 practice, I see the full spectrum. So if you take the
24 extreme, severe end of the spectrum where someone comes in
25 and their spine has been completely ripped where all the

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1 ligamentous and disc structures have been ripped and torn,
2 that is a scenario that could be consistent with what Dr. Fish
3 described. Short of that, there is an entire spectrum. You
4 have all kinds of things that are around the spine and the
5 neck. Having been someone who operates on these, someone can
6 be completely paralyzed and have a ripped spine internally,
7 and when I expose them and expose their injured spine, the
8 muscles are all still together, but yet the spine, itself,
9 has been severely disrupted. So again, you have all kinds of
10 structures that are around. Each individual structure has its
11 inherent, mechanical characteristics so you can easily have a
12 partial injury to a disk in the sense that it's injured, it
13 hurts, it's causing, but the patient is not paralyzed or the
14 spine is not completely unstable. And they're not having
15 severe weakness, numbness in their arm. It's a spectrum.

16 Q And that brings up my next testimony. Yesterday Dr.
17 Fish was showing the patient's -- Mr. Simao's MRI -- on his
18 MRIs to the jury. And he testified that the disc -- your disc
19 in your cervical spine was like a coffee table sitting in your
20 house. And that all the structures around your cervical disc,
21 like your muscles, your tendons, your ligaments, all of those
22 things are like your house. So that if you were going to have
23 an injury to your coffee table in your house, you'd have to
24 basically destroy all the structures around the house to get
25 to the coffee table and injure it. And he analogized this to

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1 the MRI and said, "So in order to have a disc injury like
2 Mr. Simao is complaining of, you would see on the MRI all this
3 damage to his ligaments and his muscles and his tendons. And
4 since you've been all -- and swelling. And since you didn't
5 see that, there couldn't be an injury to the disc." Would you
6 agree with that?

7 MR. ROGERS: Hold up. Your Honor, first it's leading.
8 And second, it exceeds the scope of the cross.

9 MR. EGLET: No.

10 MR. ROGERS: It seems to be a second direct examination
11 he's conducting.

12 MR. EGLET: He open the door when he brought up testimony
13 about what Dr. Fish said yesterday, Your Honor. This is
14 absolutely appropriate. He opened the door on it. He brought
15 up several testimony Dr. Fish gave yesterday to this witness.

16 MR. ROGERS: Just --

17 THE COURT: Sustained as to leading, only.

18 BY MR. EGLET:

19 Q Let me give you a hypothetical. Hypothetically, if
20 Dr. Fish testified for this jury that your disc was like the
21 coffee table in your house, middle of your house, and that all
22 the surrounding structures of your disc, your muscles, your
23 tendons, your ligaments, were like the walls and everything in
24 your house, the structure of your house. And in order to
25 injure your disc like Mr. Simao's injuries to his disc, using

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1 the coffee table analogy, you would have to destroy to the
2 whole house to get to the coffee table. And with the MRI up in
3 front of the jury, he said, "You would have to destroy all the
4 ligaments, the muscles, the tendons and there would be
5 swelling. And you would be able to see that on the MRI if
6 there was an injury to the disc." Would you agree with that
7 testimony?

8 A No.

9 Q Why?

10 A Do you want me to use the house analogy or just --

11 Q Use what you want. I mean, I don't know.

12 A I kind of have some funny scenarios. But I'll keep
13 is serious. In a simple sense, I see -- again, I don't know
14 Dr. Fish's experience. But I am a spine surgeon who has been
15 taking care of spine problems since 1986. And I have exposed
16 spines. I have looked at spines that have been completely
17 injured. And I have seen the full spectrum. So I have
18 injuries so bad that the spinal cord has been completely
19 ripped. The wind pipe hasn't been torn or esophagus. The
20 swallowing tube hasn't been torn. Their muscles are still
21 intact. But yes, the actual structure of the spine has been
22 severely disrupted. But, yet, to use the analogy of the
23 house, the walls are still up. So unfortunately, I would have
24 to state that the analogy of the house really isn't a good
25 analogy. I'm also an engineer. I know there's no way that

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1 would withstand the -- except the criteria of finite analysis
2 where you actually come up with a computer model that
3 simulates all the intrinsic mechanical structures of all the
4 structures of the neck so it can use computer models to
5 simulate various injury patterns. So without getting too
6 technical, you know, there is a significant variability in
7 each structure. If you use strictly the house analogy, you'd
8 have to, you know, damage all that significantly, the skin,
9 the muscles, the windpipe, the trachea, the esophagus, the
10 carotid artery. All that stuff would have to be significantly
11 damaged before you got to the coffee table or the house -- or
12 spine. And it just doesn't happen. People can have severe
13 unstable injuries with spectrums of paralysis, yet the spine
14 itself is the only injury. The muscles are still intact.
15 They haven't ripped their windpipe. They haven't ripped their
16 esophagus. They haven't ruptured their carotid arteries. See
17 it all the time.

18 Q And that would include injuries to the disc?

19 A Yes.

20 Q Okay. Dr. Fish testified yesterday that your
21 referral of Mr. Simao to the pain management center at
22 Southwest Medical for cervical spine injections was
23 unnecessary and unreasonable. Do you agree with that?

24 A No.

25 Q Why not?

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1 A I would have state all the reasons I've stated up to
2 this point.

3 Q Dr. Fish's trial testimony yesterday was that none
4 of the injections performed by any of the pain management
5 doctors at Southwest Medical, any of the injections performed
6 by you, nor any of the injections performed by Dr. Rosler, nor
7 the discography identified any pain generators in Mr. Simao's
8 cervical spine. Would you agree with that?

9 A No.

10 Q Why?

11 A Again, for all the reasons I've stated up to this
12 point. And again you said Mr. -- Dr. Fish, I'm sorry, is a
13 rehab physiatrist doctor in pain management --

14 Q Yes.

15 A -- not anesthesia?

16 Q And what is the difference between a rehab
17 physiatrist doctor who also practices pain management as
18 opposed to an anesthesiologist?

19 A Well, to be quite honest, I would ultimately defer
20 to a pain management specialist, either in anesthesia or
21 physiatry. But having dealt with -- I've been dealing with
22 this for a long time -- I would say that there's several
23 entities out there which have deemed to themselves to be
24 certifying entities for pain management. And pain management
25 has become a very diverse specialty. You have everything from

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1 a family practice doc claiming to do pain management to a
2 board certified anesthesiologist. The first person or
3 specialty that quote/unquote practicing pain management was
4 anesthesia. So the typical scenario, you were an
5 anesthesiologist. Did your residency. And you chose to do
6 additional training to become a pain management physician.
7 That was pretty much the only entity out there practicing pain
8 management. And that involved training of multiple things,
9 medicines, modalities, therapy. But also procedural training,
10 involved putting -- doing various procedures, precisely
11 putting needles where you want them, probes where you want
12 them. Doing procedures for pain. And that was the entity I
13 knew for years. I was unaware of other entities practicing
14 pain management. And then physiatry started doing pain
15 management. And I don't know the details of their board
16 certified entity. I know there are just several entities
17 which will certify you as a pain management specialist. But
18 I would say the entity that probably should be deemed the most
19 in general respected as far as deeming injections appropriate
20 and what they mean and whether or not they should be done and
21 what context they should be interpreted would be an
22 anesthesiologist, who's board certified, and additionally
23 certified and trained in pain management. And also a spine
24 surgeon who knows the anatomy of a spine who can also put
25 needles where they need to be.

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1 Q Okay. Now, Dr. Fish testified that when he
2 evaluated Mr. Simao, he documented that his pain level was a
3 seven to eight on an analog scale of zero to ten. And with
4 this documentation on this analog pain scale was not
5 consistent with Mr. Simao being able to function with
6 activities of daily living or with his work, which
7 occasionally required him to lift some objects. Do you agree
8 with that?

9 A No.

10 MR. ROGERS: Your Honor, the Defense just wants to make a
11 running objection to what appears to be a redirect exam --
12 pardon me, exceeding the scope of the cross.

13 MR. EGLET: He opened the door on this, Your Honor.

14 THE COURT: Noted for the record, please proceed.

15 THE WITNESS: No.

16 BY MR. EGLET:

17 Q And why?

18 A I would just have to interject personal experience.
19 I walked on a broken femur for three weeks. And I worked.

20 Q Okay.

21 A So I would say in general Mr. Simao impressed me as
22 a gentleman who was fairly tough and was able to withstand a
23 fair amount of discomfort and -- so I would say pain by
24 definition is a subjective experience. And having seen the
25 full spectrum of pain in individuals, it's amazing -- I'll

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1 give you a great example. I've just done tremendously huge
2 spine surgery on people for scoliosis. And they're two weeks
3 out. And they're taking Tylenol. And yet in some people, I
4 would do a very small procedure. And they're two weeks out
5 and they're taking much more than Tylenol. So the simple
6 answer is just because someone says it hurts, I mean, there's
7 just a totally variable individual makeup of people. Now,
8 some people got -- yeah, I got pain but it doesn't stop me.
9 So I don't think that is really inconsistent at all.

10 Q Dr. Fish also testified yesterday that the discs you
11 removed in Mr. Simao's spine at -- the C3/4 and C-4/5 disc
12 were not injured in the April 2005 motor vehicle crash. Do
13 you agree with that?

14 A No.

15 Q Now, yesterday Dr. Fish testified that Mr. Simao's
16 poor response to the cervical spine surgery could not be
17 caused by the first operative neuropathic pain because there's
18 no literature to support that a chemical leak from the disc
19 could irritate the nerve root and cause neuropathic pain.
20 That was his testimony yesterday. Do you agree with that?

21 A No.

22 Q Can you explain why?

23 A Well, the simple answer is, the surgery by
24 definition took out the disc. So hence the disc was no longer
25 there to be causing chemical substances to irritate the nerve.

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1 Q Does the chemical substance for irritating a nerve
2 root have anything to do with the neuropathic pain that you
3 diagnosed in Mr. Simao?

4 A As I stated two days ago, my definition of
5 neuropathic pain is alteration in the pathways as they travel
6 through the nervous system because of chronic pain.

7 Q All right. Now, Mr. Rogers asked you earlier if you
8 expect your patients to follow your recommendations and you
9 said no. Do you recall that?

10 A Yes.

11 Q Can you explain what you mean by that answer.

12 A Well, taking the context of Mr. Simao and taking the
13 context of the question, when I see a patient, my job is to
14 evaluate them and in the end, tell them what I think and tell
15 them what I think is reasonable to do. So in the end, my job
16 is to make sure I'm communicating, they get the basic
17 concepts, the important points, and it's their job to make a
18 decision. If someone makes a decision which is not having
19 surgery, that is not someone who's quote/unquote not following
20 my recommendations in a bad sense. It's just someone who's
21 decided they didn't want to go that way.

22 Q Okay. Do you fault your patients for getting
23 second opinions?

24 A No.

25 Q Okay. So even though Mr. Simao was cleared for

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1 surgery in October 2007, you don't fault him for getting a
2 second opinion by Dr. Grover?

3 A No.

4 Q Okay. Dr. Grover, did he also state that Mr. Simao
5 was a surgical candidate?

6 A To be quite honest, I don't recall seeing any Grover
7 notes that clearly state that.

8 Q Is it your understanding that he -- from Mr. Simao
9 that Dr. Grover indicated he was a surgical candidate at the
10 same level as you had indicated he was?

11 A Again, unfortunately, I don't have a Grover note in
12 front of me. I think it's fair to say Dr. Grover was
13 seriously considering the surgery otherwise he wouldn't have
14 ordered discograms.

15 Q Now, earlier -- now, earlier, Mr. Rogers talked
16 about this October 2007 note, this pre-op record. Was Mr.
17 Simao given surgical clearance on October 5th, 2007 by
18 Southwest Medical?

19 A Well, I'd have to -- well, isn't this October 9th?
20 Or is that -- I only see the bottom. Is it a visit note of
21 October 5th? I'm sorry. Okay. So can we flip down to the
22 bottom, please. Yes.

23 Q Okay. Now, on October 5th, 2007, were you still in
24 the process of obtaining further diagnostic work up of Mr.
25 Simao?

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1 A Yes.

2 Q In other words, were -- you were not planning on
3 doing surgery on Mr. Simao in October 2007, were you?

4 A Again, I just want to make sure there's not semantic
5 misunderstanding. For me, surgery is doing a fusion. Like,
6 we did -- doing an injection is, for me, a procedure. So I
7 can just tell you, as best as I recall, there was never any
8 process initiated by me directly to see he needed all this for
9 an injection. So my plan was to get an injection not do a
10 major surgery.

11 Q Thank you, Doctor.

12 THE COURT: Any follow-up, Mr. Rogers.

13 MR. ROGERS: Yeah. Just one.

14 RECROSS-EXAMINATION

15 BY MR. ROGERS:

16 Q You've testified that the two-level fusion that was
17 performed on the Plaintiff has a 85 to 90 percent success
18 rate. If, however, the levels that are fused are not injured,
19 that otherwise successful surgery is not going to succeed.
20 Correct?

21 A Again, it depends on the context.

22 MR. ROGERS: That's all, Your Honor.

23 THE COURT: Any follow, Mr. Eglet?

24 ///

25 ///

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FURTHER REDIRECT EXAMINATION

BY MR. EGLET:

Q Doctor, you actually performed the surgery on Mr. Simao?

A Yes.

Q You went in and removed the disc?

A Two of them.

Q You have visualized the disc?

A Yes.

Q You are the only who saw the disc when you went into the surgery?

A The scrub tech did.

Q Well, you were the only surgeon?

A I don't know if I had an assistant.

Q Okay.

A I don't think I did.

Q Well, out of the other doctors who treated him, you know, the major doctors in the records, you know, and the Defense doctors, you actually went in and did the surgery?

A Yes. Yes.

Q You visual -- Dr. Fish wasn't there. Right?

A No.

Q Dr. Yong wasn't there. Right?

A No.

Q Dr. Wang, I'm not sure how to pronounce his name.

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1 When you went in, you actually saw the injured disc before you
2 removed them?

3 A Yes.

4 Q Thank you.

5 THE COURT: Anything else? Going once. Going twice.
6 Thank you, Doctor. You may be excused.

7 Who's the next witness?

8 MR. EGLET: Dr. Grover, Your Honor.

9 THE COURT: Do you suppose he's here?

10 MR. EGLET: He should be here, Your Honor. He was
11 supposed to be here at 1:30.

12 JASWINDER GROVER, PLAINTIFF'S WITNESS, SWORN

13 THE CLERK: Thank you. Please be seated. State and spell
14 your name for the record.

15 THE WITNESS: Jaswinder Grover. J-A-S-W-I-N-D-E-R.
16 Grover, G-R-O-V-E-R.

17 DIRECT EXAMINATION

18 BY MR. EGLET:

19 Q Good afternoon, Dr. Grover. Dr. Grover, would you
20 please tell us the specialty in medicine that you practice?

21 A I'm an orthopedic surgeon with a subspecialty in
22 spinal disorders.

23 Q Are you board certified in orthopedic surgery?

24 A Yes, I am.

25 Q Can you tell us where you attended medical school?

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1 A I went to medical school at the UCLA school of
2 medicine.

3 Q All right. And where did you do your internship and
4 residency training?

5 A I did my internship and residency at the University
6 of Southern California Los Angeles County Medical Center in
7 Los Angeles.

8 Q And did you do a fellowship following your
9 residency?

10 A I did. I did a fellowship in spinal cord injury at
11 the University of British Columbia in Vancouver, Canada and at
12 McGill University in Montreal.

13 Q Okay. Now, can you tell us about your admission to
14 University of California Los Angeles, UCLA medical school.
15 Did you get in earlier than most students?

16 A Yes.

17 Q Can you tell us about that.

18 A I went to UCLA school of medicine. I was accepted
19 year earlier, before I graduated from college. So I
20 completed my last year of college at the University of
21 California at Riverside while I did my first year of medical
22 school at UCLA.

23 Q Okay. Now, how long -- I know the medical school is
24 four years and the internship is one year. How long was your
25 residency in orthopedic surgery?

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1 A The residency was five years.

2 Q Five years. Okay. And then following the
3 residency, you did a fellowship in spine?

4 A Yes.

5 Q And how long was the fellowship?

6 A My fellowship at the University of British Columbia
7 in spinal cord injury for six months. And I then was in
8 Montreal at the university -- at McGill University in Montreal
9 in spinal reconstructive surgery for three months. And for
10 three months, I was, actually, also in England at the
11 Nottingham Center for Spinal Studies on an academic fellowship
12 before I came to Las Vegas in 1995 when I started my practice
13 here.

14 Q Now, you belong to any professional memberships,
15 Doctor?

16 A Yes.

17 Q And what are those?

18 A I am a fellow of the American Academy of Orthopedic
19 Surgeons. I am a member of the North American Spine Society.
20 The Clark County Medical Society. The American Medical
21 Association. And the UCLA Aesculapian Society.

22 Q What is the UCLA Aesculapian Society?

23 A It's a -- as a graduate of UCLA medical school, we
24 are part of a program where we keep in touch with other
25 graduates from the medical school.

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1 Q Okay. Could you detail for us the scope of your
2 practice as an orthopedic spine surgeon here in Las Vegas.

3 A Yes. I've been in practice now for almost 16 years,
4 I believe. And when I came here, I spent a lot of time at the
5 University Medical Center taking care of a lot of the spinal
6 cord injuries and the complicated pelvis fractures in the late
7 1990s. And over the last seven to eight years have developed
8 a more elective practice in treating patients who have
9 complicated spinal disorders. And it's a referral practice,
10 that is essentially a busy surgical practice taking care of
11 patients every day to the best of our ability.

12 Q Do you have hospital privileges, Doctor?

13 A Yes, I do.

14 Q And where do you have hospital privileges?

15 A I believe I am on staff at most of the major medical
16 centers here in Las Vegas. I can list them for you if you
17 like.

18 Q That's fine. And do you have your license to
19 practice medicine in Nevada?

20 A Yes.

21 Q Are you licensed in other jurisdictions?

22 A Yes. I maintain my license in California.

23 Q Okay. And are you still licensed in British
24 Columbia?

25 A No, I'm not licensed in British Columbia. They had

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1 given me a special license to practice in Canada as a fellow
2 in 1995.

3 Q Have you been qualified as an expert in the area of
4 orthopedic spine surgery and orthopedic surgery in the courts
5 of Clark County, Nevada?

6 A Yes, I believe that I have.

7 MR. EGLET: Your Honor, we would offer Dr. Grover as an
8 expert in orthopedic surgery and orthopedic spine surgery.

9 THE COURT: Any objections?

10 MR. ROGERS: No, Your Honor.

11 THE COURT: So ordered.

12 BY MR. EGLET:

13 Q Doctor, you are one of William Simao's treating
14 physicians, treating orthopedic spine surgeons. Is that
15 correct?

16 A Yes.

17 Q Okay. On what date -- Exhibit 26, Page 7, please.
18 Doctor, there's a monitor to the right of you that we're going
19 to show some records on from your chart. If it's easier for
20 you to refer to those or if it's easier -- I know -- I saw
21 that you brought your chart with you. Whichever your
22 preference is. But what date did you first see Mr. Simao?

23 A I first saw him, I believe, on March 28th, 2008.

24 Q Okay. And what is your understanding as to how much
25 time had gone by between the date of the motor vehicle crash

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1 he was involved in to the time that you -- of your initial
2 evaluation?

3 A It was about three years.

4 Q Okay. Now, what is the clinical significance of the
5 fact that you saw Mr. Simao for the first time almost three
6 years after his motor vehicle accident?

7 A Well, I think he had been having pain for three
8 years. He had -- you know, the history that he provided to me
9 was that he had been suffering from fairly significant pain,
10 intermittently but at times quite significantly, for a period
11 of three years. So the significance was that it emerged into
12 somewhat of a chronic condition by that time.

13 Q Okay. On the initial pain questionnaire that Mr.
14 Simao filled out at that time, what did he document as the
15 date of the injury?

16 A April 15th, 2005.

17 Q And based on his pain questionnaire, where was he
18 having pain at that time?

19 A He was having pain in his neck, left shoulder and
20 his head.

21 Q And what type of relief did Mr. Simao have with
22 anti-inflammatory and/or anti -- other medications he was
23 taking before he saw you?

24 A He had temporary relief.

25 Q And how much pain relief did Mr. Simao experience

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1 with trigger point injections before your evaluation?

2 A He had some temporary relief.

3 Q And how much pain did Mr. Simao experience with
4 epidural steroid injections before you saw him?

5 A Again, temporary relief.

6 Q What is a tens unit?

7 A A tens unit is an external mechanical device that
8 provides an external stimulation to the skin and can penetrate
9 into the subcutaneous tissue to try to alter a patient's
10 perception of pain. It's commonly used in -- as a physical
11 therapy modality to treat pain.

12 Q And how much did -- how much relief did Mr. Simao
13 get from the tens unit before he saw you?

14 A He had some temporary relief.

15 Q Did Mr. Simao experience any relief from his pain
16 syndrome with home exercise?

17 A No, he did not?

18 Q Did Mr. Simao experience any pain relief with
19 physical therapy?

20 A No, he did not.

21 Q How did Mr. Simao characterize his pain on the
22 initial questionnaire he filled out?

23 A He characterized his pain on the questionnaire as
24 aching, penetrating, at times unbearable, and pain that was
25 essentially, you know, continuous.

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1 Q Did he document that anything made his pain better?

2 A No. He didn't -- he did not feel that anything was
3 really making it significantly better.

4 MR. EGLET: Go to the bottom of Page 8, please, Brendan.

5 BY MR. EGLET:

6 Q When asked to quote, write any other information or
7 thoughts that you would like us to know, end quote, what did
8 Mr. Simao document on his pain questionnaire?

9 A "I need to be able to function during the day.
10 Tried several medications, meds are tired or caused memory
11 loss, caused me to become tired or memory loss, so I just deal
12 with the pain.?"

13 MR. EGLET: Page 10, please, Brendan.

14 BY MR. EGLET:

15 Q Did Mr. Simao provide you with a history of migraine
16 headaches at the time he filled out the pre-evaluation
17 questionnaire at your office?

18 A Yes, he did.

19 Q And what did he document?

20 A He had documented and he had acknowledged in his
21 history that we obtained from him that he had had migraine
22 headaches. And he felt that those had become worsened.

23 Q Did the fact that Mr. Simao had a history of
24 migraine headaches which were worsened after this motor
25 vehicle accident impact your evaluation of his presenting

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1 symptoms of chronic neck pain?

2 A Well, I think I would -- I took it into account.
3 But I think his symptoms of neck pain were separate and
4 different from his history of migraine headaches.

5 Q And explain that for us if you will.

6 A Well, migraine headaches typically are headaches
7 that are frontal in origin. They start above the eyes.
8 Sometimes they are associated with other triggering phenomenon
9 such as light or vibration or other events. And they are
10 generally frontal headaches that affect a part of the head.
11 The type of headache or pain in the head that he described
12 when he saw me for which I felt that I was evaluating him for,
13 was pain in the back of the head, in the left side of the
14 neck, left shoulder, and the left side of the back of his
15 head. And that's what he marked on his anatomical drawing.
16 And that type of head pain is more sub-occipital pain, meaning
17 base of the skull. The occiput is the back of the skull. And
18 that type of pain is frequently related to cervical spine
19 pathology or radiating from something going on in the cervical
20 spine.

21 Q Now what history did you obtain from Mr. Simao at
22 the time of your initial evaluation of him on March 28th,
23 2008?

24 A Well, his chief complaint was neck pain, left
25 parascapular pain, and lower back discomfort. He presented on

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1 that date about, you know, as a 44-year-old right hand
2 dominant gentleman who -- and he gave a history that about two
3 to three years prior, he was the restrained driver in an
4 automobile that was involved in a rear end type of motor
5 vehicle collision. He reported that he had hit the back of
6 his head on the metal cage of the vehicle. And since that
7 time had been suffering from pain in the back of his head,
8 left parascapular, interscapular area, occasionally radiating
9 into the left arm.

10 Q What information did Mr. Simao provide to you at
11 that time of -- at the time of your initial evaluation of him
12 regarding the treatment he had received before seeing you?

13 A He had been treated through a variety of modalities
14 over that period of two to three years, including physical
15 therapy, medications, anti-inflammatories, and also having
16 undergone some specialized injection treatment into the spine.

17 Q Okay. Now, at the time of your initial evaluation,
18 did you ask Mr. Simao about a past medical history of neck
19 pain?

20 A Yes. We did. And specifically the patient denied a
21 history of neck pain or left arm pain as he was presenting at
22 that time.

23 Q In other words, when you say deny a history, do you
24 mean, did he deny a history of any of these problems before
25 this motor vehicle accident?

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1 A Yes, he was fairly clear that he didn't have the
2 symptoms prior to that event.

3 Q Based on your review of the medical records provided
4 to you regarding the care Mr. Simao received, did you find any
5 evidence that he had been seen, evaluated, or treated for neck
6 pain before the April 2005 motor vehicle accident?

7 A No. I did not have any evidence to suggest that.

8 Q Based on your review of the medical records provided
9 to you regarding the care Mr. Simao received, did you find any
10 evidence that he had been seen, evaluated or treated for left
11 upper extremity radicular symptoms before the April 2005 motor
12 vehicle accident?

13 A No, I did not have any evidence to suggest such
14 symptoms.

15 Q Okay. And based on your review of the medical
16 records provided to you regarding the care that Mr. Simao
17 received, did you find any evidence that he had been seen,
18 evaluated or treated for any cervical spine problems before
19 the April '05 motor vehicle accident?

20 A No.

21 Q What employment history did Mr. Simao provide you on
22 March 28th, 2008?

23 A He had told us that he was the owner and manager of
24 a cleaning company.

25 Q Hypothetically, if someone told this jury that Mr.

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1 Simao did have a cervical spine injury because he returned to
2 work after the April '05 motor vehicle accident, would that be
3 accurate?

4 A No.

5 Q Why not?

6 A Because I think it's very unreasonable to assume or
7 to suggest that someone does not have a problem or an injury
8 or symptoms or complaints or pain simply because they return
9 back to work. I think most people who have these types of
10 injuries that are primarily pain disorders, go back to work
11 and try to work. And certainly that's -- that would be the
12 norm. And that would be what most physicians and people would
13 encourage. I mean, there are -- most of the patients we see
14 that are evaluated, I mean, whether it's a herniated disc, a
15 pinched nerve, or this or that, and it's primarily pain
16 disorders, most people are still working. They're just
17 managing through the pain. To suggest that they're -- simply
18 because they returned back to work they don't have a problem I
19 think is misleading.

20 Q What physical examination findings did you document
21 at the time of your initial evaluation of Mr. Simao?

22 A That he had some tenderness to palpation in the left
23 parascapular area. Pain with left cervical rotation of the
24 neck.

25 MR. EGLET: Page 17, please, Brendan.

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1 BY MR. EGLET:

2 Q Did you document nerve root tension signs during
3 your initial evaluation of Mr. Simao?

4 A Yes.

5 Q And what are nerve root tension signs?

6 A Well, these are physical examination findings to
7 suggest some irritation of the nerve root originating at the
8 level of the cervical spine such as the axial compression test
9 where apply some axial pressure to the patient's head and see
10 if we can reproduce some element of the pattern of pain that
11 the patient is experiencing and/or ask the patient to tilt the
12 head in one direction and rotate in the opposite direction
13 which physically results in a greater encroachment into the
14 area where the nerve is to suggest that perhaps the nerve is -
15 - see if we can again reproduce the pattern of pain.

16 Q And what was the results of the axial compression
17 test you did on Mr. Simao?

18 A Well, they were -- it was positive for reproduction
19 of the left pain -- left parascapular pain and suboccipital
20 pain, meaning pain around the left shoulder blade and the back
21 of the head. And both axial compression and Spurling sign
22 were positive on the left side. Which, you know, suggested
23 that he did have something going on his neck that was causing
24 the type of pain that he was complaining of.

25 MR. EGLET: Page 18, please, Brendan.

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1 BY MR. EGLET:

2 Q What radiographs did you review at the time of your
3 initial evaluation of Mr. Simao, Doctor?

4 A I looked at an MRI scan of the cervical spine with
5 which he presented to me dated September of 2007.

6 Q And what findings did you document after your review
7 of this study?

8 A Yeah. I made a note on my review that I did not see
9 any significant cervical disc herniation. I saw what was a
10 suggestion of some facet tropism in the proximal segments
11 C-3/4 and C-4/5. But I felt that it was a marginal quality
12 study that I was looking at.

13 Q And what does that mean? Marginal quality study.

14 A Well, an MRI scan is sort of a picture. So it's
15 like a digital picture. It can have a good quality picture or
16 a blurry picture. It was not a high quality image that --
17 such I didn't feel I could get an accurate look at things.

18 Q And can you explain the difference between a disc
19 herniation and internal disc disruption or annular tears in
20 the discs.

21 A Sure. I mean, the disc as -- I mean, the jury
22 probably understands by now I would imagine is a structure
23 that has a peripheral annulus. It's rubbery on the outside
24 and Jell-O on the inside. It's a relatively simple structure,
25 so to speak. But the semantics, or the words, that have been

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1 used to describe problems in the discs are sometimes so
2 confusing, even for us as clinicians. But essentially if you
3 think of the disc as simply having a rubbery outside and Jell-
4 O inside. And the rubbery outside is called the annulus.
5 It's sort of like a tire sitting on the side. A disc
6 herniation is when there's a violation of the peripheral
7 fibers of the disc and some of the material from inside the
8 disc, the Jell-O material, has popped out and is sitting
9 outside the area of the disc and may be encroaching upon or
10 pinching a nerve. There is -- that is something that is
11 relatively simply to -- easy to see and easy to identify on an
12 MRI scan because you can see the disc pushing out and pinching
13 the nerve. It's a mechanical impingement upon the nerve. So
14 it's easy to see. It's easy to understand as a source of pain
15 in pathology.

16 Internal disc disruption is a term that is used to
17 describe a pathology in a disc where the disc is compromised
18 in the sense that the peripheral fibers are torn. So the
19 mechanical integrity of the disc is compromised. And this
20 type of condition in some patients can cause pain because of
21 the loss of the mechanical integrity of the disc and/or
22 because of some leakage of fluid from inside the disc through
23 the tears that then irritates the nerves that traverse and
24 pass by the disc. And I think that's -- in my opinion -- how
25 would I describe internal disc disruption.

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1 Q What was your clinical impression of Mr. Simao after
2 your initial evaluation of him?

3 A My impression was persistent neck, left
4 parascapular, left upper extremity symptomatology. And the
5 patient has had ongoing symptoms for the past two to three
6 years. And who had been recommended in the past for a
7 cervical fusion surgeon by Dr. McNulty based on some injection
8 therapy.

9 Q And what did you recommend for Mr. Simao on March
10 28th, 2008?

11 A I recommended that he undergo some more contemporary
12 diagnostic evaluations, include a new updated MRI scan of the
13 cervical spine and some electro-diagnostic studies of the
14 upper extremities. I also recommended that he be evaluated
15 with Dr. Rosler, my associate in the practice, for some C-3/4
16 and C-4/5 selective nerve root blocks.

17 MR. EGLET: And Page 24, please, Brendan.

18 BY MR. EGLET:

19 Q What was the radiologist, Dr. Bolin's,
20 interpretation of Mr. Simao's April 30th, 2008 cervical spine
21 MRI?

22 A The MRI scan that was done at that time revealed
23 annular bulging at C-3/4 and central protrusion at the C-4/5
24 level.

25 Q Did he also document an annular tear at C-2/3?

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1 A Yes. An annular, left paramedian disc protrusion at
2 C-2/3.

3 MR. EGLET: Page 27, please, Brendan.

4 BY MR. EGLET:

5 Q Now, Doctor, when you reviewed that MRI study on
6 your reevaluation of Mr. Simao on May 6th, 2008, what did you
7 document your interpretation of that MRI to be?

8 A Yeah, I looked at that MRI scan and my
9 interpretation again that there did not appear to be
10 significant neural encroachment. There was some potential
11 facet tropism, meaning that the angle of the facet joints,
12 which are the little joints in the upper cervical spine, were
13 not parallel or uniform from one side to the other. And on
14 the left side, they were angled a little bit differently. And
15 some degeneration in the proximal cervical segments. Again,
16 most significantly at C-3/4 and C-4/5.

17 Q And what does degeneration mean?

18 A Degeneration means some wear and tear or, you know -
19 - some wearing of the joint.

20 Q Is that often referred to as age-related changes?

21 A It's -- they're commonly age-related changes. And
22 we see degeneration in practically everyone as we get a little
23 older.

24 Q Now, how would you explain the difference between
25 your interpretation and the radiologist's interpretation of

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1 Mr. Simao's April 30th, 2008 MRI?

2 A I don't think it's significantly different. I think
3 the radiologist identified what he saw as some abnormalities
4 at the C-4/5, C-3/4 and in his opinion, also, the C-2/3
5 levels. And those were essentially the same levels,
6 especially the C-3/4 and C-4/5 levels where I felt that the
7 patient did have abnormalities. I think I described the
8 abnormalities a little bit differently in the way that I felt
9 that they were clinically significant. And the radiologist
10 described the abnormalities as he saw them as a radiologist.

11 Q What was your clinical impression of Mr. Simao on
12 May 26th, 2008?

13 A Well, I think he had persistent neck pain,
14 interscapular pain, suboccipital radiculopathy, with some
15 potential subaxial cervical facet pathology C-3/4 and C-4/5
16 despite a variety of modalities of treatment that had been
17 instituted to that point.

18 Q What is meant by subaxial cervical facet pathology?

19 A The subaxial cervical spine relates to the levels C2
20 to C7 as the axial cervical segments, including the occiput
21 and C1.

22 Q What is suboccipital radiculopathy?

23 A Pain radiating into the back of the head. Which is
24 -- the occiput is the back of the head. The subocciput is the
25 lower part of the back of the head.

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1 Q And when you mean radiating into the back of the
2 head, are you talking about radiating from the neck or are you
3 talking about radiating from the front of the head? What are
4 you talking about?

5 A No, we're talking about radiating from the neck
6 approximately upwards into the back of the head.

7 Q In your deposition in this matter taken on April
8 16th, 2009, did you -- did Mr. Rogers hand you a copy of the
9 February 10th, 2009 report of the Defense expert Dr. Fish?

10 A Yes, he did, I believe so.

11 Q Did Mr. Rogers ask you to review that report at that
12 time, at the time of your deposition?

13 A I believe he did, yes.

14 Q And did you do so?

15 A I believe so, yes.

16 Q And were you asked to comment on the opinions
17 expressed by Dr. Fish's report -- in Dr. Fish's report by Mr.
18 Rogers?

19 A Yes.

20 Q And did you subsequently review all the records that
21 Dr. Fish reviewed in his February 10, 2009 report?

22 A Yes.

23 Q Does this include Mr. Simao's records from Southwest
24 Medical Associates?

25 A Yes.

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1 MR. EGLET: Brendan, Exhibit 18, Page 1, please.

2 BY MR. EGLET:

3 Q When Mr. Simao was evaluated at the urgent care
4 center of Southwest Medical a little more than three hours
5 after this motor vehicle accident, what was the document
6 reason for his visit?

7 A His --

8 MR. ROGERS: Your Honor -- I apologize, Doctor. It
9 appears they're eliciting expert testimony now.

10 MR. EGLET: Can we approach, Your Honor?

11 THE COURT: Yes.

12 [Begin Bench Conference]

13 MR. EGLET: As we just went through with this doctor,
14 during his deposition --

15 THE COURT: Keep your voice down, Mr. --

16 MR. EGLET: As we just went through with the doctor,
17 during his deposition, Mr. Rogers pulled out the expert report
18 of Mr. Fish -- Dr. Fish, excuse me. This expert report
19 documents all the records that Dr. Fish reviewed including the
20 summary of all those records and then Dr. Fish's opinions.
21 And he asked him -- we actually took a break in the deposition
22 to actually review this very extensive comprehensive report
23 that [indiscernible]. Then he went on to ask Dr. Grover
24 about all of Dr. Fish's opinions and all these records he's
25 reading. So he opened the door with this treating physician

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1 by asking him to review his expert's records and reports and
2 all the records that his expert reviewed [indiscernible]. So
3 we're entitled, it was done in the deposition, we cross-
4 examined, Your Honor, in the deposition. We're certainly
5 entitled to go over this now in his direct testimony.

6 THE COURT: Mr. Rogers?

7 MR. ROGERS: Yes. There are countless things that we
8 discuss in depositions that aren't coming into evidence. The
9 fact that the Plaintiff never designated Dr. Grover as an
10 expert witness precludes him from offering testimony beyond
11 his treatment.

12 MR. EGLET: He can't allow him to be cross-examined by
13 you in his deposition on this stuff and not allow us to be
14 able to address these issues on direct. I mean, they opened
15 the door on this. They didn't have to cross-examine him on
16 their expert's report. They asked him to review the report.
17 We didn't give him the report beforehand and say, review this
18 report, review all these records. They had him do it in the
19 deposition. They opened the door for him to talk about this
20 stuff cause they had him review it and then they asked him
21 questions about it.

22 MR. ROGERS: You got to change his designation if that's
23 what you're going to do. And the Defense hasn't even arrived
24 at the door. We can't open anything.

25 THE COURT: Defense what?

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1 MR. ROGERS: The Defense hasn't even arrived at the door.
2 They're doing something in anticipation of a cross that they
3 don't know what's coming.

4 MR. EGLET: You opened the door in your deposition.

5 MR. ROGERS: No. But you have to change the designation
6 of the witness --

7 MR. EGLET: No, we don't. We do not --

8 MR. ROGERS: -- if you're going to do this.

9 MR. EGLET: We do not have to change the designation.
10 You asked this witness to review the records beyond his own
11 medical records in his deposition and then asked him opinions
12 on it, which is exactly what they did. They don't then get to
13 close the door down. They did open the door, swing the barn
14 doors wide open, and then once the horse is out of the barn
15 shut the doors and say, well, now you can't do it. Are you
16 kidding me?

17 THE COURT: I think you did open the door at the
18 deposition where you went down this road and this examination
19 of this witness as an expert witness. Overrule the objection.

20 [End Bench Conference]

21 BY MR. EGLET:

22 Q Okay. We were referring to Exhibit 18, Page 1,
23 which is on the screen in front of you, Doctor. And the
24 question is when Mr. Simao was evaluated at the urgent care
25 center of Southwest Medical a little more than three hours

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1 after the motor vehicle accident, what was the documented
2 reason for his visit?

3 A Complaints of neck, back and left shoulder pain.

4 Q And after the physician's assistant evaluated Mr.
5 Simao, at that time, what was the clinical assessment?

6 A The assessment was left elbow sprain and neck
7 sprain.

8 Q Okay. And I want to point something out. This was
9 an evaluation by a physician's assistant, not a doctor. Is
10 that right?

11 A That's correct.

12 Q Okay. And in patients who sustain traumatic
13 injuries to their cervical spine, their discs, is the initial
14 working diagnosis for that injury almost always a
15 sprain/strain to the neck or cervical spine?

16 MR. ROGERS: I'm going to object, Your Honor. It calls
17 for speculation.

18 THE COURT: Sustained. Ask you to rephrase it.

19 BY MR. EGLET:

20 Q Okay. Doctor, you treat patients who ultimately are
21 diagnosed with disc disruption or disc herniations or other
22 types of disc injuries or spine injuries from a traumatic
23 event?

24 A Yes, I do.

25 Q Do you -- many of these patients you ultimately end

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1 up doing surgery on?

2 A Yes, sometimes.

3 Q And in your practice, do you review and have you
4 reviewed the initial records from the primary care physician
5 or emergency room physician or the physical therapist or
6 chiropractor, et cetera?

7 A Yes.

8 Q And in your practice, almost universally, normally
9 and ordinarily, what is the initial working diagnosis of the
10 primary care physician or the ER physician or the physical
11 therapist?

12 A Strain/sprain.

13 Q And why is that?

14 A Because for the most part, if the patient is in an
15 injury and presents to an urgent care type of setting, and
16 they're complaining of neck pain or back pain after being
17 injured, the usual working diagnosis is a strain/sprain. And
18 it's treated as a soft tissue injury because there is a soft
19 tissue injury. And it's only if the symptoms don't get better
20 over the certain course of time that the patient may be
21 evaluated and further investigation performed whereby an
22 underlying structural problem is identified. But the working
23 diagnosis initially for most patients is a cervical
24 strain/sprain, unless some more sophisticated diagnostic
25 workup is done immediately for some reason which clearly

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1 identifies something.

2 MR. EGLET: Could you go to Page 20, please, Brendan.

3 BY MR. EGLET:

4 Q Doctor, would you please summarize for us the
5 treatment Mr. Simao received from the physician assistants
6 that evaluated him at Southwest Medical Associates in May
7 2005.

8 MR. ROGERS: What date is this you're on?

9 MR. EGLET: May of 2005.

10 THE WITNESS: Well, he was treated essentially medically
11 by prescription of some anti-inflammatory and muscle relaxant
12 medication.

13 BY MR. EGLET:

14 Q Did they document that -- whether Mr. Simao had a
15 history of migraine headaches?

16 A They've documented here that Mr. Simao has a history
17 of migraine headaches. He has experienced a change in his
18 headache intensity and character after motor vehicle accident.
19 He had cervical neck x-rays and a CT scan of the head, which
20 were normal. For the lab work, as it's been normal. And an
21 MRI scan of the brain and the head was normal. He's
22 continuing with his medications and a follow up is scheduled
23 for six months.

24 Q How would characterize Mr. Simao's documented
25 symptoms at Southwest Medical in May of 2005?

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1 MR. ROGERS: I'm going to object as vague, Your Honor.

2 THE COURT: Ask you to rephrase it.

3 BY MR. EGLET:

4 Q Your review of the records from Southwest Medical
5 Associates, how -- what is your understanding and -- of the
6 characterization and character of Mr. Simao's symptoms in that
7 period of time?

8 A Well, it's a pretty brief note. It's -- I don't --
9 it seems very hard from just reading that short note from the
10 physician assistant to really characterize his pain. I think
11 all we can ascertain from this particular note that he was
12 still in pain. Pain which he attributed to the motor vehicle
13 accident because the physician assistant made a note of that.
14 He described his pain as being headaches and an intensity in
15 his migraine headache that had changed. So that's really all
16 I can gather from this particular note.

17 Q And we're going to have to go through a couple of
18 pages now of these notes from the physician's assistants at
19 Southwest Medical in May of 2005. And I want to ask you, do
20 they document occipital pain pressure with occasional
21 radiation to the sides?

22 A Yeah. He's complaining of left elbow pain,
23 tenderness in the back of the head. Again, it's documented
24 that he struck the back of his head on a cage. Had a
25 potential hyperflexion extension injury to his neck.

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1 Q What is a hyper- -- when it says he states he had a
2 hyperflexion and extension movement, what is a hyperflexion
3 extension movement usually -- what does that even mean?

4 A Well, I think it's another way to describe what is
5 more commonly called a whiplash type of injury where if a
6 patient is unexpectedly jarred, the next -- in a rear end type
7 of collision, actually is a hyperextension and flexion injury
8 where they extend their neck first and then bounce forward.
9 And, you know, that's, you know, what is -- what we commonly
10 refer to in colloquial terms as a whiplash injury. But the
11 actual mechanism by which the neck is injured or traumatized
12 is a rapid, unexpected extension of the neck followed by a
13 return in flexion or back to neutral again. And during that,
14 you know, rapid process when the patient or an individual is
15 not prepared or has not had an opportunity to guard or control
16 their neck muscles, somebody can be injured.

17 Q Now, in this note in May, did --

18 MR. EGLET: Court's indulgence for a moment, Your Honor.

19 THE COURT: Sure.

20 [Counsel Confer]

21 BY MR. EGLET:

22 Q Okay. I'm showing you a May 5th report from
23 Southwest Medical Associates and you see down there the
24 handwritten notes under current clinical findings and
25 management. Does it say anything about occipital pain?

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1 A Yes. Now having recurring occipital pain.

2 Q Okay. Can a pain generator in the upper segments of
3 the cervical spine cause occipital pressure and pain with
4 radiation to the sides?

5 MR. ROGERS: Objection, Your Honor. That's vague as to
6 which level we're discussing.

7 THE COURT: Ask you to rephrase it.

8 MR. EGLET: What do you mean which level? I'm asking him
9 can pain -- Your Honor, the question is, can pain in the upper
10 regions of the cervical spine cause upper segments of the
11 regional spine -- so it is specific. The upper segments of
12 the cervical cause occipital pressure and pain with radiation
13 to the sides --

14 MR. ROGERS: Same objection.

15 MR. EGLET: -- of the neck. I said the upper segments of
16 the cervical spine.

17 MR. ROGERS: Right. But those segments innervate
18 different areas.

19 MR. EGLET: No. No. He's wrong. Okay. Now's he's
20 testifying.

21 THE COURT: Counsel, approach, please. We always try to
22 avoid speaking objections.

23 [Bench Conference Starts]

24 MR. EGLET: Yeah. He doesn't get to testify about what
25 the medicines --

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1 THE COURT: Keep your voice down, Mr. Eglet.

2 MR. EGLET: Okay. He may disagree with this. But he
3 doesn't get to testify about what the medicine -- he may think
4 it's the C-2 level cause that's what -- [indiscernible] on the
5 stand yesterday said but it's wrong. And this guy is about to
6 tell the truth.

7 THE COURT: Well, I think you need to specify --

8 MR. EGLET: I said the upper segments of the cervical
9 spine. And the cervical spine has seven levels, Judge. I'm
10 saying the upper segments. The C-2/3, the C-3/4 are part of
11 the upper segments.

12 THE COURT: So let's be specific about which ones.
13 Sustain the objection.

14 [End Bench Conference]

15 BY MR. EGLET:

16 Q All right. Doctor, can the -- a pain generator in
17 the upper segments, specifically the C-2/3 and C-3/4 segments
18 of the cervical spine, cause occipital and pain with radiation
19 to the sides.

20 MR. ROGERS: Your Honor, the same objection applies.
21 It's --

22 MR. EGLET: Your Honor, I just said exactly what you
23 asked me to say.

24 THE COURT: Overruled.

25 THE WITNESS: Yes. The upper cervical segments of the

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1 spine not uncommonly cause pain to radiate into the
2 suboccipital area. And that includes the C-3/4, C-2/3 and
3 sometimes the C-4/5 level also in my experience.

4 BY MR. EGLET:

5 Q And why is that? What causes that?

6 A That is because there -- the nerves that innervate
7 the suboccipital area of the spine have branches that
8 originate in the upper cervical spine, the C-2/3, C-3/4 and
9 sometimes even into the C-4/5 area. And if there's irritation
10 originating from those segments in the spine, they can
11 irritate those nerves and that can cause pain to radiate into
12 the back of the head.

13 Q Okay. You see this diagram we have out here? Now,
14 count -- Dr. Fish testified yesterday that, while -- even if
15 he had a neck injury or disc injury at the C-3/4 and C-4/5
16 levels that it couldn't be -- it couldn't radiate up into the
17 occipital area because it would have to be an injury to -- at
18 the lowest the C-2/3 disc because it wouldn't be able to reach
19 up from an injury from the C-3/4 disc to the occipital region.
20 Do you agree with that?

21 A No, I do not.

22 Q Please tell me why.

23 A I think that's an overly simplistic analysis,
24 relying upon perhaps one anatomic diagram that shows that most
25 of the innervation to the occipital nerve comes from the C-2/3

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1 level. When in fact, in reality, the human anatomy is not so
2 absolutely clearly well defined. Every human being is
3 slightly different from the other. And the nerves that
4 innervate the back of the head originate in the upper cervical
5 spine. I think in most cases the primary innervation to the
6 occipital nerve to the greatest degree probably comes from the
7 C-2/3 level. But the C-3/4 and C-4/5 level commonly send
8 branches into that part of the human anatomy. And it is -- an
9 experienced spine specialist who evaluates patients with
10 spinal disorders will see patients that have pain radiating in
11 the back of their head which originates from the upper
12 cervical segments including commonly the C-3/4 and C-4/5
13 levels.

14 Q Okay.

15 A So I would state that if Dr. Fish said that that is
16 not possible because of this, I think that's incorrect.

17 Q Now, Doctor, can an injury to the upper segments of
18 the cervical spine also cause muscle tension headaches?

19 A Yes.

20 Q Okay. Can an -- can an injury to the proximal
21 segments of the cervical spine that causes occipital pain or
22 pressure and/or muscle tension headaches also trigger migraine
23 headaches in a patient who has a history of those types of
24 headaches?

25 A Yes. I believe that's possible.

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1 Q And how does that occur?

2 A Well, migraine headaches can be triggered by a
3 variety of phenomenon as we talked about earlier such as
4 photosensitivity or even pain. And if there is a new pain
5 generator in a patient, such as a separate new disc problem or
6 a facet problem, it can cause pain isolated to that level.
7 But that pain can also trigger pain related to a -- or
8 worsening of pain related to a preexisting history of migraine
9 problems which Mr. Simao apparently also had.

10 Q Do you believe that Mr. Simao has a component of
11 occipital neuralgia as one of his pain generating sites
12 causing his symptoms of occipital pain and suboccipital pain
13 and muscle tension headaches?

14 A Well --

15 MR. ROGERS: That's compound, Your Honor.

16 MR. EGLET: No, Your Honor.

17 THE COURT: Overruled.

18 THE WITNESS: Well, I think occipital neuralgia, I do
19 believe he had an element of occipital neuralgia. But
20 occipital neuralgia is, in my opinion, a broad based term. It
21 describes nerve pain in the occipital area. And that -- that
22 can frankly originate from a variety of problems, whether it's
23 an intrinsic occipital nerve problem or a problem originating
24 in the proximal cervical spine.

25 ///

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1 BY MR. EGLET:

2 Q Now, back to the treatment he was receiving at
3 Southwest Medical by these physician's assistants in April and
4 May -- actually April, May, through the summer, most of the
5 fall and -- at Southwest Medical Associates, was it
6 appropriate for Mr. Simao's midlevel medical providers at
7 Southwest Medical to obtain diagnostic imaging studies of his
8 head and brain to rule out intracranial regions?

9 A Yes, I think it was appropriate.

10 Q And why is that?

11 A Well, because Mr. Simao presented with a significant
12 mechanism of injury where he had acute onset of pain after
13 hitting the back of his head on a metal cage and was -- must
14 have been significantly symptomatic, including symptoms of
15 headaches that they felt that they needed to get a scan of his
16 head and his brain. And I think any good practitioner in an
17 urgent care setting is always concerned about missing some
18 type of a traumatic intracranial process which they correctly
19 ruled out.

20 MR. EGLET: Bottom of Page 20, please, Brendan.

21 BY MR. EGLET:

22 Q What was physician's assistant Brit Hill's plan for
23 Mr. Simao on May 26th, 2005?

24 A His plan was that he explained the results of the
25 studies to the patient. And his opinion was that he appeared

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1 to be understandable as it relates these issues. And he did
2 not seek further treatment and will continue with medications
3 on as needed basis for his migraine headaches.

4 Q What medications -- what medications were being
5 prescribed to Mr. Simao at this time?

6 A He was being prescribed Ibuprofen, 800 milligrams,
7 every eight hours, and Cyclobenzaprin or Soma, which is a
8 muscle relaxant, 10 milligrams, every three hours.

9 Q Are Ibuprofen --

10 A I'm sorry. Three times a day.

11 Q Are Ibuprofen and Soma, this muscle relaxer
12 medications, are they the medications that are normally used
13 for the treatment of migraine headaches?

14 A No, they're not.

15 Q What are those medications normally used to treat?

16 A Those medications are used to treat soft tissue
17 injuries or inflammatory -- one is an anti-inflammatory agent
18 and one is a muscle relaxant. So they're used to treat pain
19 and discomfort for soft tissue injuries or disc injuries and
20 pain disorders.

21 Q Are these -- in other words, are these medications
22 normally used to -- or prescribed for patients who have an
23 initial diagnosis of sprain/strains in their neck?

24 A Yes.

25 Q Now, do you fault Mr. Simao for following his

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1 medical providers instructions in treating his symptoms with
2 medications and returning for routine follow up in six months?

3 A No.

4 Q Why not?

5 A You know, I think that's -- that would be the
6 ordinary course for many people, including probably myself, if
7 I were having pain and discomfort. I would back to work and
8 try to manage with the pain hoping that it would go away. And
9 try to put up with it for as long as possible, if I could,
10 hoping that it would resolve.

11 Q What do you think about the fact that there was no
12 documentation, specific documentation of neck pain, in Mr.
13 Simao's medical records by the physician's assistants who saw
14 him at Southwest Medical from May until October 2005?

15 A You know, I don't place much significance to that
16 lack of documentation specifically of a neck problem. I think
17 Mr. Simao clearly had a neck problem, which is documented
18 clearly on his -- immediately after his traumatic event. He
19 had a mechanism of injury where he hit the back of his head,
20 had an acute hyperextension flexion injury to his neck. He
21 was being treated with medications, including an anti-
22 inflammatory and a muscle relaxant by the physician's
23 assistants who evaluated him, which are medications to treat
24 his neck problems so far as I believe and understand, not to
25 treat specifically migraines which he had preexisting.

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1 Medications for that or other medications such as Fiorinal.
2 And so I believe that he had ongoing neck pain and it was
3 simply not necessarily documented.

4 Q Can soft tissue injuries to the neck result in a
5 cervical spine sprain/strain?

6 A Yes.

7 Q Can soft tissue injuries to the neck result in
8 occipital pain?

9 A Yes.

10 Q Can soft tissue injuries to the neck result in
11 suboccipital pain?

12 A Yes.

13 Q Can soft tissue injuries to the neck result in
14 muscle tension pain?

15 A Yes.

16 Q Can soft tissue injuries to the neck result in
17 myofascial pain in the neck and its adjacent soft tissues?

18 A Yes.

19 Q Can all of the soft tissue symptoms that we have
20 just described and are related to an injury to the neck be
21 present at the same time that there is an injury to the
22 cervical spine discs?

23 A Yes.

24 Q And so can injury to the cervical spine discs result
25 in neck pain?

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1 A Yes.

2 Q And can they result in occipital pain?

3 A Yes.

4 Q And suboccipital pain?

5 A Yes.

6 Q And can they be associated with occipital neuralgia?

7 A Yes.

8 Q And can they be associated with trapezial pain?

9 A Yes.

10 Q And can an injury to the cervical spine disc be

11 associated with shoulder pain?

12 A Yes.

13 THE COURT: Mr. Eglet, it's come to my attention that one

14 or more of the jurors may need a break. Let's take a

15 ten-minute break.

16 [Court Admonishes Jury]

17 [Recess]

18 [Within the Presence of the Jury]

19 THE COURT: Please be seated, ladies and gentlemen.

20 Counsel, stipulate to the presence of the jury?

21 MR. EGLET: Yes, Your Honor.

22 MR. ROGERS: Yes.

23 THE COURT: Very well. Mr. Eglet.

24 MR. EGLET: Thank you, Your Honor.

25 ///

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DIRECT EXAMINATION CONTINUED

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BY MR. EGLET:

Q All right, Doctor. Let's see if we can get finished here. Before I go forward on Mr. Simao's conditions and treatment --

MR. EGLET: Could you bring up Exhibit 18, page 1, Brendan.

BY MR. EGLET:

Q Doctor, I'd first like you to go back to the record on the day of the accident, the record from Southwest Medical on the day of the accident. Now on the day of the accident, Mr. Simao was prescribed Flexural. Do you see that?

A Yes.

Q What is Flexural?

A Flexural is a -- that's -- it's a muscle relaxant.

Q What is it normally prescribed for in your experience?

A It's prescribed for skeletal muscle injuries, to patients who have muscle spasm, and frequently prescribed for patients who are traumatically injured.

Q Like neck injuries?

A Yes.

Q And is Flexural the same type of -- or same category of medication that we talked about earlier, when we were describing the Soma that was prescribed for him later?

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1 A Yes.

2 Q Okay. All right. Now, Doctor, can soft -- can the
3 soft tissue component of a neck injury initially be more
4 painful than a coexisting injury to one of the cervical discs?

5 A Yes, I think so.

6 Q And can the initial symptoms of a cervical spine
7 injury to the discs be masked by the coexistent symptoms of a
8 soft tissue injury in the neck?

9 A Yes.

10 Q How does this occur?

11 A Well, the soft tissue component of pain is a direct
12 injury to the soft issue, such as an extension flexion injury
13 to the neck. The muscles and ligaments are stretched and
14 pulled, and there's localized pain and inflammation in that
15 part of the anatomy, in the external part of the spine, the
16 external supporting structures of the spine, the paracervical
17 musculature, the trapezius, and the softer -- just general
18 soft tissue around the neck.

19 That does not necessarily -- I mean there can be and
20 there is commonly a more significant internal injury to the
21 spine, such as a disc injury. But initially, the pain, you
22 can't differentiate one from the other. There -- it's just
23 pain and discomfort. And the patient has neck pain after an
24 injury, it's -- there's really no way to say -- or to
25 differentiate what -- you know, a disc injury from a soft

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1 tissue injury in the acute phase, because both may be present.

2 Q If someone were to tell this jury that a patient
3 would always immediately note the onset of symptoms from a
4 cervical disc injury, would that be accurate?

5 A No.

6 Q Why not?

7 A Well, I think for the reasons that I just stated, to
8 -- there are -- to state that if a patient has a disc injury,
9 the onset would be immediate and known and evident to the
10 patient and any treating clinician is total- -- completely
11 inaccurate, I believe. As a treating physician, we frequently
12 see patients who are injured, have soft tissue injuries, and
13 may have a disc injury, and may not have a disc injury. But
14 that really is more commonly not established until later on,
15 as the patient is evaluated, depending upon how their symptoms
16 progress or do not progress.

17 Q Okay. Let's return to your treatment of Mr. Simao.

18 MR. EGLET: Exhibit 26, page 27, please, Brendan.

19 BY MR. EGLET:

20 Q And let's return to your May 6th, 2008 evaluation of
21 Mr. Simao. What had you recommended him at that time for his
22 persistent symptoms and potential subaxial cervical facet
23 pathology at C4 -- C3/4 and C4/5?

24 A On that date, May 6th, I recommended a CT scan to
25 better understand the facet and some electrodiagnostic studies

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1 of his upper extremities.

2 Q Okay.

3 MR. EGLET: And page 33, please, Brendan.

4 BY MR. EGLET:

5 Q When Mr. Simao represented to you for evaluation on
6 June 17th, 2008, had the CT scan and the cervical spine been
7 completed?

8 A No, I don't think so.

9 Q What were the results of the flexion extension
10 x-rays that you obtained on him at that time?

11 A They revealed in my opinion no gross instability,
12 although there appear to be some subtle subluxation at the
13 C4/5 level. And --

14 Q What -- I'm sorry. Were you finished?

15 A I was going to say and by subluxation, I mean
16 subluxation is a term that we -- it means slight potential
17 movement, where when the neck bends forwards, backwards, and a
18 flexion extension actually -- a flexion extension actually is
19 where you get one x-ray with the patient bending forward and
20 one x-ray with the patient bending backwards. And what we're
21 looking for usually is any abnormal translation between the
22 vertebral body segment. And what I documented was that to my
23 review there was no gross instability, but there appear to be
24 some potential subtle subluxation, meaning some slight
25 movement at C4/5 that was more so than I could see, perhaps,

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1 between other segments, such as C5/6 or C3/4.

2 Q All right. What was Mr. Simao's status on June
3 17th, 2008?

4 A It was essentially the same. He had persistent neck
5 pain, left para- -- left pain around the shoulder blade area,
6 and pain in the back of the head.

7 Q What did you mean when you noted ongoing intractable
8 -- I guess I'm on the wrong note. I'm on a different note.

9 MR. EGLET: Okay. Go to page -- still on page 33.
10 BY MR. EGLET:

11 Q Was positive physical examination findings did you
12 document at this visit?

13 A He, again, had a positive Spurling sign on the left
14 and tenderness and spasm in the periscapular area.

15 Q And what was your clinical impression at this time?

16 A Again, that he had ongoing pain, persistent symptoms
17 potentially related to disruption of the disc or facet
18 mediated pathology at the C3/4 and C4/5 level.

19 Q And was he still complaining of the suboccipital
20 headaches?

21 A Yes, he was.

22 MR. EGLET: Go to page 3, please, Brendan.

23 BY MR. EGLET:

24 Q At the time of your June 2008 evaluation of Mr.
25 Simao, did you know that he had undergone left sided C4 and C5

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1 selective nerve root blocks?

2 A Yes.

3 Q Okay. And were -- had those been performed by Dr.
4 Rosler on May 10th?

5 A Yes.

6 Q And did you -- did Mr. Simao obtain any long-term
7 symptomatic improvement in his pain symptoms from these
8 blocks?

9 A No.

10 Q And how did Mr. Simao's lack of clinical response to
11 these C4 and C5 selective nerve root blocks affect your
12 clinical decision making regarding a differential diagnosis of
13 disc disruption versus facet mediated pathology?

14 A Well, I don't think I -- I think they help me
15 isolate the segment of pain that I believe that he had pain
16 coming from the C3/4 and C4/5 levels in his neck, which are
17 the levels where we have, relatively consistently, found some
18 abnormalities. He got some temporizing improvement through
19 the fluoroscopically guided selective nerve root block,
20 suggesting that there was pain originating from that level.
21 But I don't think I could clearly separate facet from disc
22 mediated pain. It could still be a combination of both. I
23 wasn't sure whether it was disc or facet, or what part of that
24 particular anatomy was causing his pain. But I felt that that
25 is where his pain -- was where his pain was originating from?

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1 Q At those levels?

2 A Yes.

3 Q Okay.

4 MR. EGLET: Go to page 33, please, Brendan.

5 BY MR. EGLET:

6 Q And, Doctor, why did you consider disc disruption as
7 a potential clinical problem for Mr. Simao in June 2008?

8 A Well, I think one has to put -- include that as a
9 differential diagnosis, because it's -- we're talking about a
10 gentleman who's had pain for the past period of more than
11 three years. The MRI scan shows some disc abnormalities, some
12 bulging, some slight protrusion at those levels based on the
13 radiologist reports. To my review, there was no substantial
14 of herniation or mechanical neural encroachment. But disc
15 disruption is something that is one of those conditions that
16 can manifest itself as longstanding persistent pain because of
17 a compromise and injury to the disc that is not so clearly
18 defined on the MRI scan.

19 Q Can you see disc disruption on an MRI scan, internal
20 disc disruption?

21 A Well, I mean you can sometimes see abnormalities to
22 suggest compromise of the disc, such as what we call reduced
23 signal intensity in the disc or some bulging of the disc. But
24 the term internal disc disruption is more definitely, you
25 know, diagnosed by discography of the cervical spine.

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1 Q Okay. What did you recommend to Mr. Simao at that
2 time, in June of 2008?

3 A You know, at that time, I recommended that he
4 consider -- that we consider discography of the cervical spine
5 to better understand his condition.

6 Q And would cervical discography of the cervical spine
7 evaluate both the potential disc disruption and a facet
8 pathology in Mr. Simao's cervical spine?

9 A I don't -- I think it helps to isolate, you know, to
10 a greater degree, a certain degree, the potential source of
11 pain, you know. And discography is really designed to
12 evaluate the disc. The post-discogram CT scan helps us
13 evaluate the segment.

14 Q Okay. Is discography the gold standard set forth by
15 the North American Spine Society by which internal disc
16 disruption is diagnosed?

17 A Yes, it is.

18 Q Okay. Did you use clinical guidelines before you
19 recommended cervical discography on Mr. Simao?

20 A Sure. I believe we did.

21 Q Could you explain for us what clinical guidelines
22 you followed and how come you recommended to Mr. Simao the
23 cervical discography?

24 A Well, I mean cervical discography is not -- is a
25 interventional procedure whereby some dye is injected into the

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1 disc and pictures are taken of the disc after the dye is
2 injected, and it is performed in a controlled setting, whereby
3 we're trying to elicit some type of provocative response and
4 in a blinded manner, whereby the patient does not know which
5 disc is being injected, trying to see if pain can be
6 reproduced in a similar pattern of pattern, the origina- --
7 that the patient is complaining of his pain symptoms.

8 So, you know, it's a -- there's controversies in all
9 parts of medicine. Discography is one of those areas that is
10 probably a little bit more controversial in the arena of spine
11 care but, nevertheless, is really an important part of the
12 diagnostic assessment of patients who have, you know,
13 complicated, difficult to diagnose spine problems in a
14 sophisticated spine practice.

15 And you know, Mr. Simao had had pain for more than
16 three years, including several months during which time I had
17 treated him prior to the time that I recommended discography.
18 And we had not clearly isolated a source of pain for him, and
19 he was having ongoing symptoms for which he was requiring
20 medication and finding to be, at time, debilitating. And I
21 think taking into consideration the duration of his symptoms,
22 the degree of his symptoms, the treatment that he had had to
23 that point, I think it was a perfectly reasonable time to
24 include that in the diagnostic, this type of treat- --
25 modality in the diagnostic assessment of Mr. Simao.

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1 MR. EGLET: Could you to page 34, please, Brandon?

2 BY MR. EGLET:

3 Q Doctor, what were the results of the cervical
4 discography that Dr. Rosler performed on Mr. Simao?

5 A The discography confirmed that there was compromise
6 at the C3/4 and C4/5 level, where the patient reported a
7 concordant pain, whereby he experienced similar pain to that
8 which he had been generally experiencing.

9 Q And did he document a normal control level at the
10 C5/6 level?

11 A He did. He documented -- Dr. Rosler identified that
12 by injection of the C5/6 level, he did not experience any
13 other pain that he had been having.

14 Q If someone were to tell this jury that Dr. Rosler
15 did not adequately perform cervical discography because the
16 lower segments he injected were intra-annular injections,
17 would that be accurate?

18 A No, I don't think so. I looked at the discogram
19 that Dr. Rosler performed. I read the report that the
20 radiologist developed looking at the CT scan immediately after
21 the discogram. And you know, in my experience, Dr. Rosler is
22 a, you know, technically superior clinician and physician, and
23 I am very confident in his ability to perform a discography
24 well.

25 Q If someone were to tell this jury that cervical

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1 discography was not indicated because Mr. Simao had a normal
2 MRI, would that be accurate?

3 A No, it would not be accurate.

4 Q And why not?

5 A Because discography is -- when it is used, it is
6 actually frequently used in patients who have persistent
7 symptoms. We cannot clearly understand, perhaps, why they
8 have symptoms. Perhaps because they have a relatively normal
9 MRI scan. If they have a clearly abnormal MRI scan, more
10 often than not, we don't even need to do discography, because
11 we can see the problem on the MRI scan.

12 We actually use discography, especially in the
13 cervical spine, in my experience, only when we have greater
14 difficulty isolating the problem, and frequently when the MRI
15 scan is not that abnormal. If someone were to suggest, well,
16 the MRI scan wasn't that abnormal, so there was no reason to
17 do the discography, well, that's contrary to the indication to
18 the discography, because if the MRI scan was clearly abnormal,
19 we wouldn't need to do the discogram.

20 In my practice, and I think in most clinical
21 practices, discography in the cervical spine is actually used
22 quite judiciously, because it is helpful in selected cases
23 but, more often than not, really not necessary. We can
24 usually isolate the problem based on an MRI scan, or a CT
25 scan, or a selective nerve root block, and these type of

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1 things.

2 I only discography, or recommend it, in cases that
3 are more difficult to understand, in a case where the MRI scan
4 is not clearly abnormal. So I would disagree with that
5 statement if that's a statement that has been made.

6 Q If someone were to tell this jury that the results
7 of Mr. Samoa's' cervical discography were invalid and
8 represented a false positive finding, because he had a normal
9 MRI, would that be accurate?

10 A No.

11 Q Why not?

12 A Well, I think for the same reasons that I just
13 mentioned. I -- and discography specifically isolate and
14 occasionally identify pathology that is not picked up on an
15 MRI scan. And to suggest that it's a false positive because
16 the MRI scan is normal is incorrect. And in this particular
17 case, the MRI scan, in fact, was not normal. There were
18 abnormalities, actually, at C3/4 and C4/5 documented by the
19 radiologist, but in my opinion relatively subtle
20 abnormalities, some slight disc protrusions, nothing overtly
21 abnormal that one would look at the MRI scan and say oh, gosh,
22 that's definitely the problem. But certainly, one would look
23 at the MRI scan and say that's not perfectly normal. There
24 may be something going on here. And that's when you employ
25 discography to try to further evaluate that possible problem.

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1 Q And, Doctor, what was your clinical impression of
2 Mr. Simao following completion of his evaluation by you on
3 September 2nd, 2008?

4 A You know, I think on September 2nd, 2008, it looks
5 like I met with him for some length. And he presented with
6 his wife at that time. And you know, we went over all of the
7 diagnostic studies, the pattern, degree, intensity, duration
8 of his symptoms.

9 You know, I recall, I believe, looking at all this
10 -- these imaging studies, evaluating him as it relates to the
11 intensity and pattern of his pain, and reviewing with him the
12 risks and benefits of surgery as an option to try to help him,
13 because he had not gotten better satisfactorily through all of
14 the other modalities that had been tried. And he had
15 pathology that appeared to be emanating from the C3/4 and C4/5
16 segments in his neck. And I think we talked about surgery as
17 an option to try to help him.

18 Q Did you diagnose him -- clinically diagnose him at
19 that time that he had C3/4 and C4/5 internal disc disruption?

20 A Yeah. My impression was C3/4 and C4/5 disruption of
21 disc with left-sided facet arthrosis and foraminal stenosis.

22 Q And how did you clinical determine that Mr. Simao
23 had left facet arthrosis and foraminal stenosis?

24 A Based on my review of the imaging studies, including
25 the MRI scans and the CT scans that he'd had done.

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1 Q Had you ruled out or ruled in cervical facet
2 mediated pain syndrome with Mr. Simao at that time?

3 A Oh, I think he had a component of facet mediated
4 pain. I think that was part of his symptom complex in my
5 opinion.

6 Q Was that important to you?

7 A Yes. I think it was all important to try to -- you
8 know, everything as it relates to trying to isolate the source
9 of his pain, I mean, was important.

10 Q What did you recommend for Mr. Simao in September
11 2008?

12 A Well, we talked about surgery as an option,
13 including the option of an interbody fusion at the C3/4 and
14 C4/5 levels. I also gave consideration to a simple left C4
15 and C5 neural foraminotomy, which is a procedure just to
16 unpinch the nerve in that area and open up the space around
17 the nerve. And these are the -- you know, the surgeries that
18 we talked about as an option. And I think I would have
19 counseled as it relates to the risks and the benefits so that
20 he could try to consider, to warrant proceeding with that or
21 whether he could try to live with the pain.

22 Q And why did you feel Mr. Simao was a reasonable
23 candidate for surgical -- intervention surgery at that time?

24 A Because I think his pain intensity was significant.
25 I think he always presented to me in a credible manner, was --

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1 appeared to be a fellow that was dealing with pain that was,
2 at times, debilitating to him, and wanted to get better. And
3 because I felt that the pain generating levels, C3/4 and C4/5,
4 had been adequately isolated to that point based on all of the
5 diagnostic studies that had been done.

6 Q If someone were to tell this jury that the C3/4 and
7 C4/5 discs were not pain generators, would that be true?

8 A I don't think that would be true, no.

9 Q Why?

10 A Because I think the discs were pain generators,
11 because they were abnormal on imaging studies, including CT
12 discography, and resulted in pain consistent with a pattern of
13 pain that the patient had been experiencing.

14 Q After your orthopedic spine evaluation of Mr. Simao,
15 your treatment of him, your evaluation and the diagnostic
16 studies that had been performed, your review of his history,
17 did you reach any conclusions with respect to what injuries he
18 sustained directly and causally from the April 15th, 2005
19 motor vehicle wreck.

20 MR. ROGERS: Objection, foundation, Your Honor.

21 MR. EGLET: We've laid foundation for two hours, Your
22 Honor.

23 THE COURT: I think you have. Overruled.

24 THE WITNESS: I think Mr. Simao sustained a significant
25 soft tissue injury to his neck with an underlying injury to

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1 his C3/4 and C4/5 discs. And I think he had some facet
2 anomalies at the C3/4, C4/5 level, which were implicated and
3 became precipitated as a source of pain. I think he had pain
4 symptom complex related to a traumatic injury at C3/4 and at
5 C4/5.

6 BY MR. EGLET:

7 Q And the C3/4 and C4/5 was disc disruption?

8 A Correct.

9 Q Okay. Are your conclusions regarding the cause of
10 Mr. Simao's injuries more likely right than wrong?

11 A I think that I'm right -- they were right.

12 Q Okay. And beyond that, are you certain, Doctor?

13 A I'm sorry. Can you say that again?

14 Q Beyond that, beyond just more likely right than
15 wrong, are you fairly certain?

16 A Yes.

17 Q Okay. And could you just summarize for us how you
18 causally relate the diagnosis of the C3/4, 4/5 disc disruption
19 and the other diagnosis you told us for Mr. Simao as being
20 caused by the April 15th, 2005 motor vehicle accident?

21 A Well, I think that one of the most important factors
22 that we take into consideration is the chronology and
23 development of a patient's symptoms. And we -- and
24 inevitably, any -- we have to take that into consideration,
25 because Mr. Simao, so far as I know and so far as everything I

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1 have reviewed, did not have any problems such as this prior to
2 the event in 2005, at the time of his rear end motor vehicle
3 collision.

4 He had an injury where he had an acute probable
5 hypertension injury to his neck, banged the back of his head
6 on the metal cage of the vehicle, and hit the -- and then bent
7 -- and then his neck probably went forward, symptoms for which
8 he was clearly evaluated a few hours after the event at the
9 Urgent Care, documenting these findings, symptoms at that time
10 which were significant enough for the physician assistant
11 evaluating him to order a scan of his head and his brain to
12 make they didn't miss anything correctly, and symptoms which
13 persisted since that time for several years, despite all
14 reasonable and appropriate treatments, including physical
15 therapy, anti-inflammatories, muscle relaxants, and some
16 periodic injections into the spine. So I think if you look at
17 the chronology and development of the patient's symptoms, take
18 into consideration the mechanism of injury, and take into
19 consideration the identified pathology, which, you know, is
20 not a clear blown herniated disc, but there's abnormalities
21 which have taken some more sophisticated analysis over several
22 years to really isolated, I think, within a reasonable degree
23 of medical probability, that event, you know, caused his
24 problems for which he was treated.

25 Q Doctor, has the medical care and treatment rendered

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1 by you to Mr. Simao that you have described to us here today
2 been necessary, reasonable, and causally related to the
3 injuries he sustained from the April 15th, 2005 motor vehicle
4 wreck?

5 A Yes.

6 Q Okay. Was the medical care rendered to Mr. Simao at
7 Nevada Spine Clinic, Newport MRI, Center for Spine and Special
8 Surgery, Las Vegas Radiology, and Nevada Anesthesia
9 Consultants also necessary, reasonable, and causally related
10 to the injuries he sustained from the April 15th, 2005 motor
11 vehicle wreck?

12 A Yes.

13 Q Doctor, to your left there is a binder. It's
14 Plaintiff's -- one of Plaintiff exhibit books. If you could
15 look at Exhibits -- just briefly look at Exhibits 10, 11, 12,
16 13, and 14, please.

17 MR. EGLET: May I approach the witness, Your Honor?

18 THE COURT: Yes.

19 [Pause]

20 THE WITNESS: Yes.

21 BY MR. EGLET:

22 Q Okay. Are these the billing statements for the
23 treatment that you and Dr. Rosler and your clinic provided to
24 Mr. Simao?

25 A Yes, I believe they are.

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1 Q Okay.

2 MR. EGLET: Brendan, could you bring up the medical
3 specialist chart, please?

4 BY MR. EGLET:

5 Q And, Doctor, is the amount for Nevada Spine Clinic
6 \$3,465?

7 A Yes.

8 Q Is the amount for Newport MRI \$1,775?

9 A Yes.

10 Q Is the amount for Center for Spine and Specialty
11 Surgery \$15,077?

12 A Yes.

13 Q Is the amount for Nevada Anesthesia \$500?

14 A Yes.

15 Q And is the amount for Las Vegas Radiology \$1,100?

16 A Yes.

17 Q Is the billing associated with the treatment
18 provided by you, Nevada Spine Clinic, Nevada MRI, Center for
19 Spine and Specialty Surgery, Nevada Anesthesia Consultants,
20 and Las Vegas Radiology for Mr. Simao customary and reasonable
21 for patients in Clark County, Nevada?

22 A Yes.

23 Q And are your conclusions regarding the care that Mr.
24 Simao was rendered by all of the providers that you have just
25 reviewed with us, as well as the associated costs, more likely

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1 right than wrong?

2 A They are wrong.

3 Q Okay. And I want to -- before I can do the final
4 concluding questions, I want to ask you a few questions about
5 some testimony that was given yesterday by Dr. Fish. Dr. Fish
6 testified yesterday that, in his opinion, Mr. Simao was not
7 injured at all in the April 2005 motor vehicle wreck. Would
8 you agree with that?

9 A No.

10 Q Dr. Fish testified yesterday that the gate theory of
11 pain could not explain Mr. Simao's initial clinical
12 presentation, because all disc injuries occur with immediate
13 onset of symptoms and are obvious and felt by the patient
14 right away. Would you agree with that?

15 A No, I would not.

16 Q Okay. Dr. Fish also testified that it would be
17 highly unusual for symptoms of disc injury not to be
18 clinically recognized within 48 to 72 hours from the time of
19 the injury. Would you agree with that?

20 A No, I would not agree.

21 Q Why not?

22 A I think we went over some of that. That's -- those
23 are all I think very unrealistic representations, because just
24 as we went over, if somebody is injured, there's absolutely no
25 way to look inside of their spine and say they do or do not

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1 have a disc injury when they're complaining of neck pain.
2 They may have a disc injury. They may not. But they've
3 injured themselves and they're in pain, and they've got soft
4 tissue pain and possibly something structural, possibly not.
5 The only way to know would be to obtain imaging studies of
6 that part of the anatomy right away.

7 It's fairly intuitive for anyone to understand that.
8 And for anyone to say something different I think is not
9 reasonable in my opinion.

10 Q Dr. Fish also testified yesterday that he had never
11 seen a patient with a cervical disc injury that was diagnosed
12 with that injury more than one-and-one-half months from the
13 date of the date of the injury. In your practice, do you ever
14 see patients with cervical disc injuries that present to you
15 more than one-and-one-half months from the date of the injury
16 and whom you subsequently diagnose with cervical disc
17 injuries?

18 A Absolutely. Most patients that we see present after
19 that period of time, because most patients are reasonable
20 people who have an injury, and they hope that their pain is
21 going to get better, and they wait a little time, and they try
22 some medications, and they do this or that. And if it doesn't
23 get better, then they go see the doctor. That's just the
24 normal course for most reasonable people.

25 Q Dr. Fish also testified yesterday that if Mr. Simao

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1 did not present to his treating providers within 48 to 72
2 hours with severe neck pain, upper extremity pain, upper
3 extremity weakness, severe upper extremity paresthesia, and/or
4 bowel and bladder dysfunction, that he could not have had a
5 cervical disc injury. Do you agree with that?

6 A No.

7 Q Why not?

8 A Well, I think it's -- I mean it's completely
9 unreasonable. It's just -- I mean I don't know how to respond
10 to that. It's not -- I mean I take care of a lot of patients
11 who have serious problems, such as spinal cord injuries, and
12 paralysis and fractures of the spine, and these are very
13 serious disorders. And those are unequivocally clear cut,
14 because somebody has fallen off of a building or been involved
15 in a vehicle crash and fractured their spine, and they're
16 paralyzed or they've got incontinence of bowel and bladder
17 function. But many patients don't have dramatic catastrophic
18 injuries such as suggested by those symptoms that would be
19 necessary for many of those complaints and -- in that -- what
20 you just told me. Many patients have soft tissue injuries and
21 pain and discomfort. And those are the type of things that we
22 really evaluate on an ongoing basis and really go through the
23 process of trying to help people when we can through further
24 diagnostic assessment. But I just -- I think it's
25 unreasonable.

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1 Q Dr. Fish also testified yesterday in front of this
2 jury that -- using this hypothetical, that these disc in your
3 cervical spine was like a coffee table in the middle of your
4 house, and that the coffee table was supported and surrounded
5 by all the structures of your house, like the walls and
6 everything. And just like a coffee -- just like in order to
7 injure the coffee -- or damage the coffee table in the house
8 from an outside trauma, that you would have to basically knock
9 all the walls down and destroy the house to get -- damage the
10 coffee table. And with the MRI up on the screen in front of
11 the jury, he told them that so, you have all these surrounding
12 structures of your disc in your neck. You have muscles. You
13 have tendons. You have ligaments that surround the muscles in
14 your -- or the disc in your neck. And so, in order to injure
15 those discs, you would see -- you would have to see the
16 tearing of all of these outside structures in your neck that
17 surround the disc, like your muscles and your tendons and your
18 ligaments, and you would have swelling, and this would all be
19 obvious on the MRI if you had an injury to your disc. Do you
20 agree with that?

21 A No, I do not.

22 Q Tell us why.

23 A Again, it's -- I mean that's a completely
24 unreasonable analogy or description, I think. That suggests
25 that you have to cut somebody's throat to injure their neck,

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1 or they have to be -- their entire soft tissue around their
2 neck has to be destroyed before you can actually get to or
3 injure a disc in the neck, and I think that's just completely
4 -- I mean it's different to respond to things like that. It's
5 just completely unreasonable.

6 I mean I take -- I've been taking care of spinal
7 cord injuries at the University Medical Center here for almost
8 16 years, and we see patients who have MRI scan evidence of
9 soft tissue injury in the neck after a major traumatic event.
10 And when we see that, we look at those cases very, very
11 carefully, because if we can see actual soft tissue injury in
12 the neck on an MRI scan, that suggests a tremendous force or
13 injury to a patient's spine. And it suggests a potentially
14 underlying injury or ligamentous injury or -- to the cervical
15 spine that, you know, we look at exceptionally carefully,
16 because we don't want to miss something that, you know, might
17 result in a patient incurring a neurologic event or paralysis
18 if we miss something.

19 I mean, by far, most people who have disc injuries
20 have no discernible evidence of -- MRI scan evidence of a soft
21 tissue injury to the neck. The soft tissue injury to the neck
22 is a clinical diagnosis. If the patient has a whiplash injury
23 and hit -- bangs their neck back and forth, and they've gotten
24 neck pain, well, they've had a soft tissue injury to their
25 neck. They've got pain in their neck. They strained a

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1 muscle. That's a clinical diagnosis. You're not going to see
2 a strained muscle on an MRI scan.

3 If you see a strained muscle on an MRI scan, that
4 means the muscle must have been really stretched and pulled
5 that fluid has poured into the muscle. And more likely than
6 not, you may have had a serious unstable injury to the neck.
7 That's a completely different category of problem. That's the
8 type of stuff we see at the trauma center not in an urgent
9 care. The patient presents to the urgent care, it's usually a
10 strain/sprain to the neck. You're not going to see any
11 identifiable soft tissue problem on an MRI scan. But the
12 patient may have had a disc injury, sure. I mean it's very
13 possible, and it's not uncommon. And so, I mean I don't know
14 how to respond to that other than I think it's not reasonable.

15 Q Thank you, Doctor. Finally, one more last question
16 about Dr. Fish's testimony. Dr. Fish testified yesterday that
17 when he evaluated Mr. Simao, he documented that his pain level
18 was a seven to eight on the scale -- on the analog pain scale
19 of zero to 10, and that this documentation on the analog pain
20 scale was not consistent with Mr. Simao being able to function
21 with activities of daily living or being able to work. Would
22 you agree with that testimony?

23 A No, I would not.

24 Q Why?

25 A You know, again, it seems -- I mean the visual

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1 analog scale for pain is a patient's perception of how they
2 feel. It has nothing to do with whether they can go back to
3 work or whether they can work. In fact, I think most
4 responsible clinicians encourage patients to continue to work
5 and remain active. Simply because they've got pain seven out
6 of -- eight out of 10, well, that's not a -- that's no reason
7 to say hey, you shouldn't go to work. Well, not going to work
8 isn't going to stop their pain, depending on what kind of work
9 they're doing. If anything, if a patient does continue to
10 work, I usually look at that as a good thing, because they're
11 really trying to remain as active as possible. And I -- to
12 suggest that the visual analog scale has anything to do with
13 functional capacity and a patient's ability to return to work
14 is I think misleading and misrepresents what the visual analog
15 scale is. And that's simply a patient's own perception of how
16 bad they feel their pain is.

17 Q Okay. Doctor, are all the conclusions you have
18 shared with us here today, have they been to a reasonable
19 degree of medical probability?

20 A Yes, they have.

21 Q And by that, do you mean your conclusions are based
22 on medical reason?

23 A Yes.

24 MR. EGLET: Thank you, Your Honor. Pass the witness.

25 THE COURT: Very well.

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1 Mr. Rogers.

2 MR. ROGERS: Very good. Just go forward?

3 THE COURT: I'm sorry.

4 MR. ROGERS: Just go ahead with it?

5 THE COURT: Unless someone needs a break. Does anyone
6 need a break? You'll let me know if you need one, right?

7 THE WITNESS: Can you take about an hour break right
8 about now?

9 CROSS-EXAMINATION

10 BY MR. ROGERS:

11 Q All right. Now to begin with, you testified that
12 this accident presented a significant mechanism of injury. So
13 I want to explore everything you know about this car accident.

14 MR. EGLET: Your Honor, I'm going to object. May we
15 approach?

16 THE COURT: Yep. Yes, I mean.

17 [Begin Bench Conference]

18 MR. EGLET: He didn't say that this represented any
19 significant mechanism of injury. When he used the term
20 significant mechanism of injury he was talking about major car
21 crash that tears the tendons and the muscles in the neck. All
22 he said was mechanism of injury. He did not say significant
23 mechanism of injury with respect to the history in this case.

24 THE COURT: I understood his testimony.

25 MR. ROGERS: He actually said it was a significant --

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1 connected to a significant injury that caused his head to
2 hyperextend and hit the cage, and then to flex forward.
3 That's exactly the context in which he said it.

4 MR. EGLET: Well, what he's trying to do, he's --
5 obviously, he's thinking that he's going to be able to get
6 into the specifics of this accident and go into -- and violate
7 the Court's ruling about the fact that he can't talk -- bring
8 up any speeds or the nature of this accident, that -- their
9 claim that it was a minor impact. And that's where he's going
10 with this.

11 THE COURT: Is that where you intend to go, Mr. Rogers?

12 MR. ROGERS: Here's where I'm going with it is that it
13 seems now that the doctor is permitted to say things about
14 this accident, to characterizing it as a significant mechanism
15 of injury, and the defense is not being permitted to respond.
16 I mean he's the one who said -- then the Plaintiff is the one
17 who introduced it, and the defense is entitled to answer that
18 change.

19 MR. EGLET: I don't --

20 MR. ROGERS: We didn't elicit that testimony.

21 MR. EGLET: First of all, I don't believe he used the
22 term significant. I believe he used the term mechanism of
23 injury. But what -- when -- that was in reference to was the
24 fact that there was documentation in the Southwest Medical
25 records that there was a hyperexten- -- hyper-flexion, and

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1 that he hit the back of his head on the catch. Now that's
2 undisputed. That's in the records, and that's all he was
3 talking about. He wasn't characterizing the accident like he
4 knew what happened.

5 THE COURT: He didn't perceive --

6 MR. ROGERS: These were his ways.

7 THE COURT: He didn't perceive it that way at all. I
8 mean I think you can cross-examine him based on the medical
9 records as being reviewed to give him knowledge about how this
10 incident occurred, but I don't think you can kind of twist his
11 response around to try to get into an area that's been
12 excluded.

13 MR. ROGERS: What I want to do is ask him where it was he
14 got the impression that led him to testify as he did, and what
15 is the basis of that --

16 MR. EGLET: Well, first of all, I don't --

17 MR. ROGERS: -- testimony.

18 MR. EGLET: All he talked about was the hyper-

19 THE COURT: Uh-huh.

20 MR. EGLET: -- hyperextension and flexion and he hit his
21 head. He -- we know where he got it. He was reading the
22 Southwest Medical record. It was right up in front of him.

23 MR. ROGERS: The first day.

24 THE COURT: I think you can follow up in cross-examining
25 him with that particular record that he reviewed, but, you

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1 know, I don't think -- I think what you stated to him is,
2 essentially, a mischaracterization of the testimony that he
3 gave.

4 MR. ROGERS: What then do we do if we get the transcript
5 of his testimony and I'm correct, and he has said those exact
6 words, he has called this a significant mechanism --

7 MR. EGLET: He's --

8 MR. ROGERS: -- we can see then if that's correct, that
9 the --

10 THE COURT: I understood him to be describing the injury.

11 MR. EGLET: He's talking about the hyper-flexion
12 extension and hitting his head on the cage. He's not
13 talking --

14 THE COURT: [Indiscernible].

15 MR. EGLET: He's not talking about the damage to the
16 vehicles or anything.

17 MR. ROGERS: He's not. I'm not talking about the damage
18 to the vehicles.

19 MR. EGLET: Oh, sure, you are. That's what you want to
20 get into. You want to get into that this is low speed --

21 MR. ROGERS: No.

22 MR. EGLET: -- and blah, blah, blah, that's --

23 MR. ROGERS: It has nothing to do with the property
24 damage. What it has to do with is the Plaintiff's response to
25 this impact, and he is describing that as significant.

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1 MR. EGLET: And --

2 MR. ROGERS: And I want to understand where he got that
3 information.

4 MR. EGLET: And the nature of the impact is not -- you
5 just used the right word, the impact, which is the collision
6 between the vehicles. The nature of the impact has been
7 excluded. What he was talking about was his head moving back
8 and forth and hitting the metal cage behind his head. That --

9 THE COURT: He talked about the --

10 MR. EGLET: That's what he was talking about.

11 THE COURT: He talked about the mechanism of the injury.
12 But in any event, you've got the record, so you can pull the
13 record and cross-examine him based on what his understanding
14 of the record was.

15 MR. ROGERS: Only the medical record?

16 MR. EGLET: What?

17 THE COURT: Well --

18 MR. EGLET: She's talking about the Southwest Medical
19 record.

20 MR. ROGERS: What I want to know is if I can cross-
21 examine what he said not just the basis for what he said, but
22 what he actually told the jury.

23 THE COURT: Well --

24 MR. EGLET: What he told the jury was about the neck
25 going back and forth and hitting the cage.

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1 MR. ROGERS: I'm telling you I wrote it as he spoke it.
2 And what he said --

3 MR. EGLET: No. You're mistaken. You're not -- you're
4 taking it out of context.

5 MR. ROGERS: That's exactly what he said, Your Honor.

6 MR. EGLET: This does not open the door for them to get
7 into that in any way, shape, or form --

8 THE COURT: Yeah, I don't --

9 MR. EGLET: -- which is what he's trying to argue here.

10 THE COURT: I don't think it opens the door. I think
11 you're entitled to inquire of him, but I'm urging you not to
12 violate any court orders [indiscernible]. So proceed on that
13 basis.

14 MR. ROGERS: Okay.

15 [End Bench Conference]

16 BY MR. ROGERS:

17 Q All right. To this testimony then about the
18 significant mechanism of injury. Do you know anything about
19 this car accident that supports that characterization?

20 A Yeah. Well, what I mean by significant mechanism of
21 injury, and I believe what I was trying to communicate by that
22 is that the patient had pain in his neck which is not
23 unplausibly [sic] and is commonly caused by that type of
24 injury. So it was significant because he had an injury, as
25 far as I'm aware, where he was the restrained driver in a

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1 vehicle that was rear ended. His neck, in all likelihood,
2 hyperextended back. He hit the back of his head on the metal
3 plate, and his neck probably went forward. So I believe
4 that's significant in that that can cause neck problems.

5 Q And your understanding is from where?

6 A That understanding is based upon the history that
7 was provided to me by the patient, that's documented within my
8 medical records, and the history that was provided to the
9 urgent care that I reviewed the medical records of from the
10 physician assistant that took that history.

11 Q Okay. Now -- so you've used two different words for
12 this item that you understand the Plaintiff struck his head
13 on. One is a cage, and one is a plate. What's your
14 understanding of this thing?

15 A Well, I -- whether it's a cage or a plate, it's some
16 metal surface that he hit the back of his head on.

17 Q What's your understanding as to whether it is
18 cushioned or there's a headrest there?

19 MR. EGLET: Objection, Your Honor. There's no foundation
20 for that.

21 THE COURT: Sustain the objection. Ask you to rephrase.
22 BY MR. ROGERS:

23 Q Is it your understanding then that there was no
24 protection there in the form of a cushion, that there was
25 simply a cage or a plate?

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1 MR. EGLET: Objection, lack of foundation.

2 THE COURT: Same ruling. Sustained.

3 BY MR. ROGERS:

4 Q And the objection goes to the question, Doctor, and
5 that is --

6 MR. EGLET: Could we not have --

7 BY MR. ROGERS:

8 Q -- do you know this?

9 THE COURT: Can I have counsel approach, please?

10 MR. EGLET: Objection was sustained.

11 [Begin Bench Conference]

12 THE COURT: It was sustained, and I don't --

13 MR. ROGERS: No. I'm getting into the -- he's talking
14 about this motion back and forth --

15 MR. EGLET: You're arguing with the Court's --

16 MR. ROGERS: How far back did his head go.

17 MR. EGLET: You are -- there's no foundation for any of
18 that.

19 THE COURT: Well, the reason I called you up is here you
20 asked the very same question after I sustained Mr. Eglet's
21 objection, and I'm wondering why you're doing that.

22 MR. ROGERS: He's explaining that there's something
23 there, and it's becoming clear that he doesn't know what it
24 is. And that's what I'm --

25 MR. EGLET: The reason I think you're --

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In the Supreme Court of Nevada

Case Nos. 58504, 59208 and 59423

JENNY RISH,

Appellant,

vs.

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

Respondents.

Electronically Filed
Aug 14 2012 04:09 p.m.
Tracie K. Lindeman
Clerk of Supreme Court

APPEAL

from the Eighth Judicial District Court, Clark County
The Honorable JESSIE WALSH, District Judge
District Court Case No. A539455

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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

1 vertebral bodies. Okay. And what you're looking for with the
2 disc is that you see a little bit of whiteness within that
3 disc. That means that it's a disc that's hydrated, or a
4 fluffy type of disc. And you can see that the 3/4 has
5 hydration. All of these have hydration. If anything, the
6 C2/3 has maybe a little bit less hydration than the others as
7 you can see.

8 THE WITNESS: Can you go to the one before that I told
9 you to skip?

10 So when you're looking at cuts -- so if you want to
11 look at what the actual disc looks like, we get these scalp
12 films, and these are cuts this way. So it's basically taking
13 the scalp film out like this and then turning it on its side,
14 so that you can see it.

15 Can you go two? One more. One more. One more.

16 Okay.

17 Here's your cut. So this is your right side, your
18 left side, the back. Your nose is here, and your feet are
19 coming at you. So you're kind of looking up your nose if you
20 will. And this is the C3/4 disc. And so, this is the left
21 side. You can see that the -- these are facet joints. So
22 they've got little smiles right through here. And so, you can
23 see it's a little bit enlarged.

24 Now the thing that you notice is that if this is the
25 spinal cord and this is the disc, you can see a space in

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1 between here. That's the Perineal space. That's where the
2 nerves come through. And you can see on this side maybe a
3 little bit less on that side, but this is nothing
4 traumatically induced. This is something that's been there
5 for a while.

6 BY MR. ROGERS:

7 Q This is the facet tropism that --

8 A Yeah, that's the face tropism you see.

9 THE WITNESS: Can you go to the next cut.

10 And basically, what I wanted to show here in this is
11 that you see how it's dark here and it's not dark here. These
12 slices aren't perfect. You know, the person is not perfectly
13 lined up. There's always going to be kind of an off on a
14 slice, so it's kind of at an angle.

15 Could you go to the next one?

16 So you can see here is the facets again and the cuts
17 across, and you can see the outline of the disc. Nice open
18 space. And it's nice and smooth on this back part of the
19 disc. Here's the spinal cord right here.

20 Next one.

21 And again, at C4/5, you see a smooth component of
22 the disc at this part right here. And the reason why it's
23 dark here is that's a lower slice. You're getting a slice
24 lower into the foramen, where the nerves come out.

25 Can you go to the next, and then the next?

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1 And this is the 5/6. Again, you can see the nice
2 disc margin.

3 Next.

4 BY MR. ROGERS:

5 Q That's the last one.

6 A Okay, great. So I don't see any trauma related to
7 this disc. Now you have to think about it. If you get this
8 disc to be injured, you have the entire neck component. It's
9 not -- in a typical injury, it's not like someone put a knife
10 or a needle right to that disc. There has to be pressure on
11 this side, and you will see this whole area is all protective
12 of that disc. It's kind of like if you have your house, you
13 have a desk -- or your living room table in your house. To
14 damage that table from the outside, you've got walls, windows,
15 doors, everything. You're going to have to damage the entire
16 part of the house to get to that table, or to get to that
17 disc. There's so much protecting around it. You would see
18 trauma related here in terms of edema, swelling, tears in the
19 muscle. You would see a lot of components of it. You would
20 also see maybe a disc where it's herniated out, where it's
21 actually squirted out into the space here. And you don't see
22 any of that.

23 Q Do any of the films, not only this March 2006 MRI,
24 but anything in the diagnostics that's been done up to this
25 point, show any evidence of trauma to the surroundings like as

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1 you described, the house, and the bushes, and windows, or
2 whatever it was?

3 A There doesn't seem to be evidence of that in any of
4 the film.

5 Q Okay. Okay, very good. Thank you.

6 MR. ROGERS: Now I want to pull up, Dan, Exhibit 22, page
7 3.

8 BY MR. ROGERS:

9 Q This is a pain diagram that the Plaintiff filled out
10 right around the time that we're talking about. And I want to
11 ask you does traumatically induced injury at C3/4 and 4/5
12 explain that pain presentation?

13 A So when I'm looking at pain diagrams I'm trying to
14 figure out where the pattern of the pain builds, how does that
15 relate to the MRI component. And when you're looking at this,
16 you can see that the entire arm, front and back, is filled
17 out. Now each of these arms, you can see these little lines
18 coming across here. All right. Each of these little lines
19 represent a level of nerve. And this is where the EMG nerve
20 conduction study can be helpful, because you're looking at
21 specific levels of the spine with these pictures. So when you
22 talk about C2 or C3, which is the head, C4, which is the neck,
23 C5, which is the shoulder, C6, which is the forearm and into
24 the thumb, C7, which is going to be the middle finger, and C8,
25 which is the other part here, almost every level of the

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1 cervical spine could be involved, C2/3, 3/4, 4/5, 5/6, and
2 6/7, to give a picture like this.

3 Q Is there any evidence to suggest that every level of
4 the cervical spine was traumatically injured in this car
5 accident?

6 A No. If I see a picture like this, especially with
7 it radiate through the head, it's hard for me to say that it's
8 specifically a spine cervical region source in the symptoms,
9 especially when the MRI looks so clean at every single level.

10 Q Okay. Now getting back to that shoulder sprain that
11 was assessed five or six months after the accident, can that
12 explain some of these symptoms?

13 A Usually not. With a shoulder sprain it's going to
14 be very focused right to the shoulder area, and you're not
15 going to have so much symptom going into the fingers, because
16 it's not a nerve type problem. Well, you think it's not a
17 nerve type problem. It's more of a shoulder joint problem.
18 So it's going to be pretty focused right through this area
19 here, which does seem like that's where it's at. But it's
20 less likely that the components came in --

21 Q Now what if some of the nerves -- you're saying
22 these nerves run from the spine into the arms and the legs
23 and --

24 A Right.

25 Q -- everything else. What if a nerve is constricted

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1 going through the shoulder?

2 A Well the way that would happen is that your whole
3 shoulder joint would have to pop out forward and crush those
4 nerves, because it sits in front of the shoulder. It's not in
5 the --

6 Q Okay. But we hear of people who sustain shoulder
7 injuries without dislocations though that might involve a
8 nerve?

9 A Well, I mean if the shoulder injuries are traumatic
10 enough or there's some kind of blunt trauma to this area, it
11 may have struck the nerve as well as the shoulder, so it's
12 hard to say. But usually, typically, shoulder components
13 don't give you kind of the hand pain symptoms -- or the hand
14 area symptoms. And it doesn't usually give you a headache
15 with a shoulder type problem. That's usually -- it's
16 typically right to the shoulder joint.

17 Q Okay. And would C3/4 and 4/5, the injuries that are
18 alleged in this case, cause the headache pattern that you see
19 drawn on this pain diagram?

20 A No. It'd be more C2/3, above that level.

21 Q And is there any evidence that C2/3 was
22 traumatically injured as a result of this car accident?

23 A It doesn't appear that way just from looking at the
24 MRI.

25 Q Now what would you expect to see symptomatically in

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1 a patient who injured every level in their cervical spine,
2 that was something that would explain that pain diagram?

3 MR. EGLET: Objection, question is overbroad. This is
4 what we discussed at the bench, Your Honor.

5 THE COURT: Sustained. Ask you to rephrase.

6 BY MR. ROGERS:

7 Q What would you expect to see in a patient who had
8 sustained traumatically induced internal disc disruption at
9 every level of the surgical spine as a result of a car
10 accident --

11 MR. EGLET: It's the same question, Your Honor.

12 BY MR. ROGERS:

13 Q -- as far as their presentation?

14 THE COURT: It's the same question. Same ruling.
15 Sustain the objection.

16 BY MR. ROGERS:

17 Q Do you see any evidence in the Plaintiff's medical
18 records that would suggest traumatic internal disc disruption
19 at C5/6?

20 A No.

21 Q And yet, you saw on that pain diagram pain
22 complaints radiating down the arm in the C5/6 -- what was it?

23 A Distribution.

24 Q Distribution.

25 MR. EGLET: Objection, leading, argumentative.

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1 THE COURT: Sustained.

2 BY MR. ROGERS:

3 Q Dr. McNulty testified that the Plaintiff's symptoms
4 do not match a C4 dermatomal pattern. Do you agree with him?

5 A Yes, I do agree with him.

6 Q Okay. And C4 is this area where this facet tropism
7 or defect is located.

8 A Correct.

9 Q Okay. What would be the pain that you would expect
10 if there were any problems resulting from that tropism?

11 A Well, as we said, you would have a component of
12 mostly in the shoulder and the upper trap area. Can't
13 explai- -- you see that? In this upper trap area. It doesn't
14 explain the symptoms down into the arm and the fingers.

15 THE COURT: You could just touch the bottom of the
16 screen.

17 THE WITNESS: So somewhere in this area here. You
18 wouldn't have symptoms here, and you would not have headaches.

19 BY MR. ROGERS:

20 Q Well, how do you explain then the headaches that the
21 Plaintiff is presenting -- we know from the records that he's
22 complaining. What's causing it?

23 MR. EGLET: Excuse me. I didn't hear that question.

24 BY MR. ROGERS:

25 Q What's causing the headaches?

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1 A You know, I think the -- that's the difficult part,
2 and that's the art, if you will, of spine medicine is to try
3 to figure that out. Since he had a history of migraines
4 before and was treated with them at Southwest Medical
5 Associates -- Association, they -- these could be just --
6 these --

7 MR. EGLET: Your Honor, I move to strike, speculating.

8 THE COURT: It is. Sustained.

9 The jury will disregard the witness' last statement.

10 BY MR. ROGERS:

11 Q The Plaintiff is -- let me just have you focus on
12 the question as I asked it. Do you see how he's drawn the
13 headaches across the top of his head and up the back? What
14 kinds of headaches would explain what he's complaining of, as
15 he drew on that pain diagram?

16 A Migraine headache, tension type headache. You can
17 see in the back of the occiput an occipital type headache.
18 Those are probably the more common things. Or even a chronic
19 daily headache.

20 Q Okay. And between those different kinds of
21 headaches, can you say to a reasonable degree of medical
22 probability degree of medical probability you know what, it's
23 this kind, it's this variety of headaches?

24 A Well, I think that would be the hard part. You have
25 to look at the different symptoms. You know, if he's

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1 describing pain behind his eyes or nausea or any kind of
2 component of pressure, it may be more of a migrainous type of
3 headache.

4 Q Your Honor, objection. This is speculation.

5 THE COURT: Counsel, approach, please.

6 [Bench Conference Begins]

7 MR. EGLET: The witness just said that that would be
8 really hard to do, and then he starts describing some of the
9 symptoms and says well, that may be a migraine headache, just
10 like if it's all -- he doesn't know one way or the other. His
11 answer is no, I don't know.

12 MR. ROGERS: I think he's explaining why, so that the
13 jury understands, because the Plaintiff has been presenting
14 the position that it's an occipital headache. He's saying no,
15 that these are the symptoms associated with the different
16 kinds of headaches.

17 MR. EGLET: He doesn't get to say it could be this, it
18 could be that.

19 THE COURT: Right.

20 MR. EGLET: That's more [indiscernible], Your Honor.
21 That's a direct [indiscernible]. Move to strike.

22 THE COURT: Does he not know that the jury is not
23 interested in possibly and that there's really no point in
24 giving testimony that calls for speculation, because it seems
25 like his last few answers call for speculation. And that's

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1 why the Court has had to sustain the objections.

2 MR. ROGERS: I think all he's doing right now is
3 explaining that the exact kind of headache is not known.
4 That's all he's say.

5 MR. EGLET: He's doing exactly what the doctor did in
6 Moore Sokato [phonetic]. He's saying it could be this, could
7 be that, could be this. You can't do that.

8 THE COURT: Sustain the objection. I'm going to ask you
9 to -- just a moment, Mr. Eglet.

10 I'm going to ask you to focus your questions
11 narrowly, so that he doesn't speculate. Otherwise, we're
12 going to have to take a break and you're going to have to
13 advise.

14 MR. ROGERS: Okay.

15 THE COURT: All right.

16 [Bench Conference Ends]

17 THE COURT: Sustain the objection.

18 BY MR. ROGERS:

19 Q All right. At this initial visit or -- yeah, the
20 initial visit with Dr. McNulty, he recommended C3/4 and 4/5
21 blocks. Was that a reasonable suggestion?

22 A I don't see how based on the pattern of pain that's
23 here and based on what the MRI shows.

24 Q What would you have done at UCLA with this
25 presentation?

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1 A Well, given that the MRI to me, and as we went
2 through it, appeared normal, in other words, there was no area
3 of pain, these are difficult types of patients that come
4 through, because they are complaining of pain and you want to
5 try to treat them in some way. The component of what we would
6 approach would multifaceted, if you will. We have an
7 acupuncture program. We have --

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

9 THE COURT: Yes.

10 [Bench Conference Begins]

11 MR. EGLET: This witness is about to violate a court
12 order, okay. He's going into this. Can you ask him not to
13 try to overhear our -- sit there and look at me and try to
14 overhear our bench conferences. It's improper.

15 THE COURT: Yeah.

16 MR. ROGERS: I'll ask him.

17 MR. EGLET: He's about to get into what they do at UCLA,
18 about it's multifaceted. And what he's going to talk about is
19 psychological counseling to make sure that it's not
20 psychological, that it's not all in their head, which gets
21 into exactly what this court has included, secondary gain
22 stuff. That's exactly what he's talking about. This what he
23 did in his deposition. This is exactly where he's going with
24 this answer. And it's improper, Your Honor, and he's -- you
25 know, he's --

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1 And second of all, what he would have done if this
2 had been his patient is not relevant here. He's not this
3 patient's doctor. He can comment on whether he thinks this is
4 improper or not proper, but I don't care what he would have
5 done. He's not my client's treating physician. It's not
6 relevant. He didn't go --

7 MR. ROGERS: That's --

8 MR. EGLET: -- to UCLA. He didn't get this treatment at
9 UCLA. What he would have done -- he can sit there and say I
10 don't think the C4/5 blocks were appropriate. I don't think
11 the discography was appropriate. I wouldn't have done them.
12 But he doesn't get to say well, if this is my patient, this is
13 what I would have done. It's not relevant.

14 MR. ROGERS: Your Honor, what he would have done is he's
15 saying would have been the more appropriate kind of way to
16 address the Plaintiff's presentation. Plaintiff has put on
17 Doctors McNulty and Dr. Rosler, both of whom have testified
18 that what we did was inappropriate, indicated necessary, and
19 so forth. And the defense is entitled to their theory of the
20 case. He's saying those injections weren't appropriate and
21 this is what would have been appropriate. He's entitled to
22 say that.

23 MR. EGLET: And he's about to get into psychological
24 counseling.

25 MR. ROGERS: I'll tell you --

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1 MR. EGLET: I know that's where he's going to. He's
2 going to go into -- that's what the whole thing is about, how
3 they have psychiatrists and psychologists who are all part of
4 the team, and they evaluate whether there's secondary gain,
5 all that stuff.

6 THE COURT: I hope he's not trying to planning to violate
7 any of the Court's orders, because I'll tell you what, I would
8 have no compunction striking his testimony all together as a
9 witness if he violates any of the Court's orders, especially
10 after we made a very fertile record why we kept our jury
11 waiting. I will have no compunction.

12 But with respect to what he would have done or how
13 he would have treated this patient, it isn't relevant as to
14 whether or not -- well, it isn't relevant for any of the
15 purposes that we're here for. So there's two things I want
16 you to instruct him. Well, actually three. I want him to be
17 instructed that possibilities and speculation are not
18 appropriate for the jury to consider, and then instructed that
19 he's [indiscernible] to go into this area which Mr. Eglet
20 seems to think he is -- I don't know if he is or isn't --
21 that's strictly off limits, and he's already been told that.
22 And third, it's not really relevant on that too, that what he
23 would have done isn't particularly relevant.

24 MR. ROGERS: I'm sorry, I didn't hear the third part.

25 THE COURT: What he would have done had this patient been

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1 his, it isn't particularly relevant. You're entitled to
2 present your theory, no question about that. But his personal
3 preference practices aren't particularly relevant for this
4 case.

5 MR. ROGERS: The way a doctor practices medicine is
6 simply a way of expressing what is, in their opinion, the
7 appropriate method of treatment. Prefacing it by stating this
8 is the way I'd do it is really no different than saying this
9 is what's appropriate. I don't understand why having --

10 MR. EGLET: [Indiscernible].

11 MR. ROGERS: -- the prefacing clause is a problem.

12 THE COURT: The objection --

13 MR. EGLET: You could ask him when --

14 THE COURT: -- as it was articulated is sustained by the
15 Court on those three grounds, and I'd ask you to instruct your
16 witness accordingly. And we're going to take about a 10-
17 minute break.

18 MR. EGLET: Thank you, Your Honor.

19 [Bench Conference Ends]

20 THE COURT: Okay, ladies and gentlemen, we're going to
21 take about a 10-minute break. Advising you of your duty not
22 to discuss this case with anyone, not to form or express any
23 opinion, not to do any research on any subject.

24 [Recess]

25 [Jury In]

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1 THE MARSHAL: Please be seated.

2 [Pause]

3 THE MARSHAL: Please remain seated.

4 THE COURT: Back on record. Counsel, stipulate to the
5 presence of the jury?

6 MR. ROGERS: Yes.

7 MR. EGLET: Yes, Your Honor.

8 MR. ROGERS: Okay. Okay. Where we left off was the
9 referral to the Southwest Pain Management Center. Where the
10 Plaintiff underwent various injections for the next 14 days --

11 [Audio Distortion]

12 MR. ROGERS: Is there a phone near a mic?

13 THE COURT: It's usually a phone sitting too close to a
14 microphone.

15 DIRECT EXAMINATION CONTINUED

16 BY MR. ROGERS:

17 Q All right. You've seen the injections that were
18 done there over those, roughly, I don't know 15 months or so.
19 Are those injections that you perform as well?

20 A Yes.

21 Q Injections that you teach to the fellows at UCLA?

22 A Yes.

23 Q Okay. Did any of those injections isolate an injury
24 or a pain generator at C34, C45?

25 A No.

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1 Q All right. Well that brings us up to the
2 Plaintiff's return to Dr. McNulty. Now we're roughly two and
3 a half years after the accident. Dr. McNulty also performed
4 an epidural. Did that injection identify any injury caused to
5 C34 and C45?

6 A No.

7 Q What did Dr. McNulty say about the injections that
8 the Plaintiff had gone through at Southwest Medical?

9 A If you can bring up the note --

10 Q It's Exhibit 222, page 9.

11 A I guess the second paragraph. "I have no definitive
12 diagnostic information as far as clearly defining pain
13 generators."

14 Q And this is after all the injections were performed?

15 A Yes.

16 Q Still no pain generator?

17 A No.

18 Q And Dr. Arita, who performed all but one of those
19 injections, what was his opinion about what they showed?

20 A Well in his deposition he didn't think that it
21 diagnostically came to a conclusion as to the source of the
22 pain.

23 Q Okay. Did you see any comment from Dr. Rita about
24 whether the conditions that he was treating with those
25 injections were even related to the accident?

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- 1 A If you bring up the note.
- 2 Q Well it's a deposition transcript that we might
3 be --
- 4 A Unable to do. All right.
- 5 Q -- unable to show.
- 6 A I believe that he did mention something to that
7 effect in the note. I'd have to see it again.
- 8 Q Okay. Now, at this point Dr. McNulty saw the
9 Plaintiff one last time and he recommended a surgery. The
10 Plaintiff didn't want to do that -- he didn't undergo that
11 surgery, but instead left Dr. McNulty, and went to Dr. Grover.
12 And a -- you've reviewed the medical records and treatment
13 from Dr. Grover's office?
- 14 A Yes.
- 15 Q And that includes the treatment rendered by Dr.
16 Rosler, the pain management physician there?
- 17 A Yes.
- 18 Q Okay. Now another injection was done this selective
19 nerve root block did -- was that diagnostic? Did it show
20 where any pain was?
- 21 A No.
- 22 Q And that, again, was at the same level we've been
23 discussing?
- 24 A Yes. The C34.
- 25 Q All right. Then Dr. Rosler performed a discogram,

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1 you've seen the records and films relating to that?

2 A Yes.

3 Q Okay. And in your opinion did that discogram show

4 where there was an injury or a source of pain?

5 A Well maybe we can look at the discogram?

6 Q All right. The discogram.

7 MR. EGLET: Are we looking at the report?

8 THE WITNESS: The actual images.

9 MR. EGLET: You mean the post CT?

10 MR. ROGERS: Yes.

11 THE WITNESS: Oh, sorry.

12 MR. EGLET: Is that what you're talking about?

13 MR. ROGERS: Yes.

14 THE WITNESS: Yes. The post CT. So --

15 MR. ROGERS: Do we have that here?

16 UNIDENTIFIED SPEAKER: I don't know that Exhibit

17 Number --

18 MR. ROGERS: Oh I'm sorry. It's dated --

19 THE WITNESS: A CT scan from 8/8/08.

20 MR. ROGERS: CT.

21 THE WITNESS: I apologize. Let me clarify, I guess when

22 you're looking at a discogram and when you're evaluating the

23 component of a discogram, you're pressurizing the disc to see

24 if that gives you a component that is similar or concordant to

25 the every day pain. It's not a very fun procedure to undergo.

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1 Needles are placed in the front part of the neck, and the
2 individual has to be somewhat awake to be able to communicate
3 whether or not they feel pressure or pain.

4 After the test is performed the images are displayed
5 to see whether or not the morphology of that disc is present
6 or not. What I noticed in looking at the discogram -- and I
7 apologize if this doesn't quite make sense here, but --

8 MR. EGLET: can we just have the witness be clear. This
9 is not the discogram. This is the post CT -- post discogram
10 CT. This is not an image from the discogram.

11 THE COURT: Let's make sure that it's clear for the
12 jury's sake.

13 BY MR. ROGERS:

14 Q Right. Very well. Explain to the jury --

15 A So --

16 Q -- how it is you do a discogram, where the --

17 A Right.

18 Q -- CT comes in.

19 A So once the needles are placed into each of the
20 discs of question, the needles are removed. The patient is
21 brought back into the recovery. And then they're sent to the
22 scanner to get a CT scan to show where the contrast was
23 placed.

24 And there's a certain amount of contrast that's
25 placed into the disc to get the images. And what you're

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1 hoping is that the disk is going to be nicely outlined.

2 Now this is the front part of the spine, if you
3 will, kind of cut like straight down the middle here, straight
4 in front. And what you can see is the bone structure. And
5 you can see the discs in between.

6 And what I noticed about the discs were that this --
7 the disc -- the top one, which was C34 you can see that the
8 contrast was spread throughout the disc. It looks very nice.
9 It's in the entire part of the disc.

10 But if you notice on the bottom two, you can see the
11 contrast is only on the side -- only on the side. It doesn't
12 actually go through the whole disc. Can you go to the next
13 image?

14 So when you're looking at --so this is a side view.
15 Like the MRI coming down the middle of your nose looking
16 sideways. And again, you can see the bone structure. All
17 right. Then you can see the space in between the discs.
18 Right? Space in between -- or the disc is the space in
19 between the bone structure. Now notice the C34 you can see a
20 little bit of haze right in here. Right in here. Right in
21 here. You can see that there's contrast within that disc.

22 But if you notice in the other ones there's only
23 just a little bit of contrast here. A little bit here. This
24 is -- you can see like a white dot right there. You can see -
25 - this is actually pretty good. You can see the white dot

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1 here. It doesn't look like it's in the entire disc. But the
2 goal of the discogram is to get into the center of the disc,
3 where the jelly part of the donut is. And not on the outer
4 part of the disc.

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

6 THE COURT: Yes.

7 [Bench Conference Begins at 3:37 p.m.]

8 MR. EGLET: This opinion that this witness is about to
9 try to give was never disclosed by this witness at any time.
10 This is an opinion that they hired Dr. Winkler (phonetic) for,
11 who was a neuroradiologist who has offered an opinion
12 regarding what's in the post CT of the discogram.

13 This witness and neither in any of his reports, nor
14 in his deposition gave this type of testimony. What he's
15 about to try to testify to is that the needles, based on this
16 post CT discogram -- that the needles were not placed properly
17 in the right place. And that that's why the contrast is not
18 throughout the disc on this CT scan taken after the discogram.

19 He was not identified as an expert to talk about
20 this. Only Dr. Winkler was. And so I would object for him
21 now to try to bootstrap and give Dr. Winkler's expert
22 testimony, when he was not disclosing in any of his reports
23 regarding this.

24 MR. ROGERS: Your Honor, he's actually written and been
25 deposed on this one. And --

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1 MR. EGLET: Show me his report where he says this.

2 MR. ROGERS: I mean he has like five reports --

3 MR. EGLET: Yeah. Well show --

4 MR. ROGERS: -- he's reviewed every single medical
5 record.

6 MR. EGLET: Show me his report where he gives this
7 opinion? It's nowhere. It's not properly disclosed. It's
8 not there.

9 MR. ROGERS: He absolutely discussed the discogram,
10 because that was what he does.

11 MR. EGLET: I'm not saying he didn't discuss the
12 discogram. He discussed the discogram and basically his
13 testimony at his deposition was, he has no reason to believe
14 that the discogram was not performed properly. That is his
15 testimony. Okay? He doesn't think it's valid because he
16 thinks it's a false positive. Okay? But not because of the
17 basis he's about to give. This is Dr. Winkler's expertise or
18 what they identified Dr. Winkler to give testimony on.

19 He has never been disclosed in this area, ever.

20 MR. ROGERS: Disclosure is exactly the fact that he's
21 been deposed on the issue. And he's written about the issue.

22 MR. EGLET: He has not written about this specific issue.

23 THE COURT: You don't seem to be responding specifically
24 to Mr. Eglet's argument.

25 MR. ROGERS: And some of these objections, I -- I mean --

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1 this is a voluminous case. And all of the details are -- and
2 I don't recall -- I mean if he wants to go through every
3 report --

4 MR. EGLET: Well --

5 MR. ROGERS: -- but that's more fertile ground for cross-
6 examination. If he's going to address this issue, and the
7 Plaintiff is on notice to discuss it with him at his
8 deposition, there's no surprise here at all. That's a full
9 disclosure.

10 MR. EGLET: It was never disclosed in his reports. Ever.

11 THE COURT: The objection is sustained.

12 MR. EGLET: Thank you.

13 [Bench Conference Ends at 3:40 p.m.]

14 MR. ROGERS: If we could approach for just one follow up.

15 [Bench Conference Begins at 3:40 p.m.]

16 MR. ROGERS: I think that I might not -- I need to ask
17 whether the pain generator was identified in the discogram and
18 leave it at that. His concerns seem to be --

19 MR. EGLET: I'm sorry, I didn't hear you, Steve.

20 MR. ROGERS: Am I allowed to conclude by asking him was a
21 pain generator or an injury identified in this discogram and
22 then leave it at that?

23 MR. EGLET: I have no --

24 MR. ROGERS: It seems --

25 MR. EGLET: I have no problem with that question, okay.

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1 As long as he didn't go into an explanation that is based on
2 this disco -- this post CT of the discogram. Because that
3 never was disclosed in his reports or his deposition. So I'd
4 ask the post CT discogram be taken down. And then if you want
5 to ask him that question -- but if he starts to go into an
6 explanation I'm going to object and ask to strike that
7 testimony if he bases it on his review of the post CT scan.

8 MR. ROGERS: No --

9 MR. EGLET: He can say -- he can offer the opinion that
10 he -- that in his opinion the discogram did not show an injury
11 at C34, C45. That's fine. But if he --

12 MR. ROGERS: Okay.

13 MR. EGLET: -- tries to explain it based on this then
14 that's improper.

15 MR. ROGERS: Well let me tell him -- or something --

16 THE COURT: Do you have any objection?

17 MR. EGLET: No. I don't have an objection to that.

18 THE COURT: All right.

19 [Bench Conference Ends at 3:41 p.m.]

20 THE COURT: Mr. Rogers, one moment, please.

21 [Bench Conference Begins at 3:42 p.m.]

22 THE COURT: Did you remove that -- could you have your
23 people remove the slide.

24 MR. ROGERS: Oh yes.

25 THE COURT: Okay. Thank you.

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1 MR. ROGERS: Dan could you --

2 THE COURT: Thank you.

3 [Bench Conference Ends 3:42 p.m.]

4 BY MR. ROGERS:

5 Q Did this discogram isolate an injury or a pain
6 generator at C34 and C45?

7 A So when looking at the discogram, placing the
8 needles into the disc --

9 MR. EGLET: Objection, Your Honor.

10 MR. ROGERS: Just --

11 THE COURT: Sustain the objection.

12 BY MR. ROGERS:

13 Q Right. Just to answer that question as asked. You
14 stated --

15 A Well you have to think about the discogram itself
16 and when you pressurize the disc --

17 Q In this instance --

18 A -- you ask somebody --

19 Q Doctor, I think the Court would prefer just a simple
20 yes or --

21 A All right.

22 Q -- no answer to that question.

23 A No. It did not.

24 Q Okay.

25 [Pause]

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1 BY MR. ROGERS:

2 Q All right. You examined the Plaintiff Mr. Simao,
3 you didn't simply review his medical records. In your
4 examination of him, I believe it was roughly a month before
5 the surgery. At that time what did he tell you about his
6 condition in terms of his abilities to perform his activities
7 in daily living?

8 A He advised me that he was able to lift a 40 pound
9 piece of equipment in and out of a truck. And that he was not
10 restricted from doing any activities or limited by any of the
11 activities by any of his providers and he was able to do all
12 the functional things that he needed to be able to do for his
13 job.

14 Q Now right around this time he was reporting pain at
15 what level?

16 A You mean on a scale from zero to ten?

17 Q Yes.

18 A I think it was around seven or eight.

19 Q Okay. And is a reported pain level of seven or
20 eight of ten consistent with the ability to continue doing all
21 of your normal activities of daily living?

22 A If you ask an individual zero being no pain at all,
23 and ten being the worst pain imaginable, if you could imagine
24 a broken arm or an arm where your bone is sticking out of your
25 arm, or a kidney stone, as being a pretty extensive pain, or

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1 even the delivery of a child can be painful.

2 If you think about where the scope is in terms of
3 that, the ten over ten pain would be the, you know, worst pain
4 imaginable and if someone's describing an eight, which is
5 almost at that point, an individual should not be able to do
6 any of their activities because of so much pain.

7 Q Was the Plaintiff taking any pain medication, Lortab
8 or codeine, anything like that at that time?

9 A No. He was not. Can you pull up my note?

10 Q Your --

11 A Do you have the page of the actual IME report?

12 Q We do have the report.

13 MR. EGLET: Your Honor --

14 MR. ROGERS: If it will refresh your recollection.

15 THE COURT: Sustain the objection.

16 MR. ROGERS: Well the question is did you not remember --

17 THE WITNESS: Well I did, but there would have been a
18 listing of the medications on that page. And I don't recall
19 him being on any of the pain medications that you had
20 mentioned.

21 MR. ROGERS: Okay.

22 BY MR. ROGERS:

23 Q All right. We have learned here in Court that the
24 Plaintiff did not respond well to surgery. Or that he has
25 continuing ongoing symptoms. Yesterday we learned that Dr.

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1 McNulty has suggested future medical care consisting of a
2 spinal chord stimulator. Do you do spinal chord stimulators?

3 A Yes. We do the trial of a stimulator and the
4 implantation of a stimulator.

5 Q You do both, trials and permanents?

6 A Yes.

7 Q Okay. And Dr. McNulty's testimony was that the
8 Plaintiff now suffers from what he called, or he might suffer
9 from what he called Neuropathic Pain.

10 MR. EGLET: Your Honor, I'm going to object. The
11 testimony was he suffered to that to a reasonable degree of
12 medical probability -- not might.

13 THE COURT: I ask you to rephrase the question, Mr.
14 Rogers.

15 BY MR. ROGERS:

16 Q Dr. McNulty testified that the Plaintiff to a
17 reasonable degree of medical probability suffers from
18 Neuropathic Pain. And that this pain was caused because the
19 Plaintiff delayed in getting the surgery that he recommended.

20 Now I want to get to the subject of spinal chord
21 stimulators in a moment. You weren't aware of this future
22 recommendation until I advised you of it after that testimony.
23 Correct?

24 A Correct.

25 Q There were no disclosures in the medical records

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1 suggesting a need for that kind of --

2 MR. EGLET: Objection. Your Honor --

3 THE COURT: Counsel approach, please.

4 MR. EGLET: -- it misstates the evidence. May we

5 approach?

6 THE COURT: Yes.

7 [Bench Conference Begins at 3:47 p.m.]

8 THE COURT: I'm not sure how much of this was in front of

9 the jury and how much it wasn't.

10 MR. ROGERS: All of it is. Dr. McNulty testified to all

11 of this --

12 MR. EGLET: No.

13 THE COURT: No. The objections about notice. And the

14 length --

15 MR. EGLET: Yeah. None of this was in front of the jury.

16 Okay. First of all it's -- it misstates the record, which the

17 Court -- Mr. Adam's been very clear to the Court what the

18 record was on this. It's argumentative. He's arguing in

19 front of the jury that it wasn't disclosed in the records.

20 And it also is leading. So it's objectionable on three

21 grounds.

22 THE COURT: Well not only that, but we know what

23 happened --

24 MR. EGLET: Right.

25 THE COURT: -- with respect to this situation, but the

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1 jury --

2 MR. EGLET: Yeah.

3 THE COURT: -- doesn't.

4 MR. WALL: Right so are you suggesting that there was
5 no --

6 THE COURT: Yeah.

7 MR. WELL: I don't know how to --

8 MR. EGLET: Yeah. So I would ask that Mister -- that the
9 objection be sustained an that Mr. Rogers comments about
10 whether or not anything was disclosed to be stricken from the
11 record.

12 MR. WELL: I think maybe that needs to come from -- I
13 don't want to put him in the position to say the wrong thing
14 and then have us come back up here -- I think that it needs to
15 be the Court saying, not only is that stricken but that -- I
16 can't remember what exact word you used -- beyond -- after
17 disclosure.

18 MR. ROGERS: That he didn't know. Is what --

19 MR. WALL: Because it's --

20 MR. EGLET: That's not what you said.

21 MR. WALL: He's saying it's not in any of the records or
22 materials.

23 MR. EGLET: Yeah. He said it was not in any of the --

24 MR. WALL: And it is. It was in Dr. Seibel's --

25 MR. EGLET: -- medical records and materials. And it

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1 was. It is. It's in Dr. Seibel's materials. So it's an
2 incorrect statement.

3 THE COURT: So -- so --

4 MR. EGLET: So there has to be a curative instruction
5 that it was -- that there is notice of this in the records.

6 MR. WALL: And based on the fact that --

7 THE COURT: Notice of what?

8 MR. ROGERS: You guys --

9 MR. EGLET: What?

10 THE COURT: Notice of what?

11 MR. EGLET: That there was notice of potential spinal
12 chord stimulator in the medical records.

13 MR. ROGERS: Okay. I -- all I'm trying to do is get
14 through this so that you guys can get to it. And I've been
15 trying to get through it as fast as I can. I'm near the very
16 end of --

17 MR. EGLET: I understand you are. But you still have to
18 do it properly, Steve. Okay? And you're making a leading,
19 argumentative, and a statement that's not true.

20 MR. ROGERS: I think let's just get this over with.

21 MR. WALL: I think if the Court says, "I'm sustaining the
22 objection." Asking the jury to disregard it is the predicate
23 that no notice is not correct.

24 THE COURT: Uh-huh.

25 MR. ROGERS: That's fine.

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1 MR. WALL: And ask your next question.

2 [Bench Conference Ends at 3:50 p.m.]

3 THE COURT: I'm going to sustain the objection and I'm
4 asking the jury to disregard counsel's statement. Because the
5 issue of no notice is not correct. I think counsel may have
6 misspoke.

7 Please proceed, Mr. Rogers.

8 MR. ROGERS: Thank you.

9 BY MR. ROGERS:

10 Q The testimony was that there is neuropathic pain.
11 Now, the theory of the case, so far, as I understand it. Is
12 that there is a compressed nerve, but rather that there is an
13 internal disc disruption that leaks onto the nerve. And
14 causes pain that way.

15 Can a person develop neuropathic pain in that
16 fashion?

17 A No. There is no evidence in any of the medical
18 literature that that can happen.

19 Q Now Dr. McNulty testified that he hadn't seen the
20 Plaintiff for roughly a year. In the patients you've done
21 spinal chord stimulators on, have you ever suggested such
22 treatment on someone you haven't seen for a year?

23 MR. EGLET: Objection, irrelevant, Your Honor.

24 MR. ROGERS: Okay. Let me rephrase it.

25 THE COURT: All right.

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1 BY MR. ROGERS:

2 Q Can the recommendation for a future spinal chord
3 stimulator be made for a patient who a doctor has not seen for
4 a year?

5 A There are a lot of factors that go into the decision
6 of going forward with a spinal chord stimulator. This is not
7 a very simple procedure.

8 Basically it's like a pace maker for the spine, if
9 you will. So you're pacing wires into the epidural space and
10 pushing electricity into the spinal chord to disrupt the gate
11 theory that we had talked about. Multiple types of stimuli
12 coming in at the chord will disrupt the pain components.

13 To implant this device you have to put a battery in,
14 and put these leads in. And there are a lot of criteria that
15 have to be met --

16 MR. EGLET: I'm just going to object. This is non-
17 responsive to the question.

18 THE COURT: Sustained. It isn't.

19 MR. ROGERS: Okay.

20 BY MR. ROGERS:

21 Q What kinds of tests need to be run to determine
22 whether a person is actually a candidate for a future spinal
23 chord stimulator?

24 A Can I ask him something?

25 THE COURT: No. Actually --

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1 THE WITNESS: You're going to put me in the --

2 THE COURT: Actually, the attorney gets to ask the
3 questions. You get to --

4 THE WITNESS: You're going to put me in a situation where
5 I can't answer that question.

6 MR. ROGERS: Okay.

7 THE WITNESS: Based on the stipulations that were given
8 to me.

9 MR. ROGERS: Okay.

10 THE COURT: Ask counsel to approach, please.

11 MR. EGLET: Your Honor, I would move to strike that
12 statement.

13 THE COURT: The jury will --

14 MR. EGLET: May we approach?

15 THE COURT: The jury will disregard the witness's last
16 two statements, please.

17 [Bench Conference Begins 3:53 p.m.]

18 MR. EGLET: That happens again I'm going to move to
19 strike this witness.

20 THE COURT: Uh-huh.

21 MR. ROGERS: You know, I'm not trying to get --

22 MR. EGLET: I'm not saying you are -- but he is.

23 THE COURT: You made the prediction that he would do this
24 very thing.

25 MR. EGLET: I know.

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1 THE COURT: And I'll admit that I was not at all certain
2 that that was the case, but I'm beginning to think that you're
3 right on this.

4 MR. ROGERS: I'm going to tell him he needs to just --
5 don't even get close. I'm not trying to do this, Your Honor.

6 THE COURT: It's almost as if he desires this.

7 MR. ROGERS: I think he's just unclear --

8 THE COURT: Because the Court's been really clear -- oh
9 no. The Court's been really clear the first 30 or 40 minutes
10 that we went over everything with him. He's most definitely
11 clear.

12 MR. ROGERS: Please allow me to tell him don't get
13 anywhere near that.

14 THE COURT: Sure. I don't have a problem with it.

15 [Bench Conference Ends at 3:54 p.m.]

16 BY MR. ROGERS:

17 Q Okay. Now, let's talk about it this way. Where a
18 person has potential pain generators, unrelated to the spine,
19 do those need to be ruled out before a doctor, such as
20 yourself, would perform the spinal chord stimulator implant?

21 A Yes. You want to make sure that the -- those other
22 factors that are ruled out, such as a shoulder injury, a
23 compression of the nerve in the wrist or the hand, a muscle
24 component. These things need to be evaluated to make sure
25 that all the things have been looked at before embarking on

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1 this invasive procedure.

2 Q Are there any suggestions in the records that the
3 Plaintiff may have unrelated pain generators, for example, as
4 you were pointing to the hand and arm?

5 A There's studies to show that he may have carpal
6 tunnel syndrome, through an EMG nerve conduction test.
7 There's myofacial (phonetic) pain. There's headaches that
8 have been well known and well documented. And a stimulator
9 for these types of headaches does not work.

10 So the headaches need to be further evaluated as
11 well as all the other factors. And the shoulder, in terms of
12 what I've seen so far has not really been fully worked up.

13 Q In your opinion, then, is there a sufficient work up
14 on this patient to recommend a spinal chord stimulator
15 implant?

16 A No.

17 Q Okay. All right, Doctor, in the end what this jury
18 is going to be wrestling with is a man who says he had
19 headaches before --

20 MR. EGLET: Your Honor, is this a speech or a question?

21 MR. ROGERS: It's a question. I'll get to --

22 MR. EGLET: Well it doesn't sound like it.

23 BY MR. ROGERS:

24 Q A man who had --

25 MR. EGLET: Your Honor, I'm going to object to him giving

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1 a speech as to what the jury is going to be wrestling with. I
2 ask he pose a question.

3 THE COURT: I sustain the objection. I ask you to
4 rephrase it, Mr. Rogers.

5 BY MR. ROGERS:

6 Q In this case one of the issues to be decided
7 medically and factually is what's the cause. The Plaintiff
8 claims that he had headaches before, and neck pain after. If
9 it's not C34 the levels that were fused. What's causing his
10 presentation?

11 A Right. So I've shown you a few of these pictures,
12 and I've discussed some of the approaches for what you're
13 looking at. And in an hour and a half I'm trying to give
14 you --

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

16 THE COURT: Yes.

17 [Bench Conference Begins at 3:57 p.m.]

18 MR. EGLET: The testimony -- in his -- first of all, his
19 testimony complete -- his opinions completely changed from his
20 reports to his deposition. He abandoned his opinions from his
21 reports when he got to his deposition.

22 Now he's changing his testimony even from his
23 deposition, which wasn't disclosed in the real course. In his
24 deposition he said, "I don't know." When he was asked this
25 question, what's causing all these problems? I don't know.

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1 Now he's about to give us a big speech on what he
2 thinks is causing all these problems, which has never been
3 disclosed.

4 MR. ROGERS: If you can give me a moment, so I can get a
5 report.

6 THE COURT: Sure.

7 MR. WALL: I see no --

8 MR. ROGERS: Dave, just give me one moment.

9 [Pause]

10 THE COURT: I did have a question submitted by one of the
11 jurors during the last break. This is the first chance I've
12 had to share it with you.

13 [Pause]

14 MR. WALL: [Indiscernible].

15 [Pause]

16 MR. EGLET: All right. So in his deposition he testi- --
17 he was asked this question about, you know, whether -- what's
18 going on. His testimony essentially is, "I don't see any
19 objective evidence in the injuries that the injections didn't
20 demonstrate any C34 -- so I don't see -- I have no idea.
21 Okay.

22 And then he's asked if there's carpal tunnel. This is
23 interesting, because he's -- you know, because I suspect he's
24 about to go into the question by Mr. Wall. And now finally,
25 he's going to refer to a hand specialist who diagnosed him

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1 with carpal tunnel syndrome.

2 And he's been referred to a shoulder specialist.
3 Have you been supplied with any of those records? His answer
4 is this is the first I've heard of it. Never does -- and this
5 is a month ago. He's never done a supplemental report;
6 there's been no disclosure that he's going to discuss the
7 carpal tunnel whatsoever. And he -- when Mr. Wall asked him
8 in the deposition, if you -- will you prepare a supplemental
9 report if you have any additional opinions or any opinions
10 change. And he says yes he would. He'd be happy to do that.
11 None of that occurred. So this is a retained expert who is
12 required to disclose in his reports.

13 THE COURT: Uh-huh.

14 MR. EGLET: And he didn't disclose anything. He didn't
15 even know about the carpal tunnel until at the very end of the
16 deposition Mr. Wall asked him one question about it. Now he
17 seems to be basing a big part of his opinion on it.

18 So we would object, because in his deposition he
19 said he didn't know what was causing -- now if he wants to
20 say, "I don't know" the same as he did in his deposition,
21 that's fine. But he's -- that's obviously not what he's
22 doing. He's about to give this long explanation about what he
23 thinks, which was never disclosed.

24 MR. ROGERS: I'd like to --

25 THE COURT: Mr. Rogers.

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1 MR. ROGERS: Very good. This is where I think he's
2 going. And this is what he said in his final report, which is
3 -- has to do with [indiscernible] and he said that in his
4 first report.

5 MR. EGLET: What's the date of this report?

6 MR. WALL: Was this addendum four?

7 MR. ROGERS: This is the one that I think he attached.

8 MR. WALL: No. Because this one is dated October 2010.

9 MR. EGLET: Where -- in October 2010? That report was
10 October 2010.

11 MR. ROGERS: I got this one from 2/10. That's the IME,
12 but that's what he said there as well.

13 MR. EGLET: But the one you just showed us is October
14 2010. The date's right up on it. It says October 18th, 2010.

15 MR. ROGERS: No. I don't think -- I don't think that's
16 the one --

17 MR. WALL: See this is -- this is -- addendum four.
18 Addendum five is the one [indiscernible] the depo.

19 MR. ROGERS: Well this is an opinion that's been repeated
20 repeatedly in his reports. And that's where I thought he was
21 going --

22 MR. EGLET: No. That's not where he was going. If he
23 starts saying this -- this report -- it says -- where you say
24 assuming the motor vehicle -- assuming the motor vehicle
25 accident caused the strength strain.

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1 MR. ROGERS: I guess that's where I was going --

2 MR. EGLET: That's not where he's going. He's going off
3 the reservation. I'm telling you that right now. He's going
4 way --

5 THE COURT: So that's not the question you asked him
6 though?

7 MR. ROGERS: What's gone is [indiscernible] if he says he
8 had before, or that he didn't have it before and had it after
9 this isn't --

10 THE COURT: If this is the answer you're seeking, I don't
11 think this answer is responsive to the question.

12 MR. WALL: He also abandoned this opinion.

13 MR. EGLET: And he abandon -- he totally abandoned --

14 MR. WALL: In his deposition.

15 MR. EGLET: -- this opinion number nine in his
16 deposition. And I'm -- I mean this opinion. And he said that
17 and Mr. Wall said -- came back and said, "Now you're
18 abandoning this position?" And he goes, "Well I don't know if
19 abandoning is the right word." And we go well that's what you
20 said. And he goes, "Okay. I'm abandoning the position." He
21 said it. That he's opinion -- he's abandoning this opinion.
22 And now he wants to come back to it?

23 MR. ROGERS: Let's just get him done with. And perhaps
24 the way I can finish it up is to say, "Doctor, is there any
25 objective evidence that -- to explain why the Plaintiff is

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1 presenting with these complaints?

2 MR. EGLET: Well that's a yes or no answer.

3 MR. ROGERS: That's not a --.

4 THE COURT: Can he do the yes or no answer?

5 MR. ROGERS: Yeah.

6 MR. WALL: Ask him for one.

7 MR. EGLET: Ask him for one.

8 MR. ROGERS: I hate to end it on that, because I've
9 already asked it. It sounds so feeble, trying to get him to
10 say, this is my opinion about what might be causing it.

11 MR. EGLET: Well what might be causing it is speculation.

12 MR. ROGERS: And if he says, "I don't know for sure
13 that's fine."

14 MR. EGLET: No. He's talking -- you're asking what might
15 be causing it? Because he doesn't know. He said in his
16 deposition he doesn't know. And now you want him to say --
17 speculate about it. And that's our point.

18 THE COURT: By the way, I didn't get a chance to show Mr.
19 Rogers this was one of the questions submitted by one of the
20 jurors.

21 [Pause]

22 MR. EGLET: [Indiscernible].

23 THE COURT: Uh-huh.

24 MR. ROGERS: And I don't mind asking him that. Unless
25 you want to.

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1 THE COURT: The Court usually asks those questions.

2 MR. EGLET: The Court asks -- the Court will ask the
3 question.

4 THE COURT: You know, I'll wait until after you're done.

5 MR. ROGERS: All right. Well I'm not sure what I'm
6 permitted to ask now, other than to ask the doctor what's
7 causing the neck pain.

8 I don't think he's going to carpel tunnel. Because
9 he can't say carpel tunnel's causing neck pain.

10 MR. EGLET: The point is, he said he didn't know in his
11 deposition. So the question should be, "Do you know, yes or
12 no" or the other question, "Is there any objective evidence of
13 a neck injury in this case? Yes or no?"

14 THE COURT: I think those are both fine questions.

15 MR. ROGERS: All right.

16 THE COURT: Sustain the objection.

17 [Bench Conference Ends at 4:05 p.m.]

18 BY MR. ROGERS:

19 Q Doctor, where we left off was a question about
20 cause. And --

21 A A question about what?

22 Q What causing these symptoms. The question is, were
23 these discs that the Plaintiff had removed and fused injuries
24 as a result of this accident?

25 A No.

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1 Q Did you see any evidence of injury to those discs at
2 any time in the roughly four year period -- five year period
3 now of treatment following the accident?

4 A No.

5 Q Of all the opinions that you've stated today as to
6 the reasonable degree of medical probability?

7 A Yes.

8 Q Thank you.

9 THE COURT: Before Plaintiff examines, there's one
10 question posed by one of the questions I wanted to read into
11 the record. And then if you can answer the question please do
12 so, Doctor. It reads: "Could the disc heal over this time
13 period, but the nucleus not heal?"

14 THE WITNESS: No. The -- if the disc is damaged it'll
15 stay damaged. It doesn't really heal, unfortunately. What
16 you're talking about is genetic applications where you're
17 placing in growth factors to try to heal a disc and we're not
18 there yet.

19 THE COURT: I'll ask this be marked as Court's Exhibit
20 Next in order.

21 Okay, whenever you're ready, Mr. Eglet.

22 CROSS-EXAMINATION

23 BY MR. EGLET:

24 Q Good afternoon, Dr. Fish.

25 A Good afternoon, sir.

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1 Q Doctor, you would agree that there's a lot of heart
2 in medicine, correct?

3 A Yes.

4 Q And you have had patients in your practice over the
5 years that have been referred out for second opinions.
6 Correct?

7 A Yes.

8 Q On occasion those second opinions have come back and
9 they have disagreed with your opinions and recommendations.
10 Correct?

11 A I think it depends on the circumstances.

12 Q On occasions that's occurred. Correct?

13 A It's possible. I don't know.

14 Q Well, do you recall testifying in a previous
15 deposition that that in fact has occurred?

16 A Yeah. I'm sure I said that.

17 Q All right.

18 A I'm sure it's occurred.

19 Q In fact while we're on --

20 A I just don't know.

21 Q While we're on the subject -- this is the wrong
22 book. This is my -- where is my deposition one? This is
23 Exhibits.

24 [Counsel Confer]

25 MR. EGLET: Your Honor, at this time we would like to

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1 publish the original deposition transcripts of Dr. Fish, which
2 have been lodged with the Court in the Tonius v. Howard case,
3 the Varvela v Lexi case, the Gilbert v. Shankar case, Laguna
4 v. Bates case, the Wiley v. Varella Bretton case, the Shultz
5 v. Young case, the Rangle v. Rashner case, the Lemon v.
6 Alderson case, the Lie v. Alderson case, as well as the Simao
7 case.

8 THE COURT: Any objection?

9 MR. ROGERS: Yes, Your Honor. May we approach?

10 THE COURT: Very well.

11 [Bench Conference Begins at 4:08 p.m.]

12 MR. ROGERS: They can't lay the foundation of any
13 relevance to testimony or treatment of a different patient.
14 And there could be the -- obviously --

15 MR. EGLET: I'm not talking about treatment right now.
16 I'm talking about publishing depositions of prior testimony
17 that this witness has made in other cases. I'm entitled to
18 use them. You've been on notice of these. These depositions
19 were attached by Mr. Wall to this witness's deposition -- to
20 this deposition. You've been on notice for a long time.

21 MR. ROGERS: It isn't simply a question of notice,
22 though. This is a question of the relevance at all to --

23 MR. EGLET: I haven't gotten to that issue --

24 THE COURT: Well I suspect where we're going, but my
25 question is, you don't dispute that these are valid deposition

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1 transcripts. Do you?

2 MR. ROGERS: it's not an authentication objection. It's
3 an objection as to -- I mean is there even a prior inconstant
4 statement?

5 THE COURT: I think --

6 MR. ROGERS: Is there any relevant use here?

7 THE COURT: I think we're about to find out.

8 MR. WALL: Yeah, because they're not admitted. The jury
9 doesn't get to take them back with them. Just --

10 THE COURT: Well, it's just going to be to get to
11 completion at this point.

12 MR. WALL: -- have it just to go through them.

13 MR. ROGERS: All right.

14 THE COURT: The motion is granted.

15 MR. EGLET: Thank you, Your Honor.

16 [Bench Conference Ends at 4:10 p.m.]

17 BY MR. EGLET:

18 Q While those are being published, Your Honor, I'll
19 move on. Now physicians don't always agree. Do they, Doctor?

20 A No.

21 Q Okay. And you have treated patients over your
22 career who have been involved in injuries that were caused by
23 the negligence or fault of some other person or company.
24 Correct?

25 A I don't understand your questions.

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1 Q You've had patients who you've been their treating
2 physician who have been injured by some other person.
3 Correct?

4 A You mean in a car accident?

5 Q Car accident, any kind of injury. Right?

6 A Oh yes. Yeah. Uh-huh.

7 Q Okay. And you've had occasion where some of the
8 patients were submitted to the defense for a defense medical
9 examination. Some of your patients. Correct?

10 A I'm sure it's happened.

11 Q Okay. And you've seen occasions when those defense
12 medical records -- defense medical examinations may disagree
13 with some of your opinions that you have regarding your
14 treatment of your patients. Correct?

15 A Correct.

16 Q Okay. And you've seen some of these physicians
17 sometimes disagree on your diagnosis of injury. Correct?

18 A Correct.

19 Q Okay. And you've seen these physicians -- these
20 Defense medical physicians hired by the Defense, where you're
21 the treating physician of the patient. You've seen these
22 physicians sometimes disagree on the appropriate treatment
23 plan for the patient. Correct?

24 A Yes.

25 Q Okay. And you've also seen these defense medical

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1 physicians who have conducted these defense medical
2 examinations of your patients disagree with you on what caused
3 the patient's particular problem. Correct?

4 A It happens. Yes.

5 Q It has happened. Hasn't it? You testified under
6 oath --

7 A I'm sure it did.

8 Q -- in the past that that has happened. Correct,
9 Doctor?

10 A I'm sure it did.

11 Q Okay. Now that didn't make you wrong as the
12 treating physicians in all those cases. Did it?

13 A I don't know. It depends on the situation.

14 Q You don't know. Okay. You would agree with me that
15 it is appropriate for your patients to follow your
16 recommendations and directions. Correct?

17 Q Well I make recommendations --

18 A Doctor, do you know what a leading question is?

19 MR. ROGERS: Objection. Your Honor, can I approach?

20 THE COURT: I sustain the objection. Ask you to move on,
21 Mr. Eglet.

22 BY MR. EGLET:

23 Q I'm asking you leading questions. They require yes
24 or no answers. Okay?

25 MR. ROGERS: Your Honor, this is counsel better given the

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1 by the Judge. Should we approach in this?

2 MR. EGLET: Your Honor, I would ask that this witness be
3 told that these are leading questions --

4 THE COURT: Well --

5 MR. EGLET: -- and he is --

6 THE COURT: Well a leading question generally calls for a
7 yes or no answer.

8 MR. EGLET: Now --

9 THE COURT: And on Cross-examination counsel is entitled
10 to ask you leading questions.

11 THE WITNESS: Oh. What was the question again?

12 BY MR. EGLET:

13 Q You believe it is appropriate for your patients to
14 follow the recommendations -- strike that. You believe that
15 it is appropriate for your patients to follow your
16 recommendations and instructions?

17 MR. ROGERS: Your Honor, I'm going to object to this as
18 well. May we approach?

19 THE COURT: Very well.

20 [Bench Conference Begins at 4:13 p.m.]

21 THE COURT: What was wrong with that question?

22 MR. ROGERS: The answer to this question bears no
23 relevance at all to the Plaintiff's burden of proof. Which is
24 to establish not to simply follow the doctors recommendations,
25 but that the treatment was necessary. That sounds like a big

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1 difference.

2 THE COURT: That sounds like fair game for follow up. I
3 overrule the objection.

4 [Bench Conference Ends 4:14 p.m.]

5 BY MR. EGLET:

6 Q You believe that it is appropriate for your patients
7 to follow your recommendations and instructions, correct?

8 A I make recommendations and hope that they consider
9 them but they're recommendations and options. They don't
10 necessarily have to follow what I'm recommending.

11 Q Well, you expect when you're the treating physician,
12 when you made a medical recommendation to a patient, you
13 normally expect your patient to follow your recommendation,
14 right?

15 A I've told patients to quit smoking, they haven't
16 stopped smoking so --

17 MR. EGLET: Your Honor, I'd move to strike as
18 non-responsive.

19 THE COURT: It is non-responsive. I'd ask you to just
20 answer the question, sir.

21 BY MR. EGLET:

22 Q Isn't it true, Doctor, that when you give medical
23 instructions and recommendations to your patients, you expect
24 your patients to follow your recommendations, correct?

25 A Not usually.

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1 Q Not usually. Okay, so when you give medical
2 recommendations for treatment for your patients, you don't
3 expect them to follow your recommendations, is that your
4 testimony?

5 A I hope they will.

6 Q Oh, you hope they will. I see.

7 A I'm making a recommendation.

8 Q You don't expect them to. You just hope they will,
9 is that right?

10 A They've come to me for an opinion. So I've given
11 them an --

12 Q Well, they come to you as a treating doctor, right?

13 A Correct.

14 Q I mean they're not medically trained, are they?
15 Most of your patients? The vast majority of your patients are
16 not doctors, are they?

17 A Correct.

18 Q They don't have the expertise you do, right?

19 A Correct.

20 Q They come to you for you to hopefully tell them
21 what's wrong with them and then tell them what treatment they
22 need, right?

23 A Correct.

24 Q And when you do that, you expect them to follow your
25 instructions, right?

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1 A I hope they do but --

2 Q You hope.

3 A -- I make a recommendation.

4 Q Okay, I see. All right. So let me ask you this.

5 Your hopes -- are your hopes achieved most of the time with
6 your patients? Do your patients actually follow your
7 instructions most of the time or are you disappointed and your
8 hopes not achieved?

9 A Well, it varies.

10 Q Okay. It varies.

11 A Depends on the aggressiveness versus conservative
12 approach. Some of the patients don't want to have an
13 aggressive injection and may just want to do something
14 conservative.

15 Q Generally, Doctor, when a patient without medical
16 training comes to you for treatment and you do tests on them
17 to reach a diagnosis and you recommend a treatment program,
18 generally you find that your patients follow your
19 recommendations, correct?

20 MR. ROGERS: Your Honor, I think the question is vague in
21 that the distinction is drawn is whether it's an invasive or a
22 conservative measure.

23 MR. EGLET: Your Honor, this is a general questions about
24 medical --

25 THE COURT: No, I don't think it was vague. Overruled.

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1 BY MR. EGLET:

2 Q Do you remember the --

3 A Well, the only thing I would say is that a
4 conservative option such as physical therapy is not as
5 invasive as a discogram or an epidural, which is very
6 invasive.

7 Q You know, I don't think I said anything about
8 discograms or epidurals. I simply in general, Doctor --

9 A You said a broad --

10 Q -- in general, answer my question please. In
11 general, when a patient comes to you for treatment and
12 diagnosis, and you diagnose them and you give them a treatment
13 plan, most of the time your patients follow your
14 recommendations, correct, Doctor?

15 A I don't know.

16 Q Okay. You don't keep track of that?

17 A Some follow them, some decide they don't want to
18 follow them. There's various -- I don't make one
19 recommendation. I make several and so they may decide that
20 they don't want to do some of -- I've made recommendations for
21 people to have invasive procedures that they didn't really
22 want to do. And even though I'm making that recommendation,
23 they decide they didn't want to do it. So I don't know if
24 that answers your question.

25 Q No, it doesn't actually. I'm not asking you about

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1 invasive procedures and you know that. Okay.

2 MR. EGLET: You've heard my question, Your Honor.

3 MR. ROGERS: Objection, Your Honor.

4 MR. EGLET: I'm asking you generally --

5 THE COURT: One at a time. One at a time. Because we
6 can only hear one person at a time.

7 BY MR. EGLET:

8 Q Generally, Doctor, generally.

9 A Right.

10 Q I want you to put the idea of discograms and
11 invasive procedures out of your mind because you don't do
12 those on every patient, do you?

13 A No.

14 Q Okay. So generally, when a patient comes to you
15 with some sort of problem and you examine him and you reach a
16 diagnosis and then you recommend a treatment program for them,
17 you recommend generally they follow your recommendations,
18 correct, Doctor?

19 A I think it depends on the recommendation.

20 Q Okay.

21 A If I recommend physical therapy, a lot of patients
22 say that they don't want to go because they don't have the
23 time. It really depends on what they can do.

24 Q So are all of your patients so non-compliant with
25 your recommendations, Doctor?

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1 A It's not non-compliant.

2 Q I mean is there something about your bedside manner
3 that your patients don't want to follow your medical
4 recommendations? I mean I'm not quite getting this.

5 A Look, my job is to educate them in terms of what the
6 diagnosis is and make recommendations based on that in terms
7 of what there's evidence base, the literature supporting it.

8 Q Most people I know who aren't trained in medicine --
9 MR. ROGERS: Your Honor, he didn't answer the question
10 yet.

11 THE COURT: Yeah, you need to let him finish answering
12 the question, Mr. Eglet.

13 BY MR. EGLET:

14 Q Okay. Are you finished?

15 A No, I wasn't actually.

16 Q Go ahead.

17 A And based on those recommendations of what we feel
18 is the most appropriate treatments, I will give them a list of
19 things that these are recommendations that I think you could
20 consider. Now that some of them get very aggressive. If you
21 have somebody with a large disc herniation and they come in
22 with weakness in their leg --

23 Q This is so far off the question.

24 THE COURT: It is. It's now non-responsive.

25 THE WITNESS: I feel like I'm trying to answer your

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1 question, sir.

2 BY MR. EGLET:

3 Q Doctor, it's very simple, okay. I mean people I
4 know who don't have any medical training, when they go to the
5 doctor with a problem, their doctor with a problem and their
6 doctor then diagnoses them and recommends them with some sort
7 of treatment, they generally follow their doctor's treatment.
8 Would you agree with that?

9 A It depends on the problem.

10 Q All right. Now, if a patient is -- if your patient
11 doesn't follow your recommendations for treatment, that might
12 be considered to be non-compliant by the patient, correct?

13 A No.

14 Q Okay. If a patient is non-compliant, oftentimes it
15 will be documented in their medical records, correct, Doctor?

16 A No.

17 Q It's a fair statement that being a non-compliant
18 patient, that that can have an effect on the patient's future
19 treatment with other physicians, correct?

20 A I think your what recommendations are versus
21 compliant.

22 Q Please answer the question. A patient who is non --
23 that's [audio skips at 4:21:22] by a treating physician that
24 they're non-compliant, that can have a [audio skips at
25 4:218:29] treating that patient, correct?

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1 A I can't answer that yes or no.

2 Q Okay. Physicians don't particularly like patients
3 that are non-compliant, do they, Doctor?

4 A No.

5 Q And you [audio skips at 4:21:46] that it is
6 appropriate for a patient to [audio skips] doctors in their
7 [audio skips] who has no medical training.

8 A [Audio skips]

9 Q Now the patient [audio skips] on his recommendations
10 for treatment [audio skips] or has [audio skips] on that
11 treatment, the patient's fault is it, Doctor?

12 MR. ROGERS: Objection. [Audio skips] to the burden in
13 this case.

14 MR. EGLET: Very relevant, Your Honor.

15 THE COURT: It is relevant. Overruled on relevancy.

16 THE WITNESS: Can you ask it again, I'm sorry.

17 BY MR. EGLET:

18 Q Sure. If a patient relies on their doctor's
19 recommendations for treatment and goes forward with that
20 treatment and has complications from that treatment, that is
21 not the patient's fault, is it, Doctor?

22 A I don't think so.

23 Q Okay. And if a patient relies on their doctors for
24 recommendations for surgery and the surgery was not the best
25 or most appropriate treatment for that patient, that's not the

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1 patient's fault either, is it, Doctor?

2 A Can I ask you a question?

3 THE COURT: No, sir, you just have to respond to his
4 question as best you can.

5 THE WITNESS: I thought I -- I can't answer that
6 question.

7 MR. ROGERS: Hold up. No, this gets back to that earlier
8 order, Your Honor.

9 THE COURT: Well, I can't advise the witness on how to
10 answer so let's move on, Mr. Eglet.

11 MR. EGLET: What order are you talking about.

12 BY MR. EGLET:

13 Q You can't fault the patient for relying, if they're
14 not medically trained, for relying on their doctor's
15 recommendations, correct?

16 A Correct.

17 Q All right. They're just following doctor's orders,
18 right? Now, you agree that Mr. Simao followed his physician's
19 recommendations with respect to the treatment he received,
20 correct?

21 A Correct.

22 Q Okay. He followed his physician's recommendations
23 with respect to the surgical procedures he underwent, correct?

24 MR. ROGERS: Your Honor, this opens the door.

25 THE COURT: Counsel approach please.

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1 [Bench Conference Begins at 4:23 p.m.]

2 MR. EGLET: Opens the door to what?

3 MR. ROGERS: You have asked that he not be allowed to
4 offer any opinions relating to surgery. He's sitting there in
5 his chair going I don't even know what to say now.

6 MR. EGLET: No, I'm not asking him opinion for
7 [indiscernible]. I'm asking him isn't it true that Mr. Simao
8 followed the recommendations of his surgeons to have surgery.
9 That's true. He knows that. That's not asking for an opinion
10 on his --

11 MR. ROGERS: The doctor, yeah --

12 THE COURT: Mr. -- and I'm not seeing that's an improper
13 question, Mr. Rogers.

14 MR. ROGERS: Well, you can see that the doctor is saying
15 simply he's looking at you going look, I don't want to get in
16 contempt here.

17 MR. EGLET: He's not going to be in contempt.

18 MR. ROGERS: That's what's happening answering that
19 question. And I --

20 THE COURT: I'm not seeing that the question is improper
21 based on any pretrial rulings.

22 MR. ROGERS: No, I'm just telling you that he doesn't
23 know now whether he can even respond to it because of you.

24 MR. EGLET: It's a yes or no answer, Steve. He can
25 respond to it.

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1 THE COURT: Overrule the objection.

2 [Bench Conference Ends at 4:24 p.m.]

3 MR. ROGERS: He can't answer it.

4 BY MR. EGLET:

5 Q All right, Doctor. The pending question was Mr.
6 Simao, isn't it true, followed his physician's recommendations
7 with respect to the surgical procedures he underwent, correct?
8 He followed his physician's recommendations, correct?

9 THE COURT: I think it's a yes or no -- calls for a yes
10 or no answer, sir.

11 THE WITNESS: But it calls for me to make a decision on
12 the surgery and make --

13 BY MR. EGLET:

14 Q No, it doesn't, Doctor. I'm not asking you for your
15 opinion of whether you think the surgery was appropriate or
16 not. I'm asking you a very simple question. Isn't it true
17 that Mr. Simao followed the instructions of his surgeons when
18 they recommended surgery, correct?

19 A It calls for me to ask about surgery which I didn't
20 think I was able to discuss.

21 THE COURT: It doesn't call for you to do anything other
22 than respond yes or no.

23 BY MR. EGLET:

24 Q It doesn't ask you to do that, Doctor, in any way,
25 shape or form. I'm asking you --

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1 A I don't know the legal aspect. I only know the
2 medicine aspect.

3 Q Did Mr. Simao follow the instructions of his
4 physicians? You've already asked that. You've already
5 answered that and you said yes, correct?

6 A And I did.

7 Q And one of the --

8 MR. ROGERS: Your Honor, can we get an instruction? Just
9 advise him that he can respond to this question.

10 THE COURT: Well, I thought I did. I thought the
11 question called for a yes or no answer. If you can't answer
12 it yes or no, I guess you can just say you can't answer the
13 question.

14 BY MR. EGLET:

15 Q One of the recommendations that was given to him,
16 Mr. Simao, by two different spine surgeons was surgery on his
17 cervical spine, correct?

18 A I can't answer that yes or no.

19 Q You can't answer whether they gave a recommendation
20 for spine surgery or not?

21 A I can't answer that yes or no.

22 Q Okay. Can you -- isn't it true that Mr. Simao
23 followed the recommendations of his spine surgeons to have
24 surgery? Yes or no?

25 A I can't answer that yes or no.

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1 Q Okay. Have you read all the records in this case?

2 A Yes, I have.

3 Q Are you aware that Mr. Simao had spine surgery on
4 his neck?

5 MR. ROGERS: Your Honor, let's just approach.

6 [Bench Conference Begins at 4:26 p.m.]

7 MR. EGLET: I'm not asking him to comment on -- it's
8 ridiculous.

9 THE COURT: I know. I know.

10 MR. EGLET: What he's saying --

11 THE COURT: It is ridiculous.

12 MR. ROGERS: He doesn't know that he can talk about
13 anything relating to surgery. That's why he's --

14 MR. EGLET: I have read the -- I've read ten depositions
15 of this guy and this is the games he plays. Every single
16 time, he won't respond to hypotheticals. He won't answer
17 questions. It goes on and on. I've read trial testimony.
18 This is his MO. Okay. This is his MO. He wants to continue
19 to look ridiculous up there. This is a simple question.

20 MR. ROGERS: Allow me to tell him that he can respond to
21 these questions and not be in violation of any order.

22 THE COURT: Well, wait a minute. The question is posed
23 as a yes or no. He can answer the question with a yes or no.
24 The question doesn't call for him to --

25 MR. ROGERS: And I'll tell him just that. Don't offer an

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1 opinion.

2 THE COURT: The Court's instructed a number of times.
3 Here's the thing. Here's the thing I don't understand. This
4 guy is making it so much worse for himself. Does he have any
5 idea?

6 MR. ROGERS: So many what?

7 THE COURT: Does he have any idea how he looks in front
8 of the jury?

9 MR. EGLET: No.

10 THE COURT: Or does he just not care?

11 MR. EGLET: This is how he does it every time. There's
12 a --

13 MR. ROGERS: Look I've never seen him here before.

14 THE COURT: I'd really like to know.

15 MR. WALL: There's a certain petulant aspect about him --

16 THE COURT: Uh-huh.

17 MR. WALL: -- where if you're not going to let me say all
18 the things I want, Judge, then I'm going to act pissed off.
19 I'm being restricted and I can't talk and find my way out, you
20 know --

21 MR. ROGERS: And to --

22 MR. WALL: Let me finish my sentence.

23 MR. EGLET: I'm not going to do a character assessment.
24 I'm just telling you that every question that relates to
25 surgery, he's looking at me and you and he just doesn't seem

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1 to get it.

2 MR. WALL: The question doesn't relate to surgery. The
3 question relates to whether the patient followed the
4 instructions of his doctor.

5 MR. ROGERS: Let me tell him. Don't offer an opinion,
6 yes.

7 [Bench Conference Ends at 4:29 p.m.]

8 THE COURT: Overrule the objection.

9 [Court and Marshal Confer]

10 BY MR. EGLET:

11 Q All right, Doctor. Now, you would agree that Mr.
12 Simao followed his physician's recommendations with respect to
13 the surgical procedures he underwent, correct?

14 A Correct.

15 Q Okay. He followed his physician's instructions with
16 respect to the diagnostic procedures he underwent, correct?

17 A Correct.

18 Q Okay. Now, you would agree that physicians rely
19 upon the history provided to them by their patients in
20 reaching opinions about causation, correct?

21 A Correct.

22 Q And you do that as well, don't you, Doctor?

23 A Correct.

24 Q Okay. And in fact, you did that in a case called
25 Gilbert, right? Gilbert v. Shanker (phonetic).

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1 A I don't remember.

2 Q Okay. Very good.

3 MR. EGLET: I'm jumping around, Your Honor, because it's
4 obvious I'm not going to finish today. So I'm just going to
5 get into some areas that --

6 BY MR. EGLET:

7 Q Doctor, you are a member of the North American Spine
8 Society, correct?

9 A Yes.

10 Q The acronym for that is NASS?

11 A Correct.

12 Q Okay. And you're familiar with the protocol of the
13 North American Spine Society, correct?

14 A Which protocol?

15 Q Well, the North American Spine Society has set forth
16 criteria or protocol for the diagnosis of internal disc
17 disruption, correct?

18 A Correct.

19 Q Okay. And you're familiar with the diagnosis of
20 injury of the disc or disc disruption or internal disc
21 disruption, correct?

22 A I'm familiar with it, yes.

23 Q Okay. And internal disc disruption can be caused by
24 a traumatic event, correct?

25 A No, I disagree with that.

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1 MR. EGLET: All right. Could I have the deposition
2 transcript for Barvella (phonetic) please?

3 BY MR. EGLET:

4 Q I'm handing you the original deposition transcript
5 in a case called Barvella. The deposition was taken of you.
6 You recall that?

7 A In 2006, five years ago.

8 Q 2006. Okay. You recall your deposition being taken
9 in this case?

10 A Yes.

11 Q Okay. And in this case, Barvella, you were hired by
12 the defense as a medical expert, correct?

13 A I don't remember.

14 Q Well, you have any reason to doubt that if I tell
15 you that?

16 A No, I don't.

17 Q Okay. And in this case, your deposition was taken,
18 you were put under oath, correct?

19 A Correct.

20 Q You're sworn to tell the truth just like you did
21 here in this Court, correct?

22 A Correct.

23 Q Okay. All right. Would you please turn to page 85
24 of your deposition transcript?

25 A Okay.

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1 Q Would you read silently lines 18 through 25 of page
2 85 and then lines 1 through 4 of page 86.

3 A And what was the other one?

4 Q The next page. To line 2, 86, line 2.

5 MR. EGLET: It's line 52.

6 THE WITNESS: Okay.

7 BY MR. EGLET:

8 Q Okay. Now you were asked in your deposition and the
9 following questions and you gave the following answers on this
10 date, correct?

11 "Q I'm assuming that a person, we won't use
12 this person, just a person that's been in an
13 accident, you would agree with me certainly that
14 with sufficient trauma that that individual could
15 have sprain/strain of a ligamentarious area and also
16 could sustain internal disc disruption?"

17 What's not on the screen here which is in the
18 deposition transcript is you say uh-uh. You see that in the
19 transcript?

20 A Yes, I do.

21 Q Thank you. Then the next question is:

22 "Q Painful internal disc disruption, agree,
23 they can have both of those things?"

24 And your answer is sure. That was the testimony you
25 gave under oath at that time, correct, Doctor?

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1 A Correct.

2 Q All right. Now, disc disruption can be painful,
3 correct, Doctor?

4 A We're not clear. I don't know.

5 Q Okay. Take a look again at this testimony. Second
6 question, second part of the question, painful internal disc
7 disruption, agreed, they can have both of those things and
8 your answer is sure, correct?

9 A Correct.

10 Q Thank you. Now, disc disruption can cause radicular
11 symptoms, correct?

12 A I don't believe that.

13 Q You don't believe that?

14 A No. Well now maybe I'm -- can we define what you
15 mean by internal disc disruption?

16 Q Well, you testified that you're familiar with the
17 diagnosis of internal disc disruption, correct?

18 A Are we talking --

19 Q You testified that you're familiar with the
20 diagnosis of internal disc disruption, correct?

21 A Correct.

22 Q All right.

23 A That's such a large term. It would be many
24 different factors. I think what you're pointing out --

25 Q Turn to page --

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1 MR. EGLET: Move to strike, Your Honor.

2 THE COURT: The jury will disregard the witness' last
3 statement.

4 BY MR. EGLET:

5 Q Turn to page 79 of the same deposition please.

6 A 79.

7 Q 79. And take a look at lines 21 through 23.

8 A Yes.

9 MR. EGLET: Okay. Put up slide 50 please, Brennan.

10 BY MR. EGLET:

11 Q Isn't it true that you were asked in this case under
12 oath, are you familiar with the term internal disc disruption
13 and your answer is yes, correct?

14 A Correct.

15 Q All right. Now, to diagnose traumatically caused
16 internal disc disruption, there's a certain criteria that
17 orthopedic spine surgeons will use that is set forth by the
18 North American Spine Society in their criteria, correct?

19 A It's a suggested criteria, yes.

20 Q Okay. And the criteria includes the history of the
21 patient, correct?

22 A Correct.

23 Q Okay. It includes their presenting complaints,
24 correct?

25 A Correct.

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- 1 Q It includes the physical examination, correct?
- 2 A Correct.
- 3 Q Including provocative physical examinations,
- 4 correct?
- 5 A Correct.
- 6 Q Okay. Such as Sperling tests and things like that,
- 7 correct?
- 8 A Correct.
- 9 Q Okay. It includes whether the patient has improved
- 10 from conservative treatment like physical therapy, pain
- 11 medications or just time, correct?
- 12 A Correct.
- 13 Q Okay. And it can include also diagnostic study
- 14 procedures like MRIs and pain management injections, correct?
- 15 A Correct.
- 16 Q Okay. And also discography, correct?
- 17 A Correct.
- 18 Q Okay. Now chronic pain, Doctor, is defined as pain
- 19 that lasts longer than six months, correct?
- 20 A Correct.
- 21 Q You will agree that a whiplash can last up to no
- 22 more than two years, correct?
- 23 A You mean -- it usually improves after two years,
- 24 yes.
- 25 Q Usually it does not last -- two years is like the

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1 outer limit that you're going to have symptoms from a
2 whiplash, right?

3 A In normal cases, yeah, you're going to pretty much
4 resolve most whiplash injuries after about two years.

5 Q Okay. In fact, you will agree that 99 percent of
6 whiplash injuries resolve on their own, correct?

7 A Correct.

8 Q And you would agree that a patient who has pain in
9 his neck after an accident say in 2005 and they still have
10 pain in their neck today, that that pain would not be
11 classified as a sprain/strain because in your opinion a
12 sprain/strain would have resolved in no more than two years,
13 correct?

14 A There's a lot of factors with that question. I
15 don't know if I can answer it yes or no.

16 Q It is also your opinion that 80 to 90 percent of
17 cervical strain/sprain injuries will resolve within three to
18 five months, correct?

19 A Correct.

20 Q Anything beyond six months where a person is still
21 having pain in the neck which would be considered chronic, you
22 would start wondering if that's actually cervical
23 sprain/strain because normally that would be resolved,
24 correct?

25 A They're still having pain.

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1 Q Yes.

2 A So, yes.

3 Q Okay. And if pain from an injury is discogenic,
4 that doesn't always resolve within six months, correct?

5 A I don't know.

6 Q Or two years, correct?

7 A I don't know.

8 MR. EGLET: Can I have the Lemon deposition transcript
9 please?

10 BY MR. EGLET:

11 Q Okay. Could you turn, sorry, I'm handing you your
12 deposition transcript from the Lemon case, Dr. Fish, where you
13 were also retained as a defense expert. You recall that case?

14 A Yes, this was 2010 so it's much more fresh in my
15 mind.

16 Q Okay. So could you please turn to page -- let me
17 ask you this question first. You would agree that if the neck
18 pain hasn't resolved in six to eight months, that would lead
19 one to think that the pain may be facet mediated or discogenic
20 pain, correct?

21 A Is the pain continuous? Is that a continuous pain?

22 Q Yes.

23 A Well, if it's a continuous pain, yes.

24 Q Okay.

25 A It's possible.

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1 Q Now, after a trauma, a patient can have both a
2 cervical sprain/strain and internal disc disruption, correct?

3 A A disc problem, yes, you can have both.

4 Q Okay. And if the trauma causes internal disc
5 disruption, it often causes sprain/strain also in the same
6 area, correct?

7 A Yes.

8 Q And that person could experience pain from both the
9 soft tissue injury as well as the internal disc disruption,
10 correct?

11 A Yes.

12 Q So if you resolve the sprain/strain issue and the
13 person is still having pain, you would agree with me that the
14 pain could be facet mediated pain or it could be pain as a
15 result of internal disc disruption, correct?

16 A Correct.

17 Q Okay. Usually a patient who is ultimately diagnosed
18 with internal disc disruption, the initial working diagnosis
19 in the emergency room or primary care physician is
20 sprain/strain, correct?

21 A I don't know.

22 Q I want you to assume for me for this question that
23 Mr. Simao had a C3,4/C4,5 disc disruption. You understand
24 that?

25 A No.

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1 Q I want you to make that assumption for this
2 question.

3 A Oh, okay.

4 Q You understand that?

5 A I understand that.

6 Q All right. With that assumption, you have not
7 calculated a more probable cause of that C3,4/4,5 disc
8 disruption than the 4/15/05 motor vehicle accident, have you?

9 A I don't understand the question.

10 Q It's a yes or no answer.

11 A I don't understand it.

12 Q Okay. Assuming he has C3,4/4,5 disc disruption, you
13 have not calculated a more probable cause for that disc
14 disruption than the April 15th, 2005 motor vehicle crash,
15 correct? You haven't done that, have you?

16 A Haven't done what?

17 Q Haven't calculated a more probable cause, have you?

18 A We're talking about a hypothetical?

19 Q Yes.

20 A I don't know how to answer that question. I don't
21 know if I understand it.

22 Q All right. Well, let me ask it this way. There is
23 no intervening traumatic event that affected Mr. Simao's neck
24 from the time of the April 15th, '05 crash to the present,
25 correct?

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1 MR. ROGERS: Your Honor, may we approach?

2 THE COURT: Sure.

3 [Bench Conference Begins at 4:44 p.m.]

4 MR. ROGERS: It's one thing to exclude evidence of an
5 unrelated accident. It's another thing to misrepresent to the
6 jury that nothing ever happened.

7 MR. EGLET: Oh, no, no, no.

8 MR. ROGERS: There's a subsequent accident, they know it,
9 then don't misrepresent it.

10 MR. EGLET: I'm not misrepresenting anything. This
11 witness has testified and he's stated under oath that no
12 intervening act even -- that's why the Court excluded those
13 intervening acts because he along with Defense experts said
14 they had no effect on his neck. That's the question.

15 MR. ROGERS: But --

16 MR. EGLET: There's been no intervening event since the
17 time of this accident which would have caused his neck injury.
18 He agreed to that.

19 THE COURT: There's no evidence of any.

20 MR. EGLET: None.

21 MR. ROGERS: There's -- but there's a fact of this event
22 and we're telling the jury it didn't happen.

23 THE COURT: Mr. Rogers, there's no [indiscernible].

24 MR. ROGERS: I'm sorry.

25 THE COURT: There's no way, counsel is [indiscernible].

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1 MR. ROGERS: Okay, that's your order.

2 [Bench Conference Ends at 4:45 p.m.]

3 THE COURT: Overrule the objection.

4 MR. EGLET: Thank you, Your Honor.

5 BY MR. EGLET:

6 Q Now, I can resume my question, Doctor. Isn't it
7 true that there was no intervening traumatic event that
8 affected Mr. Simao's neck from the time of the April 15th,
9 2005 crash to the present, correct?

10 A I can't answer that yes or no.

11 Q You don't know?

12 A I can't answer that yes or no.

13 MR. EGLET: Your Honor, may we approach?

14 THE COURT: Yes.

15 [Bench Conference Begins at 4:45 p.m.]

16 MR. EGLET: This witness is being an obstructionist
17 beyond belief. He knows he can answer that question. He did
18 not offer and he in fact specifically said that he cannot say
19 that this intervening accident had any effect on his neck.
20 For him to sit there now and try to say I can't answer that
21 question and lie otherwise, he is being an obstructionist. He
22 is evasive. I've never seen such an unprofessional expert
23 witness in all my years.

24 THE COURT: Well, I have neither quite frankly. I'm
25 really surprised that he would do this to himself.

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1 MR. EGLET: So I'm going to -- hang on one second, let me
2 look at my notes. I'll be right back.

3 THE COURT: Okay.

4 MR. EGLET: I'm going to go to another area. But I would
5 like a hearing after this real quick and I'm going to be done
6 -- I'm not -- when you're done, I'm going to be done for the
7 day. I'm going to go to another area real quick and I'd like
8 a hearing with this witness before the Judge to get this guy
9 straight. Otherwise, I'm going to make a motion to strike his
10 testimony.

11 THE COURT: I've been meaning to break now because I have
12 to leave here at 5:00 today.

13 MR. EGLET: All right.

14 THE COURT: Want to break now?

15 MR. EGLET: One second, Your Honor.

16 [Bench Conference Ends at 4:16 p.m.]

17 MR. EGLET: One question, Your Honor, and then we can
18 break for the day and we can come back to the other area.

19 BY MR. EGLET:

20 Q I'm going to move to another area real quick because
21 I want to get this in before the break, Doctor. You would
22 agree with me that according to the North American Spine
23 Society, the gold standard for diagnosing internal disc
24 disruption is discography, correct?

25 A No.

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1 Q Okay, Doctor, would you turn to the Barvella
2 deposition which you should still have in front of you. If
3 you take a look at page 80 please. Actually start on page 79.

4 A Okay.

5 Q Reading lines 21 through 25 and then on 80, lines 1
6 through 9.

7 A I can't read this.

8 Q You can't read it?

9 A Huh-uh.

10 Q What is it you can't read?

11 A That word.

12 Q You're on the wrong deposition. This is Lemon.

13 A Oh. Page 80 of which?

14 Q Page 79 --

15 A Of --

16 Q It's the only other deposition you have there,
17 Doctor.

18 A I just want to make sure.

19 Q Barvella.

20 A Okay.

21 Q Lines 21 through 25 and then -- on 79 and page 80,
22 lines 1 through 9.

23 A Okay.

24 Q Isn't it true when you testified under oath as a
25 defense expert witness in this case, you were asking the

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1 following questions and gave the following answers?

2 "Q Are you familiar with the term internal
3 disc disruption?

4 "A Yes.

5 "Q Are you familiar with the protocol of the
6 North American Spine Society?

7 "A Yes.

8 "Q Are you a member of the North American
9 Spine Society?

10 "A Yes.

11 And Brennan, please put up slide 92.

12 "Q And are you familiar with the gold standard
13 for diagnosing internal disc disruption? Would you
14 agree with me that according to the North American
15 Spine Society, it is discography?

16 And your answer was correct, correct, Doctor?

17 A I'm familiar but you're also taking it out of
18 context without the other information such as the MRI.

19 MR. EGLET: Move to strike as non-responsive, Your Honor.

20 THE COURT: Yeah, the jury will disregard the witness'
21 last statement.

22 BY MR. EGLET:

23 Q Isn't it true, Doctor, that when your deposition was
24 taken under oath in the Barvella case, you were asked the
25 following question and gave the following answer? Yes or no?

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1 "Q And are you familiar with the gold standard
2 for diagnosing internal disc disruption? Would you
3 agree with me that according to the North American
4 Spine Society is discography.

5 And your answer was correct. Did I read that
6 correctly, Doctor?

7 A Yes, you did, Mr. Eglet.

8 MR. EGLET: Thank you. That's all for today, Your Honor.

9 THE COURT: That's quite enough. All right.

10 [Court Admonishes Jury]

11 THE COURT: I ask you to return tomorrow at noon if you
12 would be so kind because we have a lot to get through and I
13 don't intend to keep you past 5:00 tomorrow. So thank you,
14 have a nice evening.

15 [Jury Out]

16 THE COURT: Okay, outside the presence of the jury. Mr.
17 Eglet.

18 MR. EGLET: Yes, Your Honor. As I indicated to the
19 bench, Your Honor, at the bench, in 24 years of practice, I
20 have never seen an expert witness be such an obstructionist
21 and refuse to answer questions. Very direct, very easy, very
22 straightforward yes or no questions on the stand. As the
23 Court is aware, I have tried more than a hundred jury trials
24 in this jurisdiction with expert witnesses in virtually every
25 one of them.

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1 Now, I was warned about Dr. Fish to be quite
2 frankly. And I did quite a bit of research. I have read at
3 least ten depositions that he has given in the past and one of
4 the depositions he has up in front of him for example is the
5 Lemon case. In that case, Mr. Banna (phonetic) took his
6 deposition and in that case this witness spent probably 30 to
7 45 minutes refusing to understand what it meant to assume
8 facts, to assume a hypothetical. And refused to answer the
9 question and it went on and on and on. And you look at his
10 deposition transcripts and what is clear is that he is the
11 biggest moving target you've ever seen. Not only in this
12 case, but in virtually every single one of these cases, he
13 changes his opinion from his reports to the time of his
14 deposition and then when he gets to trial, he changes his
15 opinion again.

16 He is the most obstructionist witness I have ever
17 witnessed in my years of practice. I don't quite know how to
18 cure this problem with him. But if this continues in this
19 fashion, it is going to take me days to cross-examine this
20 witness. So I don't know if the Court wants to have a
21 discussion with this witness or what's going to happen but
22 there's no way we're going to finish this trial in a timely
23 manner unless this witness answers the questions that are
24 posed to him instead of trying to answer questions that are
25 not posed to him. He is an expert. He knows what leading

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1 questions are. He knows he's required in cross-examination to
2 answer yes or no. And then when he doesn't want to answer a
3 question, he says well I can't answer that question yes or no.
4 Everyone in this courtroom knows what's going on including
5 this witness.

6 THE COURT: Mr. Rogers.

7 MR. ROGERS: Thank you, Your Honor. There are
8 complexities in medicine that lawyers seem to simplify to ways
9 that really don't make sense to doctors. This can be
10 confusing. When Dr. Fish said from the stand, look internal
11 disc disruption is much bigger than that, the immediate
12 picture I got was of Dr. McNulty saying that a sprain injury
13 doesn't actually meet the dictionary definition. That's not
14 what people mean when they say that. So it's not
15 obstructionist for a medical expert who's confronted with a
16 very complex topic to say hold up, it's not that simple.

17 I understand Plaintiff's counsel's intention to get
18 through this examination quickly. I don't fault him for that
19 at all. If we can give the doctor some understandable
20 manageable way to respond to these questions that doesn't
21 somehow stray from the truth, so that he can say look, this is
22 my medical opinion and that's an honest expression of it, then
23 great, let's do that. Let's have you talk to him and just say
24 look, this is how I want you to do it.

25 MR. EGLET: Your Honor, I have tried more than 50 spine

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1 cases in this jurisdiction. I am very familiar with the
2 medicine when it comes to spine patients, particularly spine
3 surgery and pain management physicians. I understand the
4 procedures. I have studied the procedures. The Court knows
5 that. I understand these procedures very, very well. These
6 questions are not complicated questions. They're very simple.
7 The Court has seen these cases before. This is unbelievable
8 what's going on here.

9 THE COURT: You know, it is unbelievable because I'll
10 tell you what. I've listened to a lot of questions and I've
11 heard a lot of witnesses give testimony and maybe because we
12 get paid to listen, we are maybe more attuned to listening
13 carefully to the questions. But these questions that Mr.
14 Eglet has posed are very, very narrow specific questions that
15 have called for a yes or no answer and we've gotten -- hardly
16 ever have we gotten yes and no responses from this witness.
17 So I can sense some of counsel's frustration. These are not
18 questions that call for narrative responses. They're not
19 questions frankly that call for anything other than a yes or
20 no answer. So, you know, I don't know what to say. I think
21 this witness is making it a lot harder for himself and for the
22 Defense's case than he needs to.

23 And I'll tell you something else. My experience
24 when I talk to jurors after a trial is that they see in here
25 everything that the Court is seeing and hearing. So I don't

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1 know what to tell you.

2 MR. ROGERS: Okay, I will meet with Dr. Fish afterwards
3 and well have that discussion.

4 THE COURT: Okay. See you tomorrow at noon.

5 MR. EGLET: Well, can we get an idea of when Dr. Fish is
6 going to return for me to finish my cross-examination of him.

7 MR. ROGERS: Right, I'll learn that as well. But I --

8 MR. EGLET: Well, I would like to know -- actually we've
9 got the doctor on the stand, we did this with McNulty and we
10 want -- we need him on the stand before Wong. Wong is going
11 on on Tuesday. So he needs to come back Monday.

12 THE WITNESS: I can't come back Monday.

13 MR. ADAMS: Well, then he'll have to take the spot of
14 Dr. --

15 MR. EGLET: And he can take the spot of Dr. Wong on
16 Tuesday.

17 THE WITNESS: I have a full patient load for these two
18 days. I can't just cancel all these patients. That's unfair.

19 MR. EGLET: Then I would move to strike this witness as
20 an expert.

21 MR. ROGERS: Let me discuss --

22 MR. EGLET: We gave them this spot as an accommodation to
23 them. The reason we are here now at 5:00, Your Honor, without
24 being close to being finished with this witness is because of
25 his refusal on the first hand in direct to comply with the

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1 Court -- pretrial Court orders because he kept going off the
2 reservation and we kept having to come to the bench on that
3 and then in cross-examination his complete obstructionist.
4 He's put us in this position. We made an accommodation to
5 take this witness out of order for them. He needs to come
6 back on Monday or Tuesday or I'm moving to strike this witness
7 has an expert in this case.

8 MR. MICHALEK: Your Honor, I don't know if that's an
9 appropriate -- and I'll stick to the issue. You know,
10 normally Defendants and Plaintiffs are entitled to bring their
11 witnesses in the order that they direct. We do appreciate
12 that Plaintiff's counsel tried to give us this time and this
13 day in order to, you know, to get through his testimony. But
14 we didn't. It's the same thing that's happened with some of
15 the other witnesses. We haven't finished Dr. McNulty. But to
16 say that, you know, he has to come back tomorrow I think is
17 improper. We have a two week or three week span here where we
18 can have days where he can come back. For the Plaintiff to
19 say well, you know, he must testify tomorrow, I don't think
20 that's proper. Otherwise, we would have had Dr. McNulty who
21 would have had to come back today to finish his testimony.
22 You know, we will make accommodations to try and get him back.
23 But to say well, you know, to cancel his schedule, to cancel
24 his patients, to cancel surgery, I don't think that's
25 appropriate when we do have a couple more weeks at the rate

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1 we're going, you know, to have him come back and testify.

2 MR. WALL: Judge, we put him as an accommodation to the
3 Defense today because we thought that he wasn't going to be
4 available once the Defense case began. That's what we were
5 told. That's why he's testifying in the middle of our case.

6 THE COURT: That's interesting.

7 MR. ROGERS: Go ahead.

8 MR. MICHALEK: What I'm saying, Your Honor, is you know
9 it's certainly easier to cancel appointments two or three
10 weeks from now than cancel something on Monday when some
11 patient is looking for surgery. You know, I know that, you
12 know, just like the Plaintiff, if they were told, you know,
13 they had surgery scheduled for a Monday and all of a sudden
14 they couldn't do it because some doctor, you know, had to
15 rearrange his schedule at the last minute, they would
16 certainly be upset. The same way Dr. Fish's patients are
17 going to be, you know, upset if their doctor is not going to
18 be available for them on Monday. We will bring him back.
19 We're not saying we won't. We're just going to try to get him
20 back in a reasonable time. I don't think that we can force
21 him to come back necessarily on Monday on short notice when
22 there are a long list of patients that, you know, need to have
23 their doctor available for them.

24 MR. EGLET: Actually the Court can force him to come
25 back. The Court has absolute authority to force this witness

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1 to come back. He's within the Court's jurisdiction right now
2 and you can order him to be back.

3 Now as Mr. Wall stated, as an accommodation to the
4 Defense, we allowed this witness to go on this day, disrupted
5 our case, and we in fact set aside in allowing them to take a
6 witness out of order on Tuesday. It is unfair for us to be
7 able to have this witness go on and on. Now this counsel's
8 now talking about two or three weeks. I don't know what he's
9 talking about, two or three weeks. This case better be done a
10 lot sooner than that. Two or three weeks now. Of course, the
11 way this examination is going, it may not be. But our point
12 is we accommodated them because they said this is the only day
13 he could be here and he couldn't be available in their case in
14 chief. He has put us in this position where we are as the
15 Court has recognized because of the way he has acted on the
16 stand in this case. He has put us in this situation. I'm
17 sorry about his patients. But either he comes back Monday,
18 comes back Tuesday, or I make a motion right now, I'm making
19 the motion that this witness be struck from this trial.

20 MR. ROGERS: If I could. The doctor told me when it was
21 getting close to 5:00 that he said I'm going to be available
22 tomorrow morning but I won't be available after that. I said
23 well we're not going to back here until noon. Perhaps what we
24 can do is go and see what his schedule will allow and get
25 right back to counsel. He naturally doesn't have everything

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1 in front of him. But he needs to find out and striking really
2 is excessive. I don't know what strategy the Plaintiff has
3 that really requires Dr. Fish to return before another given
4 witness. But striking a witness because of party strategy is
5 an improper and an excessive sanction.

6 MR. WALL: Let me add this. Two things. First of all,
7 it's certainly within the Court's province since you have
8 jurisdiction over him right now to find out when he's
9 available. Two, but for our accommodation to them, he
10 wouldn't have testified at all. So instead because we
11 accommodated them and we tried to do it with Dr. Wong and we
12 are willing to do it as all trial lawyers try to do, because
13 we accommodated them, all the jury has is his direct testimony
14 save for about 15 minutes of cross. So we are in a far worse
15 situation than if we had not accommodated them.

16 THE COURT: Uh-huh.

17 MR. WALL: And that's not -- that's a disincentive to
18 ever accommodate the other side again. I'm not talking about
19 Mr. Rogers and Mr. Michalek specifically but now we're in the
20 position where we're talking two or three weeks from now.
21 Until then, they're going to be set with only his direct
22 testimony and not his cross? And I got to tell you, my
23 opinion for whatever it's worth, is that it was not Mr.
24 Rogers' examination questions that caused the delay today. It
25 was even on direct, it was Dr. Fish's inability to answer. So

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1 you have him here now. And you have authority over him but
2 two or three weeks from now isn't going to work. Because
3 we're going to be done.

4 MR. MICHALEK: Your Honor --

5 THE COURT: What's the schedule tomorrow? I've heard
6 enough on this issue. What's the schedule tomorrow?

7 MR. WALL: We have Dr. McNulty returning.

8 MR. EGLET: We have Dr. McNulty who we would have
9 finished today but for accommodating this witness. We would
10 have finished his testimony today. We finished his direct.
11 They didn't get their cross done. We would have brought him
12 back to be finished today. But he's going on at noon
13 tomorrow. He has moved a surgery, moved a surgery so he can
14 come on at noon tomorrow. Dr. Grover has canceled his
15 surgeries for tomorrow afternoon so he can testify tomorrow.

16 THE COURT: You think we're going to hear -- you think
17 we're going to complete McNulty and Grover?

18 MR. EGLET: How long is your cross-examination of
19 McNulty?

20 MR. MICHALEK: We have -- and we're noon tomorrow, right?

21 MR. EGLET: We start at noon tomorrow.

22 THE COURT: Yeah, but -- yes.

23 MR. ROGERS: Certainly no more than an hour.

24 MR. EGLET: We'll finish.

25 THE COURT: Well, it seems to me that this witness needs

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1 to make himself available before we hear from Dr. Wong. So
2 when can you come back?

3 THE WITNESS: I have to look at my schedule but my big
4 problems are I could probably swing tomorrow possibly but I
5 have a meeting with the Chancellor at UC Berkeley in Berkeley
6 tomorrow at 5:30. So putting him off would be not so good
7 form I would imagine. And then Monday I'm in the middle of
8 teaching the medical students for their block rotations for
9 this year and I'm the director of it.

10 THE COURT: Looks like Monday might be a good day.

11 MR. EGLET: Sounds like Monday.

12 THE WITNESS: I can't -- I'm responsible for 150 medical
13 students.

14 THE COURT: Monday or Tuesday or the Court will consider
15 Plaintiff's counsel request to strike his testimony.

16 MR. MICHALEK: Your Honor, I have one thing unrelated to
17 this.

18 MR. ROGERS: No, no, but I just have a follow up that
19 maybe we can try to do an accommodation. Perhaps obviously if
20 prejudice to the Plaintiff is the concern, the Defense has
21 that same position with regard to Dr. McNulty who we didn't
22 have any time at the end of his exam --

23 MR. EGLET: He would have been here today but for this
24 witness.

25 MR. ROGERS: Just let me finish on this one. This is not

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1 an unreasonable request. If Dr. McNulty is available to move
2 his calendar, we will burden -- we will shoulder the prejudice
3 of that new information about the spinal cord stimulator in
4 his direct exam through the weekend and we'll take him
5 whenever he's next available because it sounds like Dr. Fish
6 is available for the very beginning of the day tomorrow.

7 THE COURT: We don't have the very beginning of the day
8 tomorrow.

9 MR. ROGERS: Well, I mean at noon. The beginning of our
10 day.

11 MR. EGLET: We're not going to finish him in that short a
12 period of time. I can guarantee you that. Not this witness.

13 THE COURT: Well, you know, I've made my ruling and I'm
14 not inclined to address any other issues other than
15 scheduling. It's late in the day.

16 THE WITNESS: What time does it start on Monday? Is it
17 1:00?

18 THE COURT: Monday starts at 1:00.

19 MR. EGLET: 1:00.

20 MR. MICHALEK: Your Honor, it's not an issue. It's just
21 a question of the transcript. You know, we've been getting
22 the transcripts every day and I notice that the bench
23 conferences aren't in there, you know, it just says bench
24 conference not being transcribed. Is there --

25 THE COURT: I have no idea. Everything's recorded so I

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1 don't know.

2 MR. MICHALEK: Is there a way that we can just ask that
3 for in the future transcripts, the bench conferences appear in
4 the transcript?

5 THE COURT: I don't know how it works. Ms. Boyd.

6 COURT REPORTER: I mean I explained to them that we can't
7 guarantee the quality but let me know.

8 THE COURT: I guess you have to specifically request
9 that.

10 MR. MICHALEK: I guess I'm making a specific request then
11 that --

12 THE COURT: Yeah, but I don't think it comes through me.
13 I don't have anything to do with it.

14 COURT REPORTER: The quality can't be guaranteed
15 because --

16 MR. MICHALEK: I'm just asking them then whatever you've
17 got, that it be added to the transcript.

18 THE COURT: Yeah, sure, that's not a problem.

19 MR. MICHALEK: All right.

20 THE COURT: See you tomorrow.

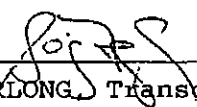
21 [Proceedings Concluded at 5:08 p.m.]

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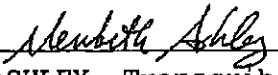
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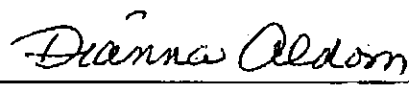
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1 ATTEST: I do hereby certify that I have truly and correctly
2 transcribed the audio/video recording in the above-entitled
3 case to the best of my ability.
4
5

6 
7 BONNIE FURLONG, Transcriber
8

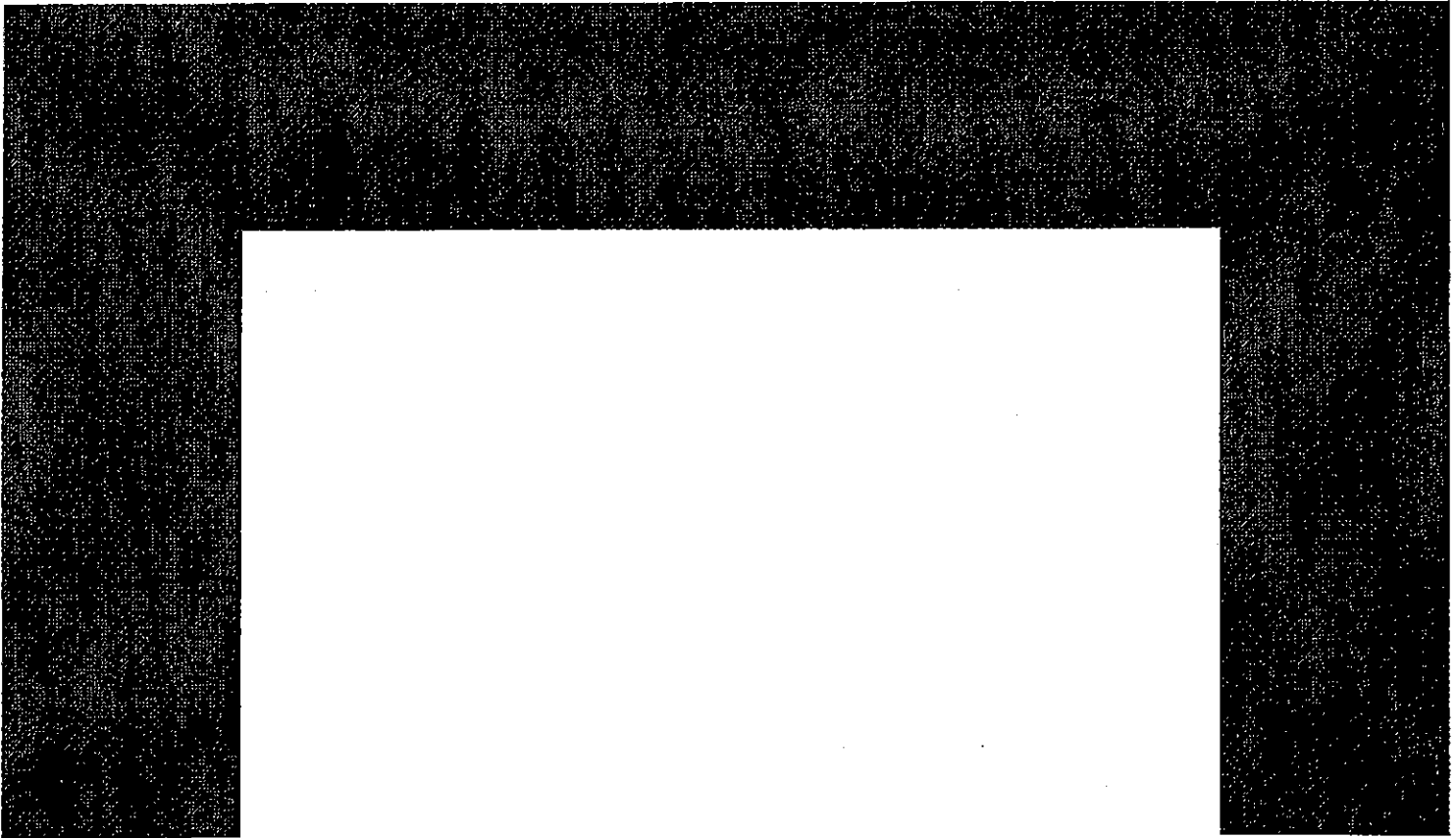
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10 ANTOINETTE M. FRANKS, Transcriber
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13 MERIBETH ASHLEY, Transcriber
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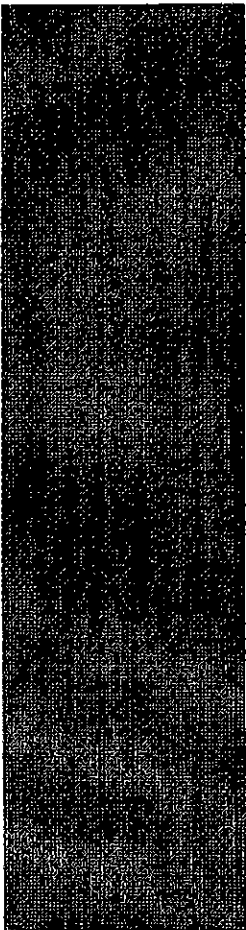
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16 DIANNA ALDOM, Transcriber
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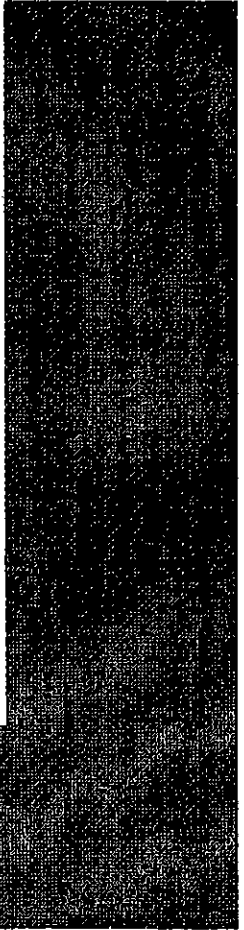
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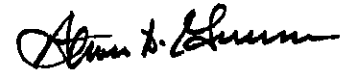
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PMEM

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Attorneys for Plaintiffs

**DISTRICT COURT
CLARK COUNTY, NEVADA**

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

Plaintiffs,

v.

JENNY RISH

Defendant.

CASE NO.: A539455
DEPT. NO.: X

**PLAINTIFFS' AMENDED PRE-
TRIAL MEMORANDUM**

COME NOW Plaintiffs, WILLIAM SIMAO and CHERYL SIMAO by and through their
attorneys, ROBERT T. EGLET, ESQ., DAVID T. WALL, ESQ. and ROBERT A. ADAMS of the
law firm of MAINOR EGLET, and respectfully submit the following Amended Pre-Trial

MAINOR EGLET

002025

1 Memorandum. Plaintiffs' are amending their Pre-Trial Memorandum at this time, in an effort to
2 notify Counsel and the Court that Plaintiffs are de-designating Kathleen Hartman, R.N., as
3 witness from the trial of this matter.

4 I.

5 **STATEMENT OF THE FACTS**

6
7 On or about April 15, 2005, Plaintiff, WILLIAM SIMAO, was driving his vehicle on
8 southbound Interstate 15 in the #1 travel lane near the Cheyenne interchange in Las Vegas,
9 Nevada. William had slowed his vehicle to a complete stop for congested traffic when Defendant,
10 JENNY RISH, failed to decrease her speed and collided with the rear end of William's vehicle.
11 As a result of the crash, William suffered severe and debilitating injuries.

12 II.

13 **LIST OF CLAIMS FOR RELIEF**

- 14
15 1. For general and special damages in an excess of \$10,000.00;
16 2. For special damages for medical care and treatment and costs incidental thereto;
17 3. For property damage and costs incidental thereto;
18 4. For loss of consortium;
19 5. For any and all pre-and post-judgment interest allowed under the law;
20 6. For reasonable attorney's fees plus costs of suit, and
21 7. For such other and further relief as the court may deem just and proper.
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III.
LIST OF AFFIRMATIVE DEFENSES LISTED IN INITIAL ANSWER OF
DEFENDANT

The following affirmative defenses have been plead by Defendant Jenny Rish:

1. The defendant alleges that Plaintiffs' Complaint fails to state a claim upon which relief can be granted.

2. That Plaintiffs' damages, if any, were caused by the acts or omissions of a third party over whom this Defendant had no control.

3. That Plaintiffs' damages, if any, were caused by the acts or omissions of a third party over whom this Defendant had no control.

4. That Plaintiff has failed to mitigate his damages.

5. Pursuant to NRCP 11, as amended, all possible affirmative defenses may not have been alleged herein insofar as sufficient facts were not available after reasonable inquiry upon the filling o the defendant's answer, and therefore, the defendant reserves the right to amend its answer to allege additional affirmative defenses if subsequent investigation so warrants.

IV.

STATEMENT OF ADMITTED OR UNDISPUTED FACTS

None.

V.

LIST OF CLAIMS OR DEFENSES TO BE ABANDONED

None.

VI.

AMENDMENTS TO THE PLEADINGS

None.

VII.

ISSUES TO BE RESOLVED AT TRIAL

1. Whether Defendant was negligent;
2. Whether Defendant was negligent per se for violating Nevada Law;
3. Whether Defendant's conduct was the proximate cause of Plaintiff's injuries; and
4. The amount of Plaintiffs' damages.

VIII.

LIST OF PLAINTIFF'S EXHIBITS

A. Plaintiffs' Exhibits which Plaintiffs expects to offer at trial:

1. Medical Summary;
2. Medical records from Southwest Medical Associates;
3. Medical records from Steinberg Diagnostics;
4. Medical records from Desert Valley Therapy;
5. Medical records from Apria Healthcare;
6. Medical records from Nevada Orthopedic and Spine Center;
7. Medical records from Medical District Surgery Center;
8. Medical records from University Medical Center;
9. Medical records from Nevada Spine Clinic;
10. Medical records from Newport MRI;

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11. Medical records from Center for Spine & Special Surgery;
12. Medical records from Nevada Anesthesia Consultants;
13. Medical records from Las Vegas Radiology;
14. Medical records from PBS Anesthesia;
15. Medical records from Ear Nose and Throat Consultants;
16. Medical billing from Southwest Medical Associates;
17. Medical billing from Steinberg Diagnostics;
18. Medical billing from Desert Valley Therapy;
19. Medical billing from Apria Healthcare;
20. Medical billing from Nevada Orthopedic and Spine Center;
21. Medical billing from Medical District Surgery Center;
22. Medical billing from University Medical Center;
23. Medical billing from Nevada Spine Clinic;
24. Medical billing from Newport MRI;
25. Medical billing from Center for Spine & Special Surgery;
26. Medical billing from Nevada Anesthesia Consultants;
27. Medical billing from Las Vegas Radiology;
28. Medical billing from PBS Anesthesia;
29. Medical billing from Ear Nose and Throat Consultants;
30. Pharmacy records of CVS;
31. Life Expectancy Table;

///

32. Films as follows:

Provider	Service Date	Type of Film
Southwest Medical Associates	4/15/05	X-Rays of the Cervical Spine
Southwest Medical Associates	4/15/05	X-Rays of the Left Elbow and Left Forearm
Southwest Medical Associates	5/11/05	CT scans of the Brain
Steinberg Diagnostic Medical Imaging Center	5/23/05	MRI scans of the Brain
Southwest Medical Associates	10/18/05	X-Rays of the Left Shoulder
Southwest Medical Associates	10/18/05	X-Rays of the Cervical Spine
Steinberg Diagnostic Medical Imaging Center	3/22/06	MRI scans of the Cervical Spine
Steinberg Diagnostic Medical Imaging Center	9/24/07	MRI scans of the Cervical Spine
Southwest Medical Associates	10/5/07	X-Rays of the Chest
Southwest Medical Associates	4/15/08	CT scans of the Mandible
Nevada Spine Clinic	4/30/08	MRI scans of the Cervical Spine
Nevada Spine Clinic	6/17/08	X-Rays of the Cervical Spine
Nevada Spine Clinic	8/8/08	CT Cervical Spine
Steinberg Diagnostic Medical Imaging Center	11/6/08	MRI scans of the Cervical Spine
University Medical Center	2/13/09	X-Rays of C3-C4 and C4-C5 Bilateral Transforaminal Epidural Injection
Southwest Medical Associates	3/19/09	X-Rays of the Chest
University Medical Center	3/25/09	X-Rays of the Cervical Spine
Southwest Medical Associates	4/13/09	CT scans of the Brain
Desert Orthopedic Center	4/14/09	X-Rays of the Cervical Spine
Desert Orthopedic Center	5/26/09	X-Rays of the Cervical Spine
Desert Orthopedic Center	7/14/09	X-Rays of the Cervical Spine

1	Steinberg Diagnostic Medical Imaging Center	8/11/09	CT scans of the Cervical Spine
2	Steinberg Diagnostic Medical Imaging Center	8/11/09	MRI scans of the Cervical Spine
3	Southwest Medical Associates	1/11/10	X-rays of the Cervical Spine
4	Desert Orthopedic Center	3/23/10	X-Rays of the Cervical Spine
5	Steinberg Diagnostic Medical Imaging Center	2/3/11	MRI scans of the Cervical Spine

7 33. Medical Records and Billing of Las Vegas Surgery Center; and

8 34. Medical Records and Billing of Hans Jorg Rosler, M.D.

9
10 **ii. Plaintiff's Exhibits which may be offered at the time of trial, if the need**
11 **arises:**

12 35. Tables of Stan Smith, Ph.D.;

13 36. Curriculum Vitae of Stan Smith, Ph.D.;

14 37. Curriculum Vitae of David Fish, M.D.;

15 38. Curriculum Vitae of Gary Skoog, Ph.D.;

16 39. Curriculum Vitae of Jeffrey Wang, M.D.;

17 40. Curriculum Vitae of Mark Winkler, M.D.;

18 41. Defendant Jenny Rish's Responses to Plaintiffs' First Set of
19 Interrogatories dated October 17, 2008;

20 42. Defendant Jenny Rish's Responses to Plaintiffs' First Set of Requests
21 for Admissions dated October 17, 2008;

22 43. Defendant Jenny Rish's Responses to Plaintiffs' First Set of Requests
23 for Production of Documents dated October 17, 2008;

24 44. Defendant Jenny Rish's Supplemental Responses to Plaintiffs' First Set
25 of Requests for Production of Documents dated December 23, 2008;
26 and
27
28

IX.

PLAINTIFF'S DEMONSTRATIVE EXHIBITS

1. **Plaintiffs may offer, at trial, certain Exhibits for demonstrative purposes including, but not limited to, the following:**

Plaintiffs may offer, at trial, certain Exhibits for demonstrative purposes including, but not limited to, the following:

1. Actual cervical plates, screws surgical tools, and surgical equipment that is recommended to be used in Plaintiff's medical treatment;
2. Demonstrative and actual photographs and videos of surgical procedures and other diagnostic tests Plaintiff may undergo;
3. Actual diagnostic studies and computer digitized diagnostic studies;
4. Samples of tools that were used and will be used in surgical procedures;
5. Diagrams, drawings, pictures, photos, film, video, DVD and CD ROM of various parts of the human body, diagnostic tests and surgical procedures;
6. Computer simulation, finite element analysis, and similar forms of computer visualization;
7. Power point images/drawings/diagrams/animations/story boards, of the incident, the parties involved, the location of the incident and what occurred in the incident.
8. Pictures of Plaintiff prior and subsequent to the subject incident;
9. Surgical Timeline;
10. Medical treatment timeline;
11. Future Medical Timeline;
12. Samples of the needles and surgical tools used in Plaintiff's various diagnostic and therapeutic pain management procedures.

13. Charts depicting Plaintiff's future medical costs;
14. Charts depicting Plaintiff's loss of household services;
16. Photographs of Plaintiff's Witnesses;
17. Charts depicting Plaintiff's Life Expectancy;
18. Story boards and computer digitized power point images;
19. Blow-ups/transparencies/digitized images of medical records, medical bills, photographs and other exhibits;
20. Diagrams/story boards/computer re-enactment of accident;
21. Diagrams of various parts of the human body related to Plaintiff's injuries;
22. Photographs of various parts of the human body related to Plaintiff's injuries; and
23. Models of the human body related to Plaintiff's injuries.

X.

LIST OF WITNESSES

- i. **Plaintiffs expect to present the following witnesses at trial pursuant to NRCP 16.1 (a)(3)(A):**
 1. William Jay Simao
c/o Mainor Eglet, LLP
400 South Fourth St., Suite 600
Las Vegas, NV 89101
702-450-5400
 2. Cheryl Ann Simao
c/o Mainor Eglet, LLP
400 South Fourth St., Suite 600
Las Vegas, NV 89101
702-450-5400

///

MAINOR EGLET

- 1 3. Jenny Rish
2 c/o Rogers, Mastrangelo, Carvalho & Mitchell
3 300 S. Fourth St., Suite 710
4 Las Vegas, Nevada 89101
5 702- 383-3400
- 6 4. Jorg Rosler, M.D.
7 Nevada Spine Clinic
8 7140 Smoke Ranch Rd., Suite 150
9 Las Vegas, Nevada 89128
10 702-320-8111
- 11 5. Jaswinder Grover, M.D.
12 Nevada Spine Clinic
13 7140 Smoke Ranch Rd., Suite 150
14 Las Vegas, Nevada 89128
15 702-320-8111
- 16 6. Patrick McNulty, M.D.
17 NV Orthopedic & Spine Center
18 2650 N. Tenaya Way, Suite 301
19 Las Vegas, Nevada 89128
20 702-878-0393
- 21 7. Daniel D. Lee, M.D.
22 NV Orthopedic & Spine Center
23 2650 N. Tenaya Way, Suite 301
24 Las Vegas, Nevada 89128
25 702-878-0393
- 26 8. Stan Smith
27 SMITH ECONOMICS GROUP, LTD.
28 1165 N. Clark Street, Suite 600
Chicago, Illinois 60610
(312) 943-1551
- ii. **Plaintiffs' witnesses who have been subpoenaed for trial:**
 1. Adam Arita, M.D.
Southwest Medical Associates
2450 W. Charleston Blvd.
Las Vegas, Nevada 89102
702-877-8660

MAINOR EGLET

1 2. Jenny Rish
2 c/o Rogers, Mastrangelo, Carvalho & Mitchell
3 300 S. Fourth St., Suite 710
4 Las Vegas, Nevada 89101
5 702- 383-3400

6 iii. **Plaintiffs' witnesses of whom Plaintiffs may call if the need arises:**

7 1. James Rish
8 c/o Cardone Dispute Resolutions
9 8689 W. Sahara Ave. Suite 130
10 Las Vegas, Nevada 89117
11 702-870-5366

12 2. Linda Rish
13 c/o Cardone Dispute Resolutions
14 8689 W. Sahara Ave. Suite 130
15 Las Vegas, Nevada 89117
16 702-870-5366

17 3. James Rish, III
18 3029 Constitution Way
19 Hill AFB, Utah 84056
20 801-774-9066

21 4. Christopher Rish
22 3029 Constitution Way
23 Hill AFB, Utah 84056
24 801-774-9066

25 5. Kaylee Rish
26 3029 Constitution Way
27 Hill AFB, Utah 84056
28 801-774-9066

 6. Nathaniel Rish
 3029 Constitution Way
 Hill AFB, Utah 84056
 801-774-9066

 7. Investigator Shawn Haggstrom, #582
 Nevada Highway Patrol
 4615 W. Sunset Road
 Las Vegas, Nevada 89119

MAINOR EGLET

- 1 8. COR/PMK Nevada Spine Clinic
2 7140 Smoke Ranch Rd., Suite 150
3 Las Vegas, Nevada 89128
4 702-320-8111
- 5 9. COR/PMK University Medical Center
6 1800 W. Charleston Blvd.
7 Las Vegas, Nevada 89102
8 702-383-2000
- 9 10. COR/PMK Medical District Surgery Center
10 2020 Goldring Ave.
11 Las Vegas, Nevada 89106
12 702-477-7000
- 13 11. COR/PMK Las Vegas Surgery Center
14 870 S. Rancho Dr.
15 Las Vegas, Nevada 89106
16 702-870-2090
- 17 12. COR/PMK NV Orthopedic & Spine Center
18 2650 N. Tenaya Way, Suite 301
19 Las Vegas, Nevada 89128
20 702-878-0393
- 21 13. COR/PMK Steinberg Diagnostics Medical Imaging Centers
22 4 Sunset Way, Building D
23 Henderson, Nevada 89014
24 702-732-6000
- 25 14. Ross Seibel, M.D.
26 Southwest Medical Associates
27 2450 W. Charleston Blvd.
28 Las Vegas, Nevada 89102
702-877-8660
15. Adam Arita, M.D.
Southwest Medical Associates
2450 W. Charleston Blvd.
Las Vegas, Nevada 89102
702-877-8660

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MAINOR EGLET

16. Britt Hill, PA.C.
Southwest Medical Associates
2450 W. Charleston Blvd.
Las Vegas, Nevada 89102
702-877-8660
17. COR/PMK Southwest Medical Associates and/or
Nader Helmi, D.O. and/or
James Metcalf, D.O. and/or
Nicholas Tibaldi, M.D. and/or
Lisa Franks, PA-C and/or
Terry Robichaud PA-C and/or;
Jennifer Davis, PA-C and/or;
2450 W. Charleston Blvd.
Las Vegas, Nevada 89102
702-877-8660
18. COR/PMK Desert Valley Therapy
2851 N. Tenaya Way, Suite 205
Las Vegas, Nevada 89128
702-655-9456
19. COR/PMK Newport MRI
7140 Smoke Ranch Road
Las Vegas, Nevada 89128
702-320-8111
20. COR/PMK Center for Spine & Special Surgery
7140 Smoke Ranch Rd., Suite 150
Las Vegas, Nevada 89128
702-320-8111
21. COR/PMK Las Vegas Radiology
7500 Smoke Ranch Rd., Suite 100
Las Vegas, Nevada 89128
702-254-5004
22. COR/PMK NV Anesthesia Consultants
PO Box 81200
Las Vegas, Nevada 89180
23. Amanda Simao
121 Bear Coat Court
Henderson, Nevada 89002

- 1 24. COR/PMK Ameri-Clean N More
2 2300 W. Sahara Ave., Suite 650
3 Las Vegas, Nevada 89102
4 702-384-411
- 5 25. COR/PMK CVS Pharmacy
6 One CVS Drive
7 Woonsocket, RI 02895
- 8 26. COR/PMK Ear Nose & Throat Consultants of Nevada
9 10001 S. Eastern Ave, Suite 209
10 Henderson, Nevada 89052
11 702-792-6700
- 12 27. Patrick O' Donnell, M.D.
13 Ear Nose & Throat Consultants of Nevada
14 10001 S. Eastern Ave, Suite 209
15 Henderson, Nevada 89052
16 702-792-6700
- 17 28. David M. Ingebretsen
18 Collision Forensics and Engineering, Inc.
19 2469 E. Fort Union Blvd., Suite 114
20 Salt Lake City, Utah 84121
21 801-733-5458

XI.**PLAINTIFFS WILL PRESENT THE FOLLOWING DEPOSITIONS AT
TRIAL PURSUANT TO NRCEP 16.1 (a)(3)(B)**

22 i. The Plaintiffs will use the deposition of *Defendant and Defendant's*
23 *representatives as allowed by Nevada law.*

24 1. Deposition of Jenny Rish.

25 ii. The Plaintiffs will present the following deposition testimony if the witness is
26 **unavailable at the time of trial:**

27 1. Deposition of Adam Arita, M.D.;

28 2. Deposition of Britt Hill, PA-C;

- 1 3. Deposition of Cheryl Simao;
- 2 4. Deposition of Gary Skoog;
- 3 5. Deposition of Hans Jorg Rosler, M.D.
- 4 6. Deposition of Jaswinder Grover, M.D.;
- 5 7. Deposition(s) of Patrick McNulty, M.D.;
- 6 8. Deposition of Ross Seibel, M.D.;
- 7 9. Deposition of Trooper Shawn Haggstrom;
- 8 10. Deposition of William Simao.;
- 9 11. Deposition of David Fish, M.D.; and
- 10 12. Deposition of Jeffrey Wang, M.D.

11
12
13 **iii. The following deposition testimony will be presented by the Plaintiffs for**
14 **impeachment, if the need arises:**

- 15 1. Deposition of David, Fish, M.D., in *Toenyes v Howard* A494349;
- 16 2. Deposition of David, Fish, M.D. in *Varvella v Legsay* A485373;
- 17 3. Deposition of David, Fish, M.D. in *Gilbert v Shainker* A507632;
- 18 4. Deposition of David, Fish, M.D. in *Laguna v Bates* A484815;
- 19 5. Deposition of David, Fish, M.D. in *Wiley v Varela-Breton* A527805
- 20 6. Deposition of David, Fish, M.D. in *Schulz v Young* A544760;
- 21 7. Deposition of David, Fish, M.D. in *Rangel v Wachner* A528929;
- 22 8. Deposition of David, Fish, M.D. in *Lemon v Alderson* A568433;
- 23 9. Deposition of David, Fish, M.D. in *Ly v Alderson* A582633;
- 24 10. Deposition of Jeffrey Wang, M.D. in *Crotty v Southwest Gas* A514313;
- 25 11. Deposition of Jeffrey Wang, M.D. in *Varella v Legsay* A485373;

- 1 12. Deposition of Jeffrey Wang, M.D. in *Smith v Las Vegas Western Cab Co.*
2 A485369;
3 13. Deposition of Jeffrey Wang, M.D. in *Lemon v Kimble* A568433;
4 14. Deposition of Jeffrey Wang, M.D. in *Rangel v Wachner* A528929;
5 15. Deposition of Jeffrey Wang, M.D. in *Ly v Alderson* A562633;
6 16. Depositions of Jeffrey Wang, M.D. in *Laddin v Northview Hospital et al*
7 05VS077733 from 2005 and 2009; and
8 17. Deposition of Gary Skoog in *Johnson v. Lucky Cab Co.*, A534111.

9
10 XII.

11 **TIME REQUIRED FOR TRIAL**

12 The Plaintiffs anticipate that the trial will require 10 to 15 days.

13
14 XIII.

15 **ADDITIONAL MATTERS FOR THE COURT**

16 None at this time.

17 DATED this 23rd day of March, 2011.

18 MAINOR EGLET

19
20
21 ROBERT T. EGLET, ESQ.

Nevada Bar No. 3402

22 DAVID T. WALL, ESQ.

Nevada Bar No. 2805

23 ROBERT M. ADAMS, ESQ.

Nevada Bar No. 6551

24 400 South Fourth Street, Suite 600

25 Las Vegas, Nevada 89101
26
27
28

CERTIFICATE OF MAILING AND FACSIMILE

I hereby certify that I am an employee of Mainor Eglet and that I served the foregoing **PLAINTIFFS' AMENDED PRE-TRIAL MEMORANDUM** via facsimile and by placing a copy thereof, first class mail postage prepaid on the 23rd day of March, 2010 to the following:

Stephen H. Rogers, Esq.
ROGERS, MASTRANGELO, CARVALHO & MITCHELL
300 South Fourth Street, Suite 710
Las Vegas, Nevada 89101
Attorneys for Defendant
(702) 384-1460



An employee of Mainor Eglet

MAINOR EGLET

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Las Vegas, Nevada 89102

Ph.: (702) 384-4111

Fx.: (702) 384-8222

Attorneys for Plaintiffs

**DISTRICT COURT
 CLARK COUNTY, NEVADA**

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

Plaintiffs,

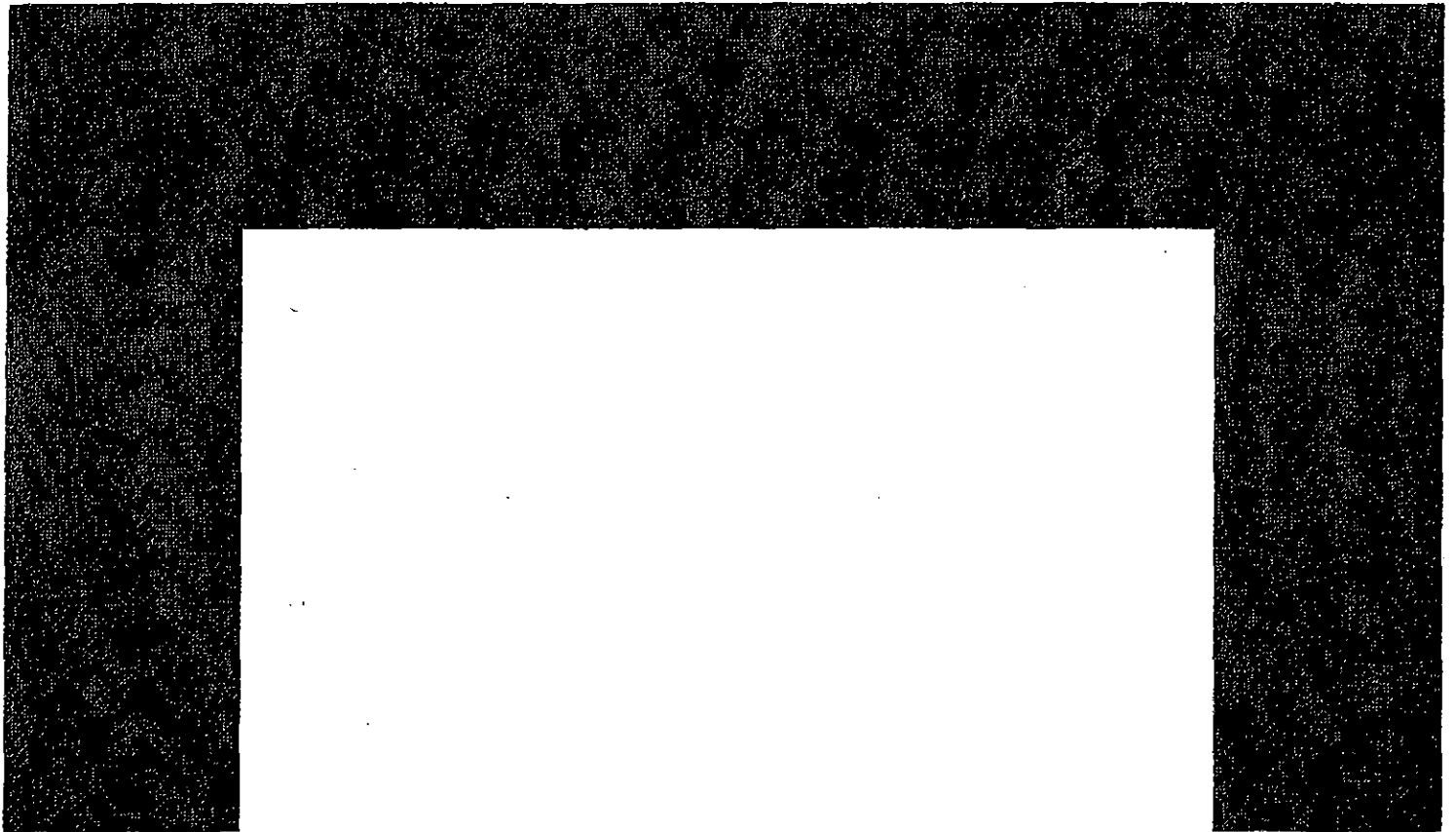
v.

CASE NO.: A539455
 DEPT. NO.: X

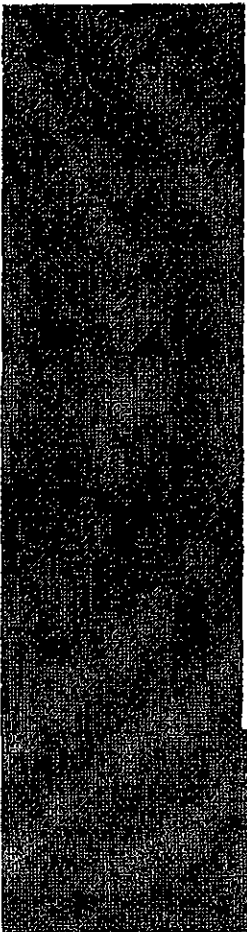
**PLAINTIFFS' AMENDED PRE-
 TRIAL MEMORANDUM**

MAINOR EGLET

002042



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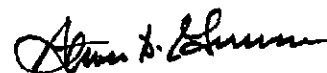
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04/01/2011 02:37:35 PMDISTRICT COURT
CLARK COUNTY, NEVADA
CLERK OF THE COURTCHERYL A. SIMAO and
WILLIAM J. SIMAO,

Plaintiffs,

v.

JAMES RISH, LINDA RISH
and JENNY RISH,

Defendants.

CASE NO. A-539455

DEPT. X

BEFORE THE HONORABLE JESSIE WALSH, DISTRICT COURT JUDGE

FRIDAY, MARCH 25, 2011

REPORTER'S TRANSCRIPT
TRIAL TO THE JURY
DAY 5 - 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: CHARLES A. MICHALEK, ESQ.
Hutchison & Steffen, LLC

RECORDED BY: VICTORIA BOYD, COURT RECORDER

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Patrick Shawn McNulty, M.D.	3
Jaswinder Grover, M.D.	66
<u>Defendants' Witness(es):</u>	
None	

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