of surgery.

Q. And are there studies out there that argue otherwise?

A. Sure. There are studies out there that receive the value of discography in the assessment of patients, but that is the nature of science and medicine in that there are differences of opinions and matters of discussion, which are healthy to a great degree in providing their quality of care for patients, but nonetheless, discography, despite the fact that there are articles that show that discography is not useful.

If there is enough evidence in articles that show it is useful, such as it is endorsed by the North American Spine Society, The Internation Spine Injection Society, which are probably the more sophistical spinal organizations in the country. The numbers of which include most fellowship trained spinal surgeons, whether they are orthopedic or neurosurgeons. So the general policy of these major organizations is to include discography in our assessment of patients when necessary.

Q. And does NASS endorse cervical dystrophy as well as lumbar?

A. Well, I believe it endorses discography.

I cannot tell you whether they separate cervical from lumbar, but just as I mentioned, at least in my practice and in many practices, cervical discography is not used as commonly as lumbar discography is, but in selected cases, it can be a helpful additional tool.

Q. Did you see the post discography CT scan?

A. I have a report of the post discography CT scan here, and I may very well have seen the scan, but I do not have a reference to that specifically in my notes.

Q. Well, from what you see in the report, can those conditions be caused by something other than a car accident?

A. Yes, they can.

Q. Let's go to your final visit, which I think was the first visit after the discogram. What were your impressions at that September 2008 visit with the plaintiff?

A. Well, I recall this gentleman at that time and again, he was a fellow who was having a lot of pain. He was exceptionally frustrated, as I recall, with pain in the back of his head, the left side of his neck, and the left shoulder blade area, and I reviewed the results of the studies with him.

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His pathology, and the options of care and treatment and the risks and benefits of surgery, the options of surgical treatment. My concern that perhaps surgery would not necessarily relieve his symptomatology and issues that he should take into consideration prior to consenting to having surgery.

My recollection of him was that he was very anxious to get something done and to get this pain behind him, but my concern was that his expectations for surgery were perhaps beyond what would possibly be able to be provided for him, so I remember having quite a lengthy discussion with him as it related to his pathology and options of care, but I did discuss with him the possibility of surgery at this time given the persistence of his symptoms despite a multitude of injection treatments not only in our facility here with Dr. Rosler, but elsewhere prior to coming here and the techniques of surgery and the rationale for surgery that we would consider.

As I recall, he was a pretty bright fellow, and he seemed to understand all of those issues. And I talked to him about a fusion surgery. I also talked to him about microforaminotomy around the left side or the C-4 or C-5 nerve root and asked

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him to consider those issues as an option of care, because he obviously did not seem to be getting better.

Q. If you were to have done surgery on the plaintiff -- you have not; right?

A. That is correct.

Q. -- would you have started with the microforaminotomy or gone straight for the fusion?

A. Well, I don't know what the answer to that is right now. I think I discussed a microforaminotomy with him in an effort to preserve and maintain his motion, but my concern would be that he would have residual problems with the microforaminotomy, because of the facet hypertrophy and potential for microinstability, especially since he had a history of some potential subtle subluxation in the C4-5 area based on my recollection, but if he told me that, Look, if I would like to preserve my motion and not have a fusion, but I would send -- and I really want to have something beyond all of the injections that I have had, I would offer him a microforaminotomy in the hopes that it would improve his condition satisfactorily with the understanding that he would possibly succumb to a fusion.

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But if I were to have a choice to choose which operation I would more strongly recommend for him, I would probably feel more secure that the fusion would give him more reliably satisfactory relief of symptoms.

Q. You used the phrase "would send." Describe the plaintiff's limitations at that time?

MR. PALERMO: Objection as to the form.

THE WITNESS: I cannot describe to you what his limitations were other than tell you that by determining by the term "would send," I mean he is expressing frustration that he is having ongoing pain despite all of the treatments that he has undergone to that point, which would have included all of the normal and usual nonsurgical modalities that we usually recommend with his therapy and medications and injections periodically.

BY MR. ROGERS:

Q. Was his pain consistent throughout the time that you treated him or did it get worse? This goes from March to September.

A. I think it was consistent. I was always impressed that he seemed to be in quite a bit of pain, and I remember him to be a fairly athletic well-built gentleman, if I recall him correctly.

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Q. I'm almost done here. Let me look through my notes.

MR. ROGERS: Let's go off the record.

(Off the record.)

BY MR. ROGERS:

Q. Doctor, while I look through my notes, I will have you read through the independent medical examination report of Dave Fish, M.D. and provide your opinion regarding his report.

A. Well, would you like me to comment on it?

Q. Please.

A. First of all, I don't know David Fish. He is obviously a physiatrist and physical medicine and rehabilitation doctor at my original alma mater of UCLA, obviously. And he has quite a lengthy commentary here, which I think outlines the fact that Mr. Simao continues to complain of headaches and neck pain.

So far as I can see without dissecting it further, he, in summary, feels that the patient had a cervical whiplash syndrome as it related to a motor vehicle accident of April 15th, 2006, which I believe is the accident that we're talking about that concerns you; is that right?

Q. Yes.

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A. Is and feels that those symptoms have somehow resolved, but he has ongoing migraine headaches, degenerative cervical spine disease, left shoulder subacromial bursitis, and myofascial pain syndrome, which all of those he feels, in his opinion, are unrelated to the motor vehicle accident.

And with all due respect, I don't think it is that simple to separate everything, so to speak. The question is what is cervical whiplash syndrome and how do you know when and if it was resolved? I think that Dr. Fish concedes that the man was injured on April 15th, 2006 by agreeing that he had a cervical whiplash syndrome.

"Whiplash" is somewhat of a colloquial term, but has come to implied patients who have some type of extension-flexion injury to the neck, and result of pain is symptomatology, but it can encompass so much more in the sense that we are all familiar with the fact that patients in their middle ages have some degenerative pathology in their neck. Most patients do. Most of the time it is not symptomatic. Sometimes it is symptomatic. Sometimes cervical disc degenerative pathology becomes symptomatic spontaneously, as you well know,

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without any injury or trauma and those are the patients that are much easier for us to treat because we do not have to set and render opinions about causation. But many times, a traumatic event such as a whiplash injury as Dr. Fish as has described, suggests an injury to a patient's neck and can cause precipitation of cervical radiculopathy or cervical facet inflammation or cervical root inflammation in pain that upon a sophisticated diagnostic workup we can isolate to specific cervical disc or facet pathology, which we did in the case of Mr. Simao.

And I would say that that Dr. Fish has a different specialty whereby his training, education, and approach to patients is to treat myofascial pain through a conservative medical modalities of care, recommendations for therapy, antiinflammatories and things like that, which is perfectly reasonable and there is a role for doctors such as that, but he is not a spinal surgeon, and he does not evaluate patients in a surgically diagnostic way to try to isolate a problem that we might correct and fix, which is how we might approach our patients. And in some cases we can successfully do that. We cannot do it successfully in every case, but in some cases

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we can, so it is a different approach, but I have nothing negative to comment upon regarding Dr. Fish's commentary, but other than he has three or four pages of comments about the fact that the patient still has some pain and he has some degenerative things going on and he had whiplash syndrome, but in Dr. Fish's opinion that was resolved at some point, even though he still has ongoing pain.

Is there something else I should mention?

Q. Or address?

A. Or address specifically that I can help you with?

You know we have exceeded your one-hour time. If you want to go a little longer, you may as well at this point.

Q. Dr. Fish comments on video surveillance done in July of 2008 right around the time of the discography and comments that there were no deficits of function or restrictions or limitations of work.

Is that consistent with the way plaintiff was presenting in your office at that same time?

MR. PALERMO: I will object as to form. Vague and ambiguous.

THE WITNESS: Well, let me read the

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sentence here.
BY MR. ROGERS:
Q. Sure.
A. The video observations further support my initial medical opinion that the motor vehicle accident caused only a whiplash injury, which fully recovered within a few months. There are no deficits of function or restrictions or limitations of work that can be seen three years after the motor vehicle accident. This would indicate that no further workup or treatment options are needed since Mr. Simao has fully recovered.

So Dr. Fish has just stated that because he has seen Mr. Simao going back to work, working, remaining gainfully employed, supporting his family and doing what he needs to do and he cannot see that the patient has a neurological deficit, which he does not, and 98 percent of patients who have cervical disc pathology do not have over observable neurological deficits.

But because he can see him going back to work and he cannot see that the patient has a neurological deficit that because of that he is fully recovered and no further workup or treatment is required, I find that to be frankly a little bit,

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let's say, overly simplistic and contradictory, in fact, because at the same time that he states that in his ultimate opinion of Mr. Simao, he stated that the patient has a variety of symptoms, which includes a myofascial pain syndrome, degenerative cervical spine disease, migraine headaches, and left shoulder subacromial bursitis.

So what he is saying, he does not have any of that either according to this sentence. Dr. Fish has an interesting three or four page dissertation with several paragraphs outlining what I see is basically a fellow who still has ongoing pain. It is just that Dr. Fish has elected now to assign the same pain that he had all to myofascial pain and say yes, he had whiplash but that stopped after this arbitrary period of time and now it is not whiplash anymore. Now it is all pain, and I will go ahead and continue to treat it, in fact, and why don't I just treat it for the next several years with physical therapy, and medications, and antiinflammatories, even though I know he is not the treating physician, but this would be an approach of a physician in his specialty, that the whiplash injury stopped and now it is all myofascial pain. Well, myofascial pain is a result of the whiplash,

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and the "whiplash" is just a mechanism of injury, frankly, and it is a colloquial term to describe what is an extension-flexion mechanism usually.

And the question is what happened during that traumatic event to the patients structurally that resulted in the precipitation of symptoms that perhaps did not exist, which we are assuming it did not exist, because as far as I know, they did not exist beforehand from the history that I have been provided.

Well, we have to investigate that. Well, hopefully, the symptoms will just resolve in a few months with therapy, et cetera. No, we do not need to go through a more sophisticated workup, but if they do not and did not, such as they did not, in the case of Mr. Simao, two to three years after his injury and he presents to a specialist such as myself, we will take the time to look at his condition more seriously and more analytically and proceed to a more site specific diagnostic workup which we did, and we isolated left-sided C3-4, C4-5 facet tropism, facet hypertrophy, and cervical disc root irritation at those same levels, so we actually did a combination of a facet nerve root and disc pathology all at the same two levels, which I think

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is and was the cause of his symptoms, and it is not unreasonable, and I agreed myself to consider surgery to help him so long as this person and patient was completely cognizant, understanding, and accepting of the risks and benefits of surgery. And I recall having a chat with him on September 2nd, and in absolutely no way I would have encouraged him to have surgery. I agreed to perform surgery because of the frustration that I appreciated in his presentation because of his ongoing symptoms, but I clearly recall going through the risks with him so he fully understood them and given the fact that he did not have surgery with me -- I'm not sure if he had surgery. I might even have frightened him from having surgery, and he may have elected to try to live with his symptoms, but that is his prerogative.

Q. You mentioned that Dr. Fish cut off his treatment, I think, where it is in an arbitrary time. What was the time and what was arbitrary about it?

A. Well, I did not say that Dr. Fish "cut off" his treatment. I don't think I used that term. I believe that I stated that Dr. Fish concedes that the patient had a whiplash injury, but feels that it ended at a specific arbitrary time that he assigned,

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and I'm not sure when that was.

MR. PALERMO: I think for the record, he says May of 2005 at the end of the report.

BY MR. ROGERS:

Q. What is arbitrary about the question?

A. Well, my question is how do you determine a date when the whiplash injury ended and the myofascial symptoms now continued relating to a preexisting problem. I do not personally know how you determine that or I would be curious now as to how Dr. Fish determined that.

Q. Well, what I want to know is why you assigned the word "arbitrary" to it? Do you know what was going on in May of 2005?

A. No. I'm stating that I do not quite understand how Dr. Fish determined that the whiplash injury stopped at a certain point. I don't understand how you can make that determination. And by that I mean he determined an arbitrary time where he said, Okay. Now it is stopped.

You have to understand I only read this here right in front of me. You have not given me the opportunity to really look at it for 30 minutes or so to really go through it.

From what I can ascertain briefly having

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read this, is that the gentleman had a whiplash injury, but the whiplash injury symptoms stopped at a certain point, but he still has a problem and now we have whiplash and now it is myofascial pain. Is that correct or am I missing something here?

Q. I'm asking for your interpretation.

A. That is my interpretation.

Q. Or your opinion of it?

A. That is my opinion of the interpretation. That is my interpretation of the opinion or vice versa.

MR. PALERMO: Your interpretation of his opinion.

THE WITNESS: I'm not being overcritical of Dr. Fish. He is a physical medicine rehabilitation doctor. He has a certain approach to things, but I don't entirely agree with some of his comments.

BY MR. ROGERS:

Q. Now, Jeff Long, M.D., has also been identified as an expert in this case, and he performed an independent medical examination. Do you know him?

A. I know of him, yes.

Q. What is your professional opinion of him?

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A. I have a good professional opinion of all of the physicians at UCLA. I went to medical school there, so I certainly would not say anything anything negative about him or Dr. Fish.

(Off the record.)

BY MR. ROGERS:

Q. In your opinion, is there any correlation between the severity of a motor vehicle accident and the likelihood of cervical disc injury?

MR. PALERMO: Objection to form.

THE WITNESS: I think that is overly simplistic. I would say there is a correlation between the severity of a motor vehicle accident and injury, period.

For instance, if you are in a car, and you are in a catastrophic accident or you roll the car six times on the freeway and hit the center median, the chances of you being injured are pretty good. The chances of you surviving may not be so good. It could be potentially a fatal accident, but I cannot tell you that I believe that there is any correlation within the category of accidents which are, in general, considered minor or moderate, the rear-end type collisions and this and that where I see patients who are involved in fairly significant

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accidents sometimes having taken calls at the trauma center many times, they have no significant upper and back problems, but then we see patients who are in a rear-end type collision where there is no or little damage to them, so to speak, to the vehicle, but the patients are significantly injured. They have significant cervical disc pathology or lumbar disc pathology that requires treatment, and it is a problem, so I do not think you can correlate, for instance, the degree of damage to the injury with degree of injury.

BY MR. ROGERS:

Q. With the likelihood of injury, you mean?

A. With the degree or even the likelihood of injury, and I can tell you that simply based on my experience as a practicing physician and clinician for 15 years and also based on my own personal experience having been in a car that was stationary, rear-ended by another vehicle with my children in it, and it was a tremendously traumatic experience, shocking to feel, you know, with developed some neck pain, et cetera, and obviously I am fine. Surprisingly, I walked out of the vehicle, my child's car seat was knocked out of the seat and the rear-end of this Mercedes M Class was completely

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normal. The front-end bumper of the car behind us had fallen off, but the rear-end bumper of this fiberglass thing had a little scratch on it. Now, the car behind us, his bumper was on the floor. So one can say, Hey, there was no damage to our vehicle. Well, I know how much of what I felt and obviously none of us were seriously injured, but I can see how patients are really injured in these type of injuries.

It is not unreasonable that a patient is injured in a rear-end type of collision. A whiplash where a patient's neck goes back and forth does not necessarily mean that it is soft tissue injury for a few weeks. Sometimes people have serious problems on an ongoing basis that they require treatment for and each case is individualized, and you have to take it case by case. Certainly, I believe people can be injured even relatively in minor appearing accidents.

Q. To state that succinctly then, is it your testimony that there is no correlation between the likelihood of injury and the severity of the accident when it comes to low impact accidents?

A. I do not think I can simply state that. I can simply tell you what my experience has been

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and you can kind of take it from there.

Q. You did mention, though, in that statement that you can see how someone can sustain a whiplash injury. And by that you mean hyperflexion and extension injury; right?

A. Well, I am not sure --

Q. That is the mechanism that is hyperflexion or extension.

A. Well, extension, flexion, if a patient -- I believe that whiplash type of injury, so to speak, as Dr. Fish has described injury with Mr. Simao, I am not necessarily simply always soft tissue injuries that the problems of which resolve are stopped at a certain time or date after the time of the injury.

Q. At this point, though, I'm not talking about the assessment or the diagnosis, rather the mechanism. What I mean is if someone is going to injure their neck, it is because of the motion that their neck experiences; is that right?

MR. PALERMO: I will object as to form.

THE WITNESS: It can be because of a variety of reasons, but it is certainly the rapid motion in a patient that is not prepared to protect for that type of motion can result in a disc injury,

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nerve root irritation inflammation around a facet, absolutely.

BY MR. ROGERS:

Q. And so if there is a headrest or something behind your head, that prevents an over flexion or extension?

A. There is no doubt about it. Since the advent of headrests in motor vehicle accidents, we have seen a reduction in serious cervical spinal cord injuries. The number of quadriplegics in the hospital is significantly less since the advent of headrests on motor vehicle automobiles.

MR. ROGERS: I think I am done.

EXAMINATION

BY MR. PALERMO:

Q. I have a clarification question. I think when you read your history, you explained in this case there was a solid cage behind the plaintiff in that and during the accident eventually he ends up hitting his head on the solid cage behind him. Could that mechanism of injury cause the injuries that the plaintiff is complaining of?

MR. ROGERS: Objection. Vague and ambiguous.

Go ahead, Doctor.

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THE WITNESS: Well, certainly, if he hit his head on something, it could have contributed to his current condition and injuries.

MR. PALERMO: No further questions.

(Thereupon the taking of the deposition was concluded at 7:40 p.m.)

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CERTIFICATE OF DEPONENT

PAGE	LINE	CHANGE	REASON

* * * * * *

DECLARATION OF DEPONENT

I, JASWINDER S. GROVER, M.D., deponent herein, do hereby certify and declare the within and foregoing transcription to be my deposition in said action; that I have read, corrected, and do hereby affix my signature to said deposition this _____ day of _____, 2009.

_____

JASWINDER S. GROVER, M. D.

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REPORTER'S DECLARATION

STATE OF NEVADA)
) ss.
COUNTY OF CLARK)

I, CAMEO L. KAYSER, CCR No. 569, declare as follows:

That I reported the taking of the deposition of the witness, JASWINDER S. GROVER, M.D., commencing on Thursday, April 16, 2009, at 6:05 p.m.

That prior to being examined, the witness was by me duly sworn to testify to the truth, the whole truth, and nothing but the truth; that, before the proceedings' completion, the reading and signing of the deposition has been requested by the deponent or a party.

That I thereafter transcribed my said shorthand notes into typewriting and that the typewritten transcript of said deposition is a complete, true, and accurate transcription of said shorthand notes taken down at said time.

I further declare that I am not a relative or employee of any party involved in said action, nor a person financially interested in the action.

Dated at Las Vegas, Nevada this 25th day of April, 2009.

CAMEO L. KAYSER, RPR, CCR No. 569

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EXHIBIT "2"

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Independent Medical Evaluation and Record Review

DATE OF REVIEW: 02/10/2009

RE: SIMAO, William

AGE: 45 currently; 42 at the time of the motor vehicle accident

DATE OF INJURY: 04/15/2005

To Whom this May Concern:

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I was asked by the law offices of Rogers, Mastrangelo, Carvalho and Mitchell to review the medical records and physically examine William Simao. Below is my review of the medical records and physical examination. I was also asked to give my opinions, based on these records, as to assessment of medical damages caused by the accident, causation, future care needs, necessity for treatment, and overall recommendations. All of my opinions below are based on a reasonable degree of medical probability.

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I am currently full time faculty member at UCLA Medical Center. My position is Director of Physiatry and Interventional Pain Management at the UCLA Spine Center. I am board certified in Physiatry and Pain Management. I have provided by CV.

RECORDS REVIEWED:

1. Traffic Accident Report
2. Southwest Medical Associates
3. Steinberg Diagnostic Medical Imaging
4. Desert Valley Therapy
5. Nevada orthopedic and Spine Center
6. Las Vegas Surgery Center
7. Medical District Surgery Center
8. University Medical Center
9. Navada Spine Clinic
10. Center for Spine and Spinal Surgery
11. Newport MRI

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12. Las Vegas Radiology
13. Nevada Anestheisa Cond.
14. Video Surveillance 1:13:29
15. Video Surveillance 0:35:26

CHIEF COMPLAINT: Left-sided head, neck and shoulder pain.

HISTORY OF PRESENT ILLNESS:
Mr. William Simao is a 45 year old who was involved in an MVA on April 15, 2005. According to the traffic accident report, he was slowing down to a stop for upcoming highway congestion when the car behind him collided with the rear-end of his van. No air bags were deployed. He informs me that he was in his work truck, which had a steel cage behind the driver's seat and at the time of impact he hit the back of his head on the cage. He had no loss of consciousness. Paramedics presented to the scene however, Mr. Simao refused any evaluation or treatment. Both vehicles were able to drive away from the accident. He reports that he did go to an Urgent Care later that afternoon, as he began to have neck and left elbow pain. X-rays were done not demonstrating any acute trauma and he was discharged home from the Urgent Care. He went to a follow up appointment 2 weeks later and there were no focal neurological deficits noted in the report. Also, he had no complaints of neck pain at this follow up appointment or his next appointment on May 12, 2005, but complaints of blurred vision, dizziness, and headaches.

He reports today that his neck pain persisted and he underwent intermittent conservative treatment since then including cervical epidural injections. He reports that the epidurals gave him less than four weeks of improvement after each injection. He informs me that his physician has advised him that surgery is a viable option to control his symptoms. He states that he is planning on having surgery soon.

Today, he reports having symptoms on the left side of his face and head. He also reports having left shoulder pain. The pain that he describes is rated 7/10. He reports it to be a stabbing, deep pressure, tightness-type pain for which he feels that movement or certain positions worsen the symptoms. He does report that it is somewhat better after the injections. Mr. Simao also reports that the pain does not limit him in that he is able to do all the activities that he was doing prior to the MVA of April 15, 2005.

Mr. Simao reports having a significant history of migraine headaches. He informs me that he had been treated by neurology and tried abortive therapies in the past before the MVA, but he has not tried these type of medications since the MVA. However, he did complain of headaches directly after the MVA for

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which imaging studies of the brain were performed and ruled out possible intracranial lesions. He continues to complain of migraines one to two times per week that can be severe with a pain level of 10/10 at times. He describes the migraine headaches as pain around the eye and into the head on the left side.

PAST SURGICAL HISTORY: None.

ALLERGIES: Penicillin.

PAST MEDICAL HISTORY: High blood pressure, high cholesterol, and neck pain.

CURRENT MEDICATIONS: Enalapril and Lovastatin.

FAMILY HISTORY: He denied arthritis, diabetes, bone disease, cancer and heart disease. Father, age 70, is healthy; mother is deceased at age 56.

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SOCIAL HISTORY:
He reports that he is the owner of a floor care company that polishes floors. He had been the manager of the same company before the motor vehicle accident and recently took over ownership of the company. He informs me that he did not take off much time from work since the motor vehicle accident. He has two employees. At work he is required to do some of the manual activities, which include polishing. The polisher weighs up to 40 pounds, which he loads in and out of a company truck. He tells me that he was never given any restrictions from his treating physicians. There are no changes in his work patterns that he describes, although he will give others jobs if he is not feeling well.

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He reports that he does not work out in a gym. He has two children at home, ages 20 and 24, and a wife. There are stairs to get into his house. He denies alcohol use. He does smoke one pack of cigarettes a day. He can walk without a cane. He can dress himself. He can drive his car independently, but he cannot sleep at night without pain.

REVIEW OF SYSTEMS:
Mr. Simao reports headaches, muscle pain and poor sleep. Otherwise, the patient denies problems with his eyes, skin, ears, genitourinary, respiratory, anemia, bleeding, bruising, depression, nervous breakdown, hallucinations, abnormal growth, goiter, heat/cold intolerance, palpitations, chest pain, leg swelling, fevers, chills, weight loss, nausea, vomiting, dermatitis, hay fever, appetite changes, jaundice, and hemorrhoids.

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PAST ACCIDENT HISTORY:

He reports a motor vehicle accident with a motorcycle one year prior to the April 2005 MVA. Since the motor vehicle accident, he feels he has had more headaches and migraines, which were initially diagnosed ten years ago.

PHYSICAL EXAMINATION:

General: The patient is well developed, well nourished, in no acute distress; alert and oriented x 4 with appropriate mood and affect.

Lymphatic: There are no enlarged cervical or inguinal lymph nodes.

Spine: The cervical area is symmetric without kyphosis or scoliosis. No palpable masses and no complaints of significant muscle tenderness, or point tenderness along the spine. Complains of mild discomfort with Spurling's test; into left shoulder. Leg length discrepancy not noted. Range of motion normal in all planes of the cervical and lumbar spine.

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Upper Extremities: Left shoulder evaluation: Impingement signs, Hawkins, and Neer's reportedly produce pain to the left shoulder region. Palpation tenderness is noted at the subscapularis, semispinalis capitis, trapezius and levator scapulae on palpation, which reproduces the patient's typical pain on a day-to-day basis.

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Skin: Without lesion, rash, or scar at the neck or trunk. No lesions of the hands or feet.

Neurological: Normal gait without assistive device or brace. Patient is able to walk on toes and heels without difficulty. Coordination is intact. Sensory is intact to light touch, cold, and pinprick in the upper extremities. Motor exam is 5/5 in the bilateral upper extremities. Reflexes are symmetric at 2+ in the upper extremities. No Hoffmann's or Babinski's. Muscle tone is normal without clonus or muscle atrophy. Upper extremity Tinel, Phalen, Roos, and Spurling tests were normal.

Extremities: Pulses intact distally with no cyanosis, clubbing, or edema.

IMAGING AND WORK UP:

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CT of the BRAIN 5/13/05 showed by report, but actual images were not reviewed by me personally, a normal unremarkable head CT.

MRI of the CERVICAL SPINE 3/22/06 showed by report, but actual images were not reviewed by me personally a mild broad-based disk bulge 2-3 mm with left C4 nerve root contact possible within the neural foramen. No canal stenosis is seen at the C34 and C45 levels.

MRI of the BRAIN 5/23/05 showed by report, but actual images were not reviewed by me personally, a normal unremarkable head MRI for age with no abnormal enhancing lesions.

MRI of the CERVICAL SPINE 9/24/07 showed by report, but actual images were not reviewed by me personally, negative MR of the cervical spine for age.

MRI of the CERVICAL SPINE 4/30/08

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IMPRESSION AND DIAGNOSES:

Related to the motor vehicle accident of April 15, 2006:
1. Cervical whiplash syndrome, resolved.

Unrelated to the motor vehicle accident of April 15, 2006:
1. Migraine headaches.
2. Degenerative cervical spine disease.
3. Left shoulder subacromial bursitis.
4. Myofascial pain and muscle spasm.

COMMENTARY AND MEDICAL DECISION MAKING:

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I am seeing the Mr. Simao today for evaluation purposes only. There is no doctor patient relationship implied. Evaluation is consistent with history and previous physical examination by treating physicians. All records sent to me are reviewed for the purpose of a medical decision based upon the events of the current pain complaints. The opinions of this report are based upon examination of Mr. Simao and/or review of the medical records provided to me. All of my opinions have been rendered with a reasonable degree of medical probability but are preliminary to the extent that there is relevant information that I have not yet had the opportunity to review.

My opinions in regards to Mr. Simao are based upon my clinical experience as an active treating Physiatrist who specializes in Physiatry, Pain Medicine, and Electrodiagnostic Medicine. I am currently on staff at the UCLA School of Medicine in the UCLA Spine Center and the UCLA Medical Center. I am involved with resident and fellowship training of physicians at UCLA and must maintain updated and clinically relevant evidence-based guidelines for treatment of patients that fall within the standards of care. I would approach the patient as I would approach any patient with similar pain complaints as a treating physician. Based also upon my forensic review of the records, I made the following conclusions.

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Mr. Simao was involved in a motor vehicle accident in which he was a restrained driver, struck from behind. Mr. Simao complained of headaches and neck pain, and soon after the accident went to Urgent Care where he was given conservative treatment and ruled out for significant trauma. According to the medical records, over the next seven months, Mr. Simao did not pursue any aggressive treatment options. His care was sporadic and mostly related to his pre-existing headaches. It was not until October that his pain began to get worse, for which he was again evaluated and underwent radiographs which were reported as normal for the cervical spine. It was not until December that he was started on pain medications and January of 2006 that he began therapy for his neck, nine months post-MVA.

Regarding Mr. Simao's complaints of headaches, he had a history of headaches prior to the MVA of April 15, 2005 and was treating for this complaint at the time of the MVA. Furthermore, Mr. Simao has a history of a motorcycle accident which he has admitted worsened his headaches. Therefore, it is not surprising that the chronic migraine headaches continued since the April 15, 2005 MVA. Current work up with Neurology and Imaging studies did not find an organic source for his pain; thus, with medical probability, the new worsened headaches are merely a natural history and progression of his underlying disease and not due to the April 15, 2005 MVA. Some of his initial sub-occipital symptoms may have been a part of his whiplash injury; however, his headaches after about 4-6 weeks were more consistent with migraines that he had complained for many years prior to the MVA in question.

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Regarding his cervical spine, his treating orthopedic surgeon noted that the pain pattern and the MRI did not match. In my experience, I do not see a cervical spine source for migraine headaches; especially in an individual who has a history of migraine headaches for ten years and a previous MVA. The cervical MRI in 2006 was reported to demonstrate C3-4 and C4-5 disc protrusions and other degenerative changes without compression effects on the C4 or C5 nerve roots. This MRI is age appropriate and does not demonstrate any structural changes consistent with trauma. Mr. Simao subsequently underwent pain management injections. Reportedly, his headaches improved with the epidurals. I would suggest that his improvement with injections to the C3-4 foraminal space are due to steroid and lidocaine use to relax the tension or migraine headache muscle pain. I would have expected some improvement in the headaches, but not enough of a resolution to confirm the pain generation source from the cervical spine. These symptoms of headaches pre-existed the MVA of April 15, 2005. This is why the injections did not resolve his symptoms but just temporarily improved them.

The video observations further support my initial medical opinion that the MVA on April 15, 2005 caused only a whiplash injury, which fully recovered within a few months. There are no deficits of function or restrictions or limitations of work that can be seen three years after the MVA. This would indicate that no further work up or treatment options are needed since Mr. Simao has fully recovered. He does not display any range of motion limitations, lifting precautions, or functional deficits consistent with a cervical spine problem that requires any interventions or surgery. In my experience, cervical spine surgery does not resolve or improve the pain experienced by migraine headache patients. Cervical fusion of the C34 and C45 will not help Mr. Simao's headache complaints and therefore I do not feel that a surgery is medically necessary.

Based on my physical examination today, Mr. Simao probably has a myofascial component to his pain based on his continued chronic migraine headaches. His left shoulder examination corresponds with the current pain complaints that he describes today and in reviewing the medical records, none of his physicians had suggested bursa injection to the shoulder. I do not see how the motor vehicle accident could have caused the shoulder issues since the medical records do not indicate a shoulder problem nor do they indicate that his physician's needed to address the shoulder joint as an issue. Typically significant shoulder injury after trauma causes restriction of daily activities, limited range of motion of the shoulder joint, and results in immediate need for treatment directly after the MVA. This is not the case here. Also, Mr. Simao continues to do manual labor and uses his shoulder daily to help with balancing and lifting objects. This, in medical probability, may be the cause of his left shoulder symptoms today. It is therefore my opinion that his shoulder may require future assessment and treatment, but probably not related to the MVA.

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Furthermore, given the delay in care, his current activity levels, the findings on MRI, and my current evaluation of Mr. Simao, it is my opinion that the motor vehicle accident did not cause injury to the cervical spine necessitating injection therapy or surgery. The epidural injections did not seem to last for more than two weeks according to my discussion with Mr. Simao today. This indicates that the cervical spine levels are probably not the source of his complaints. Most likely, the MVA caused a whiplash type injury that resolved around May of 2005 based on his records review. The symptoms he began to describe in October of 2005 are more likely related to his migraine headaches, myofascial pain, and shoulder issues that are unrelated to the motor vehicle accident, but more likely in medical probability a pre-existing condition. He also has arthritis of the cervical spine which can be symptomatic based upon his work, his prior MVA, and his chronic migraine history.

Mr. Simao is a smoker which further increases the likelihood of degenerative disease of his cervical spine. Furthermore, in discussing the migraine pain symptoms that he describes on the left side of his eye and head, these can be easily mistaken for cervical pain referral patterns. It is medically probable that his complaints are more likely related to the migraine headaches than to any cervical injury. Headaches such as these can give myofascial components of pain and develop into abnormal shoulder usage. This can lead to subacromial bursitis which was seen on my examination of Mr. Simao today. Thus, any surgical intervention for his cervical spine would be unindicated and medically unnecessary.

The care Mr. Simao received directly after the MVA through the return to a routine follow up at the end of May 2005 for headache complaints was reasonable and may be related to the MVA. His care after this time frame was probably not caused by the MVA but by his pre-existing chronic medical problems. As far as his neck pain goes, I would apportion a small amount, 20% to the MVA, based on Ms. Simao's report of having neck pain directly after the MVA. However, given his history of a previous MVA one year prior, his job description of a manual laborer, the reported delay in onset of pain, and a 10 year history of migraine headaches, such apportionment would end with the treatment in May of 2005.

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FUTURE MEDICAL CARE:

At this time, based on his treatments and his pain complaints, there would be no future medical care treatment options related to the motor vehicle accident. Since there was a delay of care of up to five months, there is no way to relate any shoulder or myofascial component of pain to the motor vehicle accident. His consistent headaches and shoulder issues are more likely related to his complaints of underlying migraine headaches and bursitis, these are a pre-existing conditions that are unrelated.

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Associate Professor, UCLA Department of Orthopaedic Surgery
Physical Medicine and Rehabilitation, UCLA Spine Center
Electrodiagnostic Medicine, Pain Medicine
David Geffen School of Medicine at UCLA

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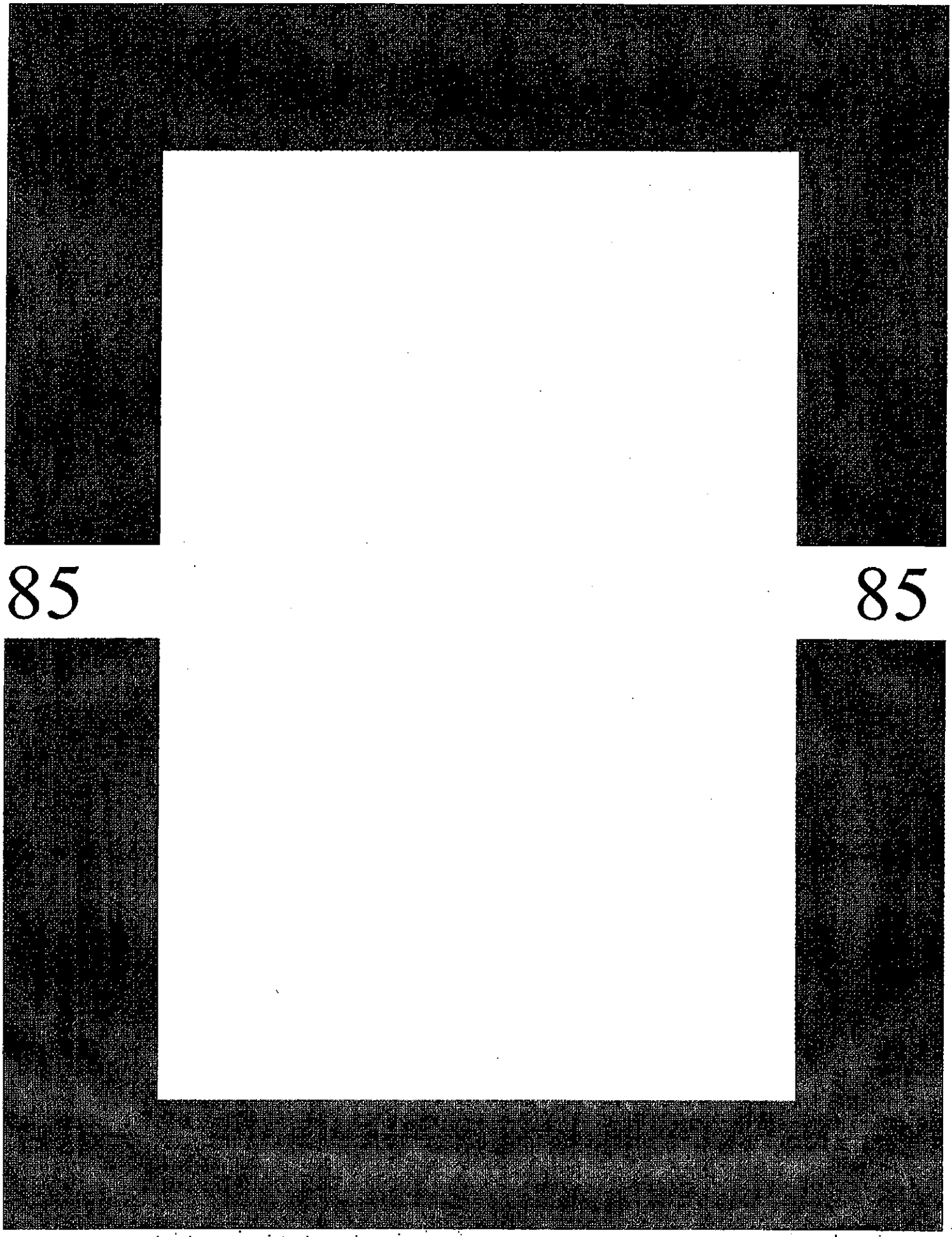

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DISTRICT COURT
CLARK COUNTY, NEVADA

WILLIAM JAY SIMAO, individually and CHERYL ANN SIMAO, individually, and as husband and wife, Plaintiffs, v. JENNY RISH; JAMES RISH; LINDA RISH; DOES I through V; and ROE CORPORATIONS I through V, inclusive, Defendants.	CASE NO.: A539455 DEPT. NO.: X **PLAINTIFFS' THIRD SUPPLEMENT TO THEIR CONFIDENTIAL TRIAL BRIEF; THERE IS NO SURPRISE TO THE DEFENSE REGARDING EVIDENCE OF A SPINAL CORD STIMULATOR**

This Trial Brief is served pursuant to Eighth Judicial District Court Rule 7.27 which specifically states:

> Unless otherwise ordered by the court, an attorney may elect to submit to the court in any civil case, a trial memorandum of points and authorities prior to the commencement of trial by delivering one unfiled copy to the court, without serving opposing counsel or filing the same, provided that the original trial memorandum of points and authorities must be filed and a copy must be served upon opposing counsel at or before the close of trial.

I.

INTRODUCTION

During the trial of this matter, Plaintiff expects to elicit testimony from at least one of his treating physicians, that Plaintiff requires a pain management device known as a spinal cord stimulator. It is anticipated that the defense will claim surprise. However, as will be shown, there is no surprise since the defense learned during discover, that one of the future treatment options for Plaintiff was a spinal cord stimulator.[1] Moreover, after obtaining this information, the defense had the opportunity to ask one of their medical experts, David Fish, M.D., to comment and render opinions with regard to Plaintiff's medical need for a spinal cord stimulator.[2]

II.

ARGUMENT

1. During Dr. Seibel's Deposition, The Defense Was Put on Notice that a Spinal Cord Stimulator was Future Treatment Option for Mr. Simao.

During the discovery phase of this case, the defense took several depositions. Many of these depositions were of Mr. Simao's treating physicians.[3] Dr. Ross Seibel is one of the Pain Management Specialists that treated Mr. Simao during the early stages of his treatment, and then again during the later stages of his treatment.

Dr. Seibel was deposed on August 20, 2010. At the time of Dr. Seibel's deposition, he was providing ongoing medical treatment (pain management) to Mr. Simao. During the

[1] Also referred to as a dorsal column stimulator.
[2] Dr. David Fish is a Board Certified Pain Management Specialist retained as an expert by the defense.
[3] Moreover, the defense deposed some of the treating physicians twice. (i.e. Dr. McNulty).

deposition, Dr. Seibel was asked several questions regarding the medical treatment of William Simao. Moreover, Defense Counsel questioned Dr. Seibel regarding future medical treatment that Mr. Simao would require. In response, Dr. Seibel responded, that he did not have a plan not right now.

> Q. Let me shift gears here. Do you have a future treatment plan for the Plaintiff?
> A. I don't **right now** in front of me.

(Seibel Deposition, at p. 53, lines 20-22.)[4] *Emphasis added.*

Later in his deposition, Dr. Seibel was asked more refined questions regarding Mr. Simao's future medical treatment. Specifically, Dr. Seibel was asked what treatment that Mr. Simao should next undergo, so that the future treatment plan of Mr. Simao could be determined.

> Q. What treatment plan would you recommend to Mr. Simao at this point in time to more definitely diagnose and his condition and also to treat his condition?
> A. It seems like there is two questions. One is - -
>
> Q. Well, lets break it down to - -
>
> Q. Therapuetic. Let's talk about diagnostic first.
>
> A. From a diagnostic standpoint, based on the last time I saw him, I would pursue again a selective nerve root block at C4 level.
>
> Q. What would be the purpose of that? Would you explain?
>
> A. To see if he's having C4 nerve-root mediated pain caused by compression of the nerve root.

(Seibel Deposition, p. 67, lines 17-25 thru p. 68, lines 1-14.)

As testified by Dr. Seibel on August 20, 2010, he could not diagnose Mr. Simao's current condition, without first performing an additional diagnostic pain management procedure. Dr. Seibel goes on to testify that this additional procedure would provide him with the critical diagnostic information that he would need before being able to formulate the future medical plan of Mr. Simao.

[4] Exhibit 1, (Dr. Seibel's Deposition Transcript)

Q. Okay. And what -- **assuming that that has a positive outcome**, what would be your treatment options for -- or your treatment recommendations for him?

A. Again, from my perspective, I'm not the spine surgeon. But my job is to provide some diagnostics, but also some therapeutic interventions, which range from the modalities we mentioned before. Would it be a medication management or a repeat steroid injection? Or consider re-referral back to the surgeon to see if he felt there was any other surgical interventions that could help alleviate this based on those diagnostic results.

(Seibel Deposition, p. 68, lines 17-25 thru p. 69, lines 1-3.)

In other words, Dr. Seibel testified that **if Mr. Simao had a positive** outcome to the diagnostic pain management procedure, then there would be a range of future treatment options available to him.

Next, Dr. Seibel was asked what the treatment options would be if the results of the pain management diagnostic procedure was **negative**.

Q. And assuming the result was negative, what would be your next step?

A. If the result was negative, I'd probably continue to do myofascial treatments for him, medication management. He may not have any further interventional or surgical modalities that are available to him.

(Seibel Deposition, p. 69, lines 4-9.)

In other words, Dr. Seibel testified that if there was a negative result, then the only future treatment available would be medications and physical therapy.

In an effort to understand what Dr. Seibel meant by the term "modalities," he was questioned with regard to various types of treatment options. Specifically, he was asked about two specific options, a spinal cord stimulator and a morphine pump. The testimony is as follows:

Q. At that point in time, is it foreseeable to you that he would be recommended for, say, an implant of an

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electronic stimulator or other type of pain-relief modality, such as the Morphine pump for –

A. I could see where some might consider that an option. I don't consider a Morphine pump or any intrathecal device **right now** a likely option for that.

(Seibel Deposition, p. 69, lines 10-16.)

Clearly, Dr. Seibel testified that an implant of a spinal cord stimulator would be a viable treatment option. Moreover, he felt that it was a treatment option that other physicians might also recommend. However, "right now" (April 20, 2010), Dr. Seibel could not recommend a spinal cord stimulator, since Mr. Simao required an additional diagnostic procedure. This is confirmed by Dr. Seibel's additional deposition testimony.

Q. No, I understand right now. But I'm saying -- and I understand that there still has to be further workup with Mr. Simao; is that fair?

A. Yes.

A. I could see where somebody would think that's a reasonable option. I don't particularly think that's an option for him. But, yes, those are treatment modalities that somebody would feel is appropriate.

(Seibel Deposition, p. 69, lines 4-9.)

BY MR. ROGERS:

Q. To wrap up plaintiff's line of questioning, it sounds as though you're not in a position right now to formulate a future treatment plan; but at this point you are not inclined to recommend any invasive procedures like intrathecal implantation –

A. No.

Q. -- is that correct?

A. That's correct.

In sum, on August 20, 2010, Dr. Seibel was asked several questions regarding Mr. Simao's future treatment options. He informed the attorneys that he did not have a future

treatment plan right now because he needed to perform an additional diagnostic procedure. He testified regarding the range of future treatment options available, but that he first would need to know if Mr. Simao had a either positive or a negative result from the diagnostic test. Lastly, Dr. Seibel testified that two of these modalities could include an intrathecal morphine pump or a spinal cord stimulator. (Each of these are pain management devices). According to Dr. Seibel, some physicians might believe that Mr. Simao is a candidate for one of these two options right now. However, at the time of his deposition, Dr. Seibel could not state whether a spinal cord stimulator was a viable future treatment option until he first determined if Mr. Simao had a **positive** outcome from the diagnostic procedure.

On November 11, 2010, Dr. Seibel performed the diagnostic injection that he discussed in his deposition. [5] Shortly after the injection, Mr. Simao followed up with Southwest Medical Associates. The chart note for the follow up visit indicates that Mr. Simao had a 75-80% reduction in his left sided extremity and neck pain as a result of the pain management injection which is clearly a **positive** outcome.[6] More importantly, based on this positive outcome, there is now a diagnostic basis in which to form future treatment options. Specifically, Dr. Seibel testified that if Mr. Simao had a positive outcome from the diagnostic procedure then one of then Mr. Simao would be a candidate for future treatment modalities, i.e. a spinal cord stimulator.

While the defense may argue that they are surprised by the fact that a spinal cord stimulator is a viable future treatment option for Mr. Simao, the evidence shows that this is not true. The defense was put on notice at the time of Dr. Seibel's deposition. Moreover, if the defense would have simply read the Southwest Medical record of November 23, 2010, (the follow up note immediately after the diagnostic procedure performed by Dr Seibel) they would have known that Mr. Simao had a positive outcome from the diagnostic procedure, thus

[5] Exhibit 2, (Trial Exhibit 18, p. 263-264).
[6] Exhibit 3, (Trial Exhibit 18, p. 265-266).

affording Mr. Simao a range of treatment options such as a spinal cord stimulator. Simply put, the positive outcome from the diagnostic procedure provided the diagnostic basis for Mr. Simao's treating physician(s) to formulate future treatment recommendations. Once Mr. Simao had a positive outcome from the diagnostic procedure, a spinal cord stimulator (pain management device) was now an appropriate treatment recommendation and not just a viable option. This is further confirmed by Dr. Daniel Lee, who is one of the spine surgeons who treated Mr. Simao. On February 24, 2011, Dr. Lee examined Mr. Simao and noted that he recommended future pain management for Mr. Simao.[7] As discussed above, a spinal cord stimulator is a pain management device.

2. The Fact that David Fish, M.D. Rendered Opinions Regarding Plaintiff's Need for Spinal Cord Stimulator Is Evidence that the Defense is NOT Surprised.

By it's very nature, a surprise is something that you could not anticipate, or something that you were not expecting. Here, the defense cannot claim surprise with regard to a spinal cord stimulator being a future medical treatment option for Plaintiff, since their expert offered an opinion on the same.

The defense has retained Dr. David Fish as an expert. Dr. Fish is a Board Certified Pain Management Specialist. Dr. Fish examined Plaintiff, conducted a records review (of all of Plaintiff's medical records), read all of the depositions and drafted at least (4) four expert reports. On February 9, 2011, approximately one (1) month before the start of the trial, Dr. Fish authored a report outlining his opinions regarding Plaintiff's future medical treatment. At page seven (7) of his report, Dr Fish states:

> "There is no indication based on the MVA, a dorsal column stimulator, cervical degenerative arthritis, and need for revision surgery to the cervical spine is necessary."[8]

[7] Exhibit 4, Chart Note of Dr. Lee, dated February 24, 2011 (Trial Exhibit 22, p. 79)
[8] Exhibit 5, Dr. Fish Report, dated February 9, 2011.

The fact that Dr. Fish authored a report containing opinions regarding a spinal column stimulator is evidence of the fact that the defense is not surprised. Clearly, Dr. Fish understood that a spinal cord stimulator was a treatment option discussed by Plaintiff's treating physicians, otherwise, he would not have rendered an opinion on the subject. Moreover, the fact that Dr. Fish rendered opinions regarding a spinal cord stimulator is evidence that he anticipates evidence of the same, and is prepared to address the issue at trial.[9]

III.

CONCLUSION

In sum, the Defense has no valid basis in which to claim surprise regarding evidence of a spinal cord stimulator. The evidence is clear, that the Defense was put on notice by: (1) Dr. Seibel's Deposition; (2) Plaintiff's medical records of both Southwest Medical Associates and Dr. Lee; and (3) their own medical expert, David Fish, M.D. Accordingly, it is proper for this Court to permit evidence of Plaintiff's need for a spinal cord stimulator.

DATED this 28TH day of March, 2011.

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[9] If the defense claims surprise by this evidence, the only plausible reason for their surprise would be that they did not read Dr. Fish's report.

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EXHIBIT "1"

CONDENSED TRANSCRIPT DEPOSITION OF ROSS SEIBEL

Date: August 20, 2010

Case:

William Simao

vs.

Jenny Rish

Case No.: A539455

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DISTRICT COURT
CLARK COUNTY, NEVADA

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

Plaintiffs,

vs.

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

Defendants.

) CASE NO.: A539455
) DEPT NO.: X

DEPOSITION OF ROSS SEIBEL, M.D.

Taken on Friday, August 20, 2010
At 3:14 p.m.

At 300 South Fourth Street, Suite 710
Las Vegas, Nevada

REPORTED BY: JEAN DAHLBERG, RPR, CCR NO. 759, CSR 11715

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INDEX

EXHIBITS

LAS VEGAS, NEVADA; FRIDAY, AUGUST 20, 2010
3:14 P.M.
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Whereupon --

(In an off-the-record discussion held prior to the commencement of the proceedings, counsel agreed to waive the court reporter's requirements under Rule 30(b)(4) of the Nevada Rules of Civil Procedure.)

ROSS SEIBEL, M.D.,

having been first duly sworn to testify to the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

EXAMINATION

BY MR. ROGERS:

Q. Would you state your name, please.

A. Ross Seibel, S-e-i-b-e-l.

Q. Okay. Before we went on the record I asked you if you'd given a statement under oath before; you said you had.

A. Yes.

Q. How many times have you given testimony in a deposition?

A. Six or seven times.

Q. And each time in the capacity of a treating

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medical provider?
A. Yes.
Q. Do you have a curriculum vitae with you?
A. I don't.
Q. Is this something that you have at your office?
A. Yes.
Q. Is it something I can request and attach as an exhibit?
A. Yes, you can. I can provide that.
Q. Very good. We'll attach your curriculum vitae as Exhibit A.
(Exhibit A will be sent via e-mail to the reporter, and it will be marked as Exhibit A for identification.)
BY MR. ROGERS:
Q. Do you have a testimony history; you know, a written account of these cases in which you've testified?
A. No.
Q. Okay.
A. Let me rephrase that. Testifying as in coming here to do depositions for it?
Q. Right.
A. Yes.
Q. Well, have you ever --

A. Not a testimony as in trial or in a courtroom; it's always depositions --
Q. Only in a lawyer's office?
A. Yes.
Q. You've never testified in court?
A. No.
Q. Let's get a couple of the admonitions out of the way, then.
First of all, you understand that you're under oath and obligated to tell the truth?
A. Yes.
Q. And the penalties could apply if you don't?
A. Yes.
Q. All right. One thing I want you to keep in mind is that the court reporter can't take us both talking at once. And while it's clear that you know where I'm going with some of my questions before I'm done, wait for me to finish so she can get us both clearly. Okay?
A. Yes.
Q. Now, while we're going to attach your C.V., let me walk through, just for purposes of brevity, the educational history that I'm aware of. It's that you went to medical school at Wisconsin, did an internship at St. Joseph's Hospital in Wisconsin, your residency at Stanford in anesthesia, and your fellowship in pain

management at Stanford?
A. Yes, that is correct.
Q. Impressive.
Are you Board certified?
A. Yes.
Q. In what?
A. Both anesthesia and pain medicine.
Q. When did you pass your Boards?
A. Around 2004, 2005.
Q. Is that --
A. One came before the other, so anesthesia Boards, I think, were 2004, and pain was, like, 2005.
Q. All right. Are you a member of any medical societies -- ISIS, things like that?
A. A few. I have been a member of ISIS. I don't know if my membership's up to date. But ISIS; ASA, American Society of Anesthesiologists.
Q. Will those societies be included in your curriculum vitae?
A. Yes.
Q. All right. What did you do to prepare for today's deposition?
A. I printed up some of the documents available on our electronic medical records, just to refresh my memory.

Q. Okay. You haven't reviewed any deposition transcripts?
A. No.
Q. And no medical records from providers outside of Southwest Medical Associates?
A. No.
Q. You haven't reviewed any of the medical expert reports in this case from Drs. Jeff Wong, David Fish or Winkler?
A. No.
Q. Do you know any of those doctors?
A. No, not that I know of.
Q. Okay. Will you be testifying as an expert in this case?
A. No.
Q. What percentage of your practice, if any, involves patients who are making personal injury claims?
MR. CRAFTON: Object to form. Foundation.
BY MR. ROGERS:
Q. You can go ahead and answer.
A. In my practice, we typically don't see patients in a personal injury claim, per se. We typically see them as they're involved in a personal injury as their primary insurance providers. So it's typically after they've seen other providers regarding their personal

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injury.
Q. Do you do any personal injury lien work?
A. No.
Q. And Southwest was the plaintiff's primary -- or pardon me, was the plaintiff's health insurer?
A. Yes, Southwest Medical is the physician group for his primary health insurer.
Q. When was the last time you spoke with the plaintiff?
A. Based on what I can recall, at least from his medical records, I saw him in the clinic on March 5, 2010. I believe I saw him for a procedure in subsequent months, but I can't tell you the exact date. I only have --
Q. Well, before we went on the record plaintiff's counsel showed us a more recent procedure that was a -- what was it?
A. He had a steroid injection, a transforaminal steroid injection. I believe he had a date of sometime in April. We looked at the note --
Q. Well, let's take a look --
A. -- that he had on the computer.
Q. -- just so that we're certain here.
A. Sure.
MR. CRAFTON: Now you're making me scroll though

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this and find it again --
MR. ROGERS: While plaintiff's counsel --
MR. CRAFTON: I think I've got it.
THE WITNESS: A little bit more there. Now you're looking at -- there you go.
June 10th, 2010.
BY MR. ROGERS:
Q. And what was the procedure?
A. Left -- or cervical transforaminal steroid injection, left C3-4.
Q. And according to the records produced by Southwest Medical Associates, the first time you saw the plaintiff was June 7, 2006; is that right?
A. Do you have records there that you want me to verify, or based on what I've brought in here?
Q. Well, let's do both.
A. I may not -- I may not have all of them.
Q. You may have something in addition to what I have, though.
A. Yes.
Q. The initial procedure note that I see with your signature is June 7th, 2006.
A. That is correct. I have a note prior to this from May 10th, 2006, from a P.A. within our office during the patient's initial evaluation.

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Q. Okay. But you didn't see him in May; your P.A. did?
A. Correct.
Q. I have that, yeah.
Okay. You never saw him at any time before June 7th, 2006? I mean, Southwest did; I'm asking of you personally.
A. Right. Typically, if the P.A. was in the office seeing him, I would see him then with the P.A. The P.A. might have presented the case to me and we may have discussed it with the patient. But as far as this note goes, I'm not on it. The P.A. is on here, but I was probably in the clinic that day with him.
Q. Okay. Would you have done the physical exam that the P.A. reported?
A. Not necessarily. Probably not, on this note here. If I did, it would have been documented that I went and did the physical exam in addition to what he had to say. But that's not what's on this note here, so I would say that I didn't do it that day.
Q. Well, take a look at that note and tell me what you can infer from reading it and that you would have done in that May 2006 consultation, if anything.
A. Well, there was extensive documentation of the patient presenting with neck pain. There's reference to

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him having a motor vehicle collision. There's reference to his MRI that he had from March of 2006 that demonstrated -- do you want me to repeat some of these MRI findings?
Q. You're free to.
A. He had a C3-4; he had some mild narrowing of the left neuroforamen, maybe some contact over the exiting C4 nerve root. At C4-5 he had a broad-based disk protrusion. So based on this, he was set up for some trigger-point injections that we did in the clinic, and also scheduled for a transforaminal steroid injection on the left, C3-4.
Q. Okay. Now, after having reviewed that, can you tell what you did at that visit, if anything?
A. There's no indication that I did anything at this visit.
Q. Okay. What I'm trying to understand better is your earlier comment that if the P.A. is examining the patient, it's not uncommon that you're in the room, maybe talking to this patient, in some way involved. I'm wanting to understand what your involvement was, if any, in this visit?
A. Not necessarily. P.A. Young, here on the record, would have seen the patient and likely would have presented to me if there were issues that he felt

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that I needed to do an exam on him, or do something different than he had already done and presented in this manner. I might go do that. There's no indication that I did that here, though.

Q. Okay, I get it.

Then the patient comes to see you for the procedure on June 7th, 2006. You have a section of this report entitled "Active Problems." Are those your diagnoses?

A. They can be. These are -- on electronic medical records, they can actually be drawn in from the patient's chart. So, for instance, he has -- on the note of June 7th, 2006, he has four entries here. One says migraine headache; one says episodic-tension-type headache; one says cervicalgia; and the last says cervical radiculopathy at C4. So, for instance, at our clinic we may have assessed those last two on his initial evaluation, which would then be put into his active problem list.

Q. Okay. But my question, however, is this: Is the phrase "active problems" synonymous with diagnoses?

A. Yes.

Q. All right. Are these diagnoses, particularly the facet hypertrophy, confirmed by the MRI study that was done at this time? And feel free to take a look at

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that MRI study that I handed to you before the deposition. What's the date of that, Doctor?

A. I have two. The first one is 3/22/06.

Q. Okay. That would be the one that you would have been referring to in this June 2006 report, then?

A. Yes.

Q. All right. So tell me, is this diagnosis of facet hypertrophy confirmed by that MRI?

A. Yes, at -- on the report it says, "At C3-4, facet hypertrophy greater on the left mildly narrowing at the left neuroforamen. There may be contact at the left exiting C4 nerve root."

Q. All right. Now, can the conditions seen in that MRI be caused by something other than a single traumatic event, such as a car accident?

MR. CRAFTON: I'll object to form and foundation.

THE WITNESS: Yes, it can.

BY MR. ROGERS:

Q. Okay, what other potential causes are there?

MR. CRAFTON: Same objections.

THE WITNESS: Degeneration. Age.

BY MR. ROGERS:

Q. Do you remember the plaintiff's age at the time that MRI was taken?

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A. I don't remember his age.

Q. I think it was on the report.

A. It's on the report. And date it -- I could date it and determine his age.

Q. His date of birth was May 1963, so --

A. He was --

Q. All right. Doing the math roughly --

A. 47 years old.

Q. Okay. Are the findings in the plaintiff's initial cervical MRI from March 2006 consistent with age appropriate degeneration?

MR. CRAFTON: Object to form.

THE WITNESS: In general, I would think so. But these are, in some ways, nonspecific findings too. Having facet hypertrophy can be seen at a wide age span and may have various meanings.

BY MR. ROGERS:

Q. Okay. Dr. Arita was deposed in this case, and he testified similarly to you. He said that the plaintiff's condition could be normal, that what's seen in this MRI could be a normal finding. Do you agree with that?

A. It depends on how you define "normal." But I think if you defined normal as a finding that I might find in the general population, whether they're

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symptomatic or asymptomatic, it is possible that you could find facet hypertrophy, say, in an asymptomatic patient and consider that a, quote, "normal finding," end quote.

Q. Okay. But "normal," given a person's age, in other words?

A. Correct.

Q. The Southwest Medical records reflect that the plaintiff had a nicotine addiction, that he was a smoker. Can smoking cause greater degeneration than you find in patients who aren't smokers?

MR. CRAFTON: Object to form. Foundation.

THE WITNESS: I think that calls for more of an expert witness on this, not as it pertained to this patient. I don't have any reason to believe that this particular finding on here is caused by him smoking.

BY MR. ROGERS:

Q. All right. And by "this particular finding," what you're referring to is facet hypertrophy?

A. Correct.

Q. Dr. Arita testified with regard to facet hypertrophy that it, quote, "was either preexisting or has no relation to this particular accident," closed quote; meaning, the car accident. Do you agree with that statement?

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MR. CRAFTON: I'll object to form. Foundation. Misstates prior deposition testimony.

THE WITNESS: I think it's a bit of a broad statement in trying to relate a cause and effect of an event to the findings here. But if I was reading this report and asking out of context of an accident, "Is this a normal, degenerative-type finding," I would agree, yes, it is, and not necessarily caused by trauma.

BY MR. ROGERS:

Q. Do you see anything in the cervical MRI findings or impression that will likely result only from a single traumatic event, like a car accident?

MR. CRAFTON: Object to form and foundation. Incomplete hypothetical.

THE WITNESS: There's nothing on this or, for that matter, I think, any imaging of your MRI that could only be caused by trauma to the region. But if I was looking at this MRI, particularly noting statements such as a C4-5 central-braced disk protrusion, that is typically that might come from trauma, but could also be found in the absence of it. So I don't think you could draw a conclusion on this MRI of any of these type of things coming from a trauma.

BY MR. ROGERS:

Q. Okay. In a patient who sustained a

traumatically induced disk protrusion, such as the one you just referred to, what is the typical pain presentation?

MR. CRAFTON: Object to the form and foundation, as to the word "typical."

THE WITNESS: Well, first of all, again, this finding on here of a 2- to 3-millimeter disk protrusion, is not necessarily something I consider associated with a trauma. The only way I think you could technically know that is if you had an MRI sometime in the near vicinity of the trauma before, and then took an image of his afterwards. So in the absence of that, I don't think you can draw that direct conclusion.

But if you ask how would a patient typically present after a trauma with a disk protrusion showing on a subsequent MRI, typically will have neck pain, give or take some radiation into his upper extremities.

BY MR. ROGERS:

Q. Okay. Now, as I look through the Southwest Medical records, I didn't see any complaints of neck pain or arm pain between April 15, 2005, and October, I believe, 6, 2005; so for nearly five and a half months. Would it be typical for a person who sustained a traumatically induced disk protrusion to have no pain for that length of time?

MR. CRAFTON: Object to form. Foundation. Calls for speculation. Also calls for an incomplete hypothetical.

THE WITNESS: I'm sorry, could you repeat the date? I believe you're referencing some time period before we saw him, or before his injury?

BY MR. ROGERS:

Q. The time frame is April 15, 2005, to October 6th, 2005. The context is this: The car accident occurs on April 15 — yeah, April 15, 2005. Then as you go through the Southwest Medical records, there's the initial presentation; he complains of neck pain and left shoulder pain. And then for the next five and a half months, nothing but headaches, migraines. And then on October 6, 2005, he again complains of neck pain. My question is: If you have a traumatically induced cervical disk protrusion, is that a typical pain presentation?

MR. CRAFTON: Same objections.

THE WITNESS: Again, meaning a roughly five-month delay between when he had the trauma and the presentation of the neck pain? Is that what you're referring to?

BY MR. ROGERS:

Q. That's what I'm getting to, yes.

A. I don't know if I consider it typical; although, in my practice, patients don't always have immediate neck or back pain after an injury, but it's not unusual for them to present weeks to even up to a month or two later. I think five or six months after an accident is starting to get into a gray zone about a cause and effect type relationship.

Q. Okay. When you first saw the plaintiff, was he on any medication at that time?

A. Are you referring to his initial eval in our clinic on May 10th, 2006?

Q. Yes. And by "our clinic," what you're referring to is the pain management clinic in Southwest; right?

A. Correct.

Q. Okay, go ahead.

MR. CRAFTON: I'm sorry, what was the question?

BY MR. ROGERS:

Q. What medication was he on at the time that he presented to the pain management clinic in May of 2006?

A. Based on this, we have a few references to his medication. Via the electronic medical record, there's a listing of his current medications. There are several in there that may be related to pain, such as an anti-inflammatory or a muscle relaxant. But also in the body of the notes there's reference to a previous

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medication trial that he's been on. Would you like me to list some of those?
Q. What I want to know is the medications he was taking at that time.
A. Based on this record, the medications at this time were Ibuprofen, Soma, Piroxicam, and Butalbital product as needed.
Q. Clarify for me what those medications are for. The reason I say that, is the only medication I see in this report is Elavil.
A. Elavil is something that we prescribed to him afterwards. But if you look to the body of this note, he'll have current medications.
Q. Okay.
A. I can list a couple of these. For instance, the Ibuprofen and the Piroxicam would be considered for pain, an anti-inflammatory medication.
Q. All right.
A. The Carisoprodol or Soma is a muscle relaxant. And the Fioricet is Butalbital containing medication typically used for headaches.
Q. Okay. I see in this initial exam that the plaintiff's cervical range of motion was without provocation of pain. Would you characterize that as normal?

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A. Yes.
Q. The motor function in his arms was normal as well?
A. Yes.
Q. The only thing that I can see that is abnormal on the physical exam is tenderness to palpation. Am I reading this correctly?
A. That was correct.
Q. Can a person have tenderness to palpation without having a problem with their facet joints or cervical disks?
MR. CRAFTON: Object to the form.
THE WITNESS: Yes.
BY MR. ROGERS:
Q. That can be a simple whiplash-type problem?
MR. CRAFTON: Object to form.
THE WITNESS: It depends how you define "whiplash." Without clarifying --
BY MR. ROGERS:
Q. As a soft tissue is --
A. It would be a soft tissue --
Q. -- is what I'm talking about?
A. -- a myofascial problem, yes.
Q. Well, trigger-point injections address myofascial or soft-tissue problems; correct?

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A. Yes.
Q. And what was the plaintiff's response to the trigger-point injections administered in April 2006?
MR. CRAFTON: He had trigger-point injections in April '06?
BY MR. ROGERS:
Q. May. May 10.
A. On my record, I don't have a record from May 10. I don't see a follow-up in my records until --
Q. At the conclusion of the May 10 report, it reads, "He tolerated the procedure well. There were no complications. Mr. Simao was monitored in the clinic for 15 minutes after the injections, and he was discharged in stable condition." Was there any further response to his response to the trigger-point injections?
A. No.
Q. And the next time he was seen at Southwest Medical Associates was when?
A. Based on the records I have here, he was seen June 7th, 2006, for a procedure. We ordered transforaminal steroid injections, left C3-4.
Q. Okay. What was his response to the injection?
A. I don't have a note in front of me documenting that.

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Q. I have a June 20 follow-up report.
A. Based on this note, the interval history from June 20, 2006, states that he had a good overall response to the steroid injection, decrease in the severity and frequency of his headaches, continuous with some pain of the left trapezial area. Says he did respond well to trigger-point injections previously.
Q. Okay. Did the plaintiff respond better to the trigger-point injections than the epidural?
MR. CRAFTON: Object to form and the foundation.
THE WITNESS: I don't know if you can tell from this note in front of me.
BY MR. ROGERS:
Q. Can you tell from your file?
A. I can't.
Q. The plaintiff was first deposed back -- or pardon me, he was deposed a second time in October 2009. At that time he testified that he would be treating with a shoulder expert. Are the plaintiff's complaints from May and April 2006 consistent with a shoulder injury?
A. Not based on the records I have here, no.
Q. Okay. You've looked at this as facet hypertrophy, because it seems to follow a C4 dermatome; right?
A. Two different things.

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Q. Well, the MRI --
A. Facet hypertrophy doesn't necessarily correlate to a C4 dermatome. The narrowing of the foramen at the C3-4 level could correlate to a C4 dermatome, yes.
Q. Okay. And that's because the pain he complained of was across his neck and then over his left trapezius?
A. Correct.
Q. Was it down as far as his shoulder?
A. From what I could tell in my records, it looks like it went just to the dome, or the edge of the shoulder here, but not down his arm.
Q. Okay. You've also testified that his physical exam was consistent with myofascial or soft-tissue pain; right?
A. Correct.
Q. And we've learned now that he responded well to trigger-point injections. Is that --
MR. CRAFTON: Object to form.
THE WITNESS: Correct.
BY MR. ROGERS:
Q. Could it be that the trapezius pain that he was complaining of was not being caused by impingement at C4 but rather just soft tissue?
MR. CRAFTON: Form. Foundation. Calls for speculation.

THE WITNESS: Yes, it's possible.
BY MR. ROGERS:
Q. Did the plaintiff complain of any hand symptoms when you saw him back in May and June of 2006?
A. It indicates here -- the records from May 10th, 2006, indicate a history of worsening neck and hand pain over the past year.
Q. Were you aware that the plaintiff was diagnosed with carpal tunnel syndrome?
A. I don't believe so at the time. Without jumping ahead, I do recall on my re-eval, which was several years later, a mention of a possible carpal tunnel syndrome. But that -- there's no indication of that on this initial eval in 2006, though.
Q. What did the plaintiff tell you about his history at the time of that 2006 initial evaluation?
A. A little vague. What do you mean by "about his history"?
Q. Sure. Let's start with his past medical history.
A. Based on this, he has a history of migraine headaches, which have been increasing. He said he has insidiously worsening neck pain, chronic recurrent headaches, a year ago involving the motor vehicle accident, which appeared to -- which he called as a

whiplash-type injury after the accident. And then again noticing increasing frequency of his migraines and increasing pain over the left trapezial area.
Q. Did he tell you about any other car accidents he'd been involved in?
A. Not that I can see here, no.
Q. Did he tell you about a prior motorcycle accident?
A. Not that I can see here, no.
Q. Did he tell you anything about this car accident that would give you an understanding of the kinds of forces involved?
A. Not based --
MR. CRAFTON: Form.
BY MR. ROGERS:
Q. Go ahead.
A. Not based on the report here, no.
Q. Well, as you sit here, do you have any understanding of what kind of a car accident this was?
A. No. I have no recall from 2006.
Q. Right. In your opinion, does the severity of force correlate to the likelihood of cause of injury?
A. I think it's a fair statement. I would agree.
With that being said, I have to say that I've seen people who have been in very severe accidents with

a lot of force who don't have injuries that you would expect to correlate with them.
Q. Back in 2006, what was the plaintiff's reported pain level?
A. I'm assuming you mean on a zero- to ten-point scale, or some type of scale?
Q. Yes.
A. I don't have it here. It may be on his intake questionnaire, which I don't have a copy of in front of me. It might -- it's about a ten-page form, if you want me to look.
Q. Keep your thumb where it is, because that's about where the May report is.
A. Going forward or backward?
I have a copy of his intake questionnaire. On this he indicates the pain level of six out of ten on a zero- to ten-point scale with exacerbations to ten-plus.
Q. Okay. Do you know whether the plaintiff was working full time at the time of that evaluation?
A. I can't tell exactly. He did not indicate when he last worked. But the information I do have here says he worked for the past one and a half years and missed ten days from work in the last six months.
Q. Is the physical exam consistent with those pain complaints?

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A. Yes.
Q. Is a finding that there is no pain on cervical range of motion consistent with a pain score of six to ten-plus of ten?
A. It can be.
Q. Can it not be as well, then?
A. Yes.
Q. The car accident that the plaintiff reported to Southwest involved roughly rounding up 500- and, I believe, 70 dollars of damage. There was no ambulance and he drove from the scene. Is what I just told you everything you know about this car accident?
MR. CRAFTON: Object to the form. Foundation.
THE WITNESS: Yes.
BY MR. ROGERS:
Q. All right. Do you have an opinion on the cause of the condition with which you diagnosed the plaintiff?
A. No.
Q. And why is that?
A. Because I -- as I stated before, I'm working under his primary insurance, evaluating the patient independently of what may have occurred in the accident. I don't draw a conclusion necessarily that one is a cause of the other. I certainly take it into consideration as a mechanism of injury when I'm trying

to assess his presentation. But with pain, myofascial pain, limit findings on MRI, as we spoke of before, it's often hard to draw a conclusion as to a cause and effect of this.
Q. And has the medical field tested the reliability of a causation opinion based on the plaintiff's word in a personal injury lawsuit?
MR. CRAFTON: Object to form.
THE WITNESS: Could you rephrase your question?
BY MR. ROGERS:
Q. Okay. I'll put it this way: Is there a known potential error rate in basing a causation opinion on the patient's word?
MR. CRAFTON: Same objection.
THE WITNESS: I don't know.
MR. CRAFTON: Foundation as well.
THE WITNESS: I don't know if I could tell you an actual rate. I would agree that clinically, in some sense, there's a high rate of error in causation between patients having any type of accident and presenting with pain symptoms.
BY MR. ROGERS:
Q. I've heard of publications documenting some concern about the reliability of a patient's word in a Workers' Compensation setting. Are you familiar with

any of these kinds of publications?
A. Yes.
Q. All right. Are those same concerns -- let me rephrase that.
Do those same concerns apply to personal injury lawsuits?
MR. CRAFTON: Form. Foundation.
THE WITNESS: In my practice, sometimes I think they do.
BY MR. ROGERS:
Q. Did your epidural injection positively identify the plaintiff's pain generator?
MR. CRAFTON: Are we still talking June '06?
BY MR. ROGERS:
Q. Yes.
A. I don't think based on his follow-up there that you can necessarily identify a single pain generator. It's referencing that he had a good overall response to the steroid injection, but he also states he had a -- you know, a good response to some trigger-point injections. So I don't think I particularly identified a discrete pain generator at that time. I would say that sometimes it is often difficult to identify a very focal pain generator.
Q. Where we leave off in June of 2006, I understand

that the plaintiff reported relief from the trigger-point injections, but I'm not clear on what his response to the epidural was. Did he have relief and, if so, what was it on an immediate and a long-term basis?
A. I can't tell what the long-term basis would have been based on his follow-up in June of 2006. It merely indicates that he had an overall good response to the injection.
Q. Was that in reference to the trigger point or to the epidural?
A. To the epidural.
Q. Okay.
A. This --
Q. I believe there's a -- look here. This may help answer the question, in a July 27, 2006 report.
A. This note indicates, again, July 27, 2006, that he continues to do well. His headache frequently has significantly reduced, as his neck pain has. He wasn't taking any medication. He seems to be very satisfied with the outcome of the procedure and the treatment. And I will see him back in three months or on an as-needed basis. He continues to do well.
Q. Okay. Now, let me move on to the follow-up visits there. But what does this July 2006 report tell

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you, at least as of July 27?
A. It means that for the -- you know, the next month or two after the procedure that he had significant improvement in his symptoms.
Q. Okay. Now I'm going to show you the next visit, August 24, 2006. And what does it say there about his response?
A. It says he returns to the clinic with complaint of exacerbation of his left trapezial pain. It says we discussed in the past the result of his transforaminal steroid injections were not stellar. It says he did have a reduction in the frequency of his tension-type headaches, however the pain over the C4 distribution of the left continues to worsen and having more frequent exacerbations.
And it goes on to say we talked about trying a left C4 selective nerve-root block to evaluate how he did during the anesthetic period as such.
Q. Okay. Now, do you know what the exacerbation was? In other words was there an aggravating event that caused this change we see in August?
A. Not that I can see here. It doesn't indicate there was any event that caused this exacerbation.
Q. What I mean by that is that some people use the term "exacerbation" to reference an event; others use it

differently. Do you know how that term was meant here?
A. Based on this, it looks like it was just an escalation or an increase in the symptoms he had, not based on there was an event that occurred and therefore "I have more pain." It looks like he's just had an exacerbation or an increase in the symptoms that he initially presented with.
Q. Now, if the problem in the plaintiff's neck was facet hypertrophy, why start with an epidural?
A. The facet hypertrophy was causing some narrowing of the foramen and possibly compressing on the C4 nerve root. And if he has pain radiating down into his trapezial region, that could come from a number of reasons. Like we mentioned before, it could be a myofascial pain in that region. It could be a radiant pattern from a facet degenerative problem. But it could also be a dermatomal pattern for a C4. So unfortunately with that presentation, you have several different options to pursue as far as trying to identify a discrete generator for this pain.
Q. You said that your injection did not isolate the pain generator. Dr. Arita followed up with pulsed radiofrequency, and the injection responses were basically the same, perhaps even shorter-lived. What does that response suggest to you?

MR. CRAFTON: Object to form and foundation.
BY MR. ROGERS:
Q. Go ahead and take the time to look at Dr. Arita's the notes, if you'd like. They're right in front of you.
A. Prior to having a pulsed radiofrequency modulation, you'd typically have a selective nerve-root block prior to that.
Q. He did a selective nerve-root block as well.
A. So using a -- referencing back to my procedure, what we did was a transforaminal steroid injection. Although, you can attempt to try to identify the relief he had during the anesthetic phase, it's typically more a therapeutic injection; whereas the selective nerve-root block is much more selective and much more short-term relief, and really looking for that post-procedure-type relief. Depending on the local anesthetic you use, anywhere from two to six hours.
If he subsequently proceeded with a pulse radiofrequency modulation, that would presume that he had a certain amount of relief during the diagnostic selective nerve-root block.
Q. All right. Well, take a look at that note in front of you, and you'll see the very injections you're talking about.

A. A follow-up from October 11, 2006, with Dr. Arita, indicates he underwent a left C4 selective nerve-root block and had 50- to 75-percent relief. Pulse radiofrequency was discussed. And will schedule for such.
Q. Okay. What does 50- to 75-percent relief suggest?
A. I consider that a moderate relief. There's certainly enough to point in a direction as being at least a good portion of his pain generator. At this point in time, it becomes sort of a practice variable for myself. If I'm doing a diagnostic procedure, I typically want to see in the range of 75 percent or greater pain relief. In other people's practice having 50 percent sometimes can represent a reasonable measure of relief. It depends on the individual provider.
Q. You testified earlier that it can sometimes be difficult to isolate a pain generator. And in this case, the plaintiff had the responses you've described to the epidural, the trigger point, and the select nerve-root block, and generally the same responses to the pulse radiofrequencies that followed. Is there something about the cervical spine that makes it more difficult to isolate the pain generator as compared to, let's say, the lumbar spine?

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MR. CRAFTON: Object to form. Misstates prior testimony.

THE WITNESS: One of the things that makes it difficult in the cervical spine, particularly in this presentation here, is the overlap between some of the radiant patterns of pain that may come from disk degeneration, myofascial pain, possibly even facet-mediated pain, versus a radicular-type pattern that would be mediated by a nerve root, particularly when you're talking about an area of the trapezial region. Because that pain pattern tends to overlap.

So, for instance, if somebody was felt to have a discrete pain generator at an inferior nerve root, such as a C6 or a C7, it might be a little more -- a little easier to diagnose, as we might expect some symptoms further down into the arm and into the hand. But when you're in the trapezial region and the shoulder region, a lot of the pain generators in the way they present will overlap. So in that sense, that area can be difficult to isolate one pain generator.

BY MR. ROGERS:

Q. Okay. Do you do discograms?

A. I do in some areas.

Q. What areas?

A. The lumbar spine.

Q. You don't do them in the cervical?

A. No.

Q. Have you ever?

A. I did a few in training, but not in practice.

Q. Do you have an opinion on the reliability of cervical discography in terms of isolating the level that should be operated on?

MR. CRAFTON: Object to form and foundation.

THE WITNESS: Yeah, in general. I think at best it's a marginal predictor. And from my practice, often I think the risk of the procedure outweighs any diagnostic information you're going to get from it.

BY MR. ROGERS:

Q. What risk are you talking about?

A. The risk of complications from the procedure itself; meaning, hematoma particularly in your neck.

Q. Can discography actually injure the disk?

A. I think that's a bit of a debatable medical question right now. I think in the sheer sense of causing trauma to the disk with a needle, you could say that it could damage the disk. But again, I think in the medical literature there's always debate about the trauma and the long-term effects about doing a discography. But I don't think I could testify here to you as to a cause and effect of that at all.

Q. Is there any concern in the medical field about a surgeon doing a diagnostic block and then basing a surgical decision on this block?

MR. CRAFTON: I'll object to form. Foundation. Go ahead.

THE WITNESS: I can't comment on any particular literature. From my perspective, I have a concern over somebody doing a diagnostic block as such and making a surgical decision after that.

BY MR. ROGERS:

Q. What's your concern?

A. My concern is that, in general, a discography can have a very high false-positive rate. And that if a provider who is performing such has such false-positive rates and then uses that information for a subsequent and very interventional procedure, like a surgery, may be making a poor decision based on that.

Q. Would that same concern you have about discography apply equally to epidural blocks?

A. Well, typically an epidural block is not a diagnostic procedure, so something wouldn't necessarily come from that.

Q. So let's say a selective nerve-root block.

A. Yeah. I think what you might be thinking is if I do a selective nerve-root block and subsequently do a

pulse radiofrequency modulation on that. I think there is some concern, but I think you have to weigh the risk and the long-term outcomes that occur with the subsequent procedure. For instance, if you do a selective nerve-root block and you deem there's been a specific amount of benefit, and you choose to do a pulse radiofrequency modulation, I think the risk of exacerbating or making these symptoms worse by such procedure are relatively low.

Q. You know what? I think my question wasn't clear. My question is: Where a spine surgeon does his own epidural or selective nerve-root block and then bases a surgical decision on that block, is there any concern in the medical field about that approach?

A. Oh. All right.

MR. CRAFTON: Object to form. Foundation. Go ahead.

THE WITNESS: I'm sorry, I understand the question now.

Again, same thing with discography. I can't cite you specific detail in medical literature, but I have my own personal opinion about that, and I do have concern about making surgical decisions based on a diagnostic block like that.

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BY MR. ROGERS:
Q. In other words, in your professional experience, there's a reason for this sort of separation between the surgeon and the pain management provider?
A. In my practice and opinion, yes.
Q. When you have confusion about the pain generator in a case like the plaintiff's where the pain is up in the trapezial region and you get varying responses from different injections, is it important to employ other studies, other diagnostic studies like EMG, nerve conduction studies, things like that to help isolate the pain generator?
A. It can be a reasonable option.
Q. Is it something that you would recommend doing before performing an invasive procedure like a fusion?
A. Not routinely, no.
Q. Did Dr. McNulty ever recommend facet injections to the plaintiff?
A. At any period in a time period, or would you like me to reference a particular period?
Q. Well, each time he sent the plaintiff out, he referred him to Southwest Pain Management, to your office. Do you see any record of a recommendation for a facet injection?
A. I don't see any requests to me, per se, for a

facet injection, but there are several hundred pages of documents here that I haven't gone through.
Q. All right. When he came back to see you after the surgery, the plan, as I understand it, was medial branch blocks? At least as of April 20, 2010.
A. I have a note from April 6th, 2010, indicating that the patient had gone back to see Dr. McNulty and re-referred to this office for evaluation of possible medial branch blocks --
Q. Okay.
A. -- for the facet which would be -- not a facet injection, per se, but a block of the nerve that goes to the facet.
Q. Right. Well, let's go back, then, for a moment to March, so that we get that first return visit. We now haven't seen the plaintiff --
A. Sorry, which year?
Q. 2010.
A. Okay.
Q. So you now haven't seen the plaintiff, well, for nearly four years. He comes back to see you and he's had this two-level fusion. You write, "He seems to present in a very similar fashion as he did preoperatively several years back, still primarily axial neck pain, radiation to the left trapezial region."

What does the fact that the plaintiff had little to no pain relief from that surgery suggest in terms of anyone having isolated that pain generator?
MR. CRAFTON: Object to the form. Foundation. Go ahead.
THE WITNESS: Yeah, I think that's a tough conclusion to make. I see a lot of patients who have surgeries after reasonable isolation of a pain generator that don't have pain relief afterwards and, in fact, can often have worsening of their pain after their surgery. So I don't think I could draw any direct conclusion between a -- necessarily a pain generator workup and a response the patient had.
BY MR. ROGERS:
Q. Do you know whether there was a reasonable isolation of the pain generator in this case?
A. I don't know. We hadn't seen him for years.
Q. Right. You weren't part of that workup?
A. No.
Q. But it is accurate to state that when the plaintiff returned to you, he was in a very similar fashion, as you put it, to the pain he had before?
A. It appears that way, yes.
Q. Was there any difference in either the location or the severity of the pain between June 2006 and

March 2010?
A. He did not appear to have any significant difference.
Q. You saw the MRI that was taken after the surgery. Did the surgery relieve the stenosis that you observed on the March 2006 MRI?
MR. CRAFTON: I guess I'll object. I didn't understand the question.
THE WITNESS: It's a good thing I did.
MR. ROGERS: Okay. I'll just have her repeat it, and then you can take a look at that Steinberg pile, if you want.
Can you read that back, please.
(Question read by the reporter.)
MR. ROGERS: Did that make better sense?
MR. CRAFTON: Yeah, thank you.
BY MR. ROGERS:
Q. Okay.
A. I have two things to look at. Based on my note of March 5th, 2010, it indicates that an updated CT scan of the cervical spine was made from August 11th, 2009, which showed an anterior cervical disk fusion from C3 through C5. There was a C3-4 stable left-sided joint arthropathy resulting in moderate left neuroforaminal stenosis potentially affecting the exiting L4 nerve

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root. And it says, parentheses, similar to previous imaging of the studies of the left-sided C3-4 level, period.

Q. That L was a typographical error?

A. I would note that that seems like a typo, yes.

Q. Go ahead.

A. That was my note from 2010. I think you are referencing another MRI we have of the cervical spine from 11/6/08 here, which is compared from 9/24/07, which shows at C3-4 no significant discogenic disease, possible mild left neuroforaminal narrowing, secondary to facet hypertrophy, which was unchanged. And the impression being a possible mild left C3-4 neuroforaminal narrowing.

Q. So is there anything in those films to illuminate us on whether the stenosis that you diagnosed the plaintiff with back in June of 2006 was relieved by the surgery?

MR. CRAFTON: I'll object to form, foundation.

BY MR. ROGERS:

Q. Go ahead, Doctor.

A. Not based on these documents here.

Q. Now, I want you to take a look at this Newport MRI. And you'll see in it findings and impressions of annular tears or fissures. There's no comment on such a

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condition in any of the Steinberg studies. Do you know why that difference?

MR. CRAFTON: Object to form. Foundation.

BY MR. ROGERS:

Q. And for the record, I'm going to attach some of these exhibits while you're looking that over.

As Exhibit A we'll attach the Steinberg --

THE REPORTER: Exhibit B.

MR. ROGERS: Exhibit B, we'll attach the Steinberg records we've been referencing. Exhibit C will be the Newport MRI records. Exhibit D will be the Southwest Medical records that the doctor brought. And the Exhibit E will be the Southwest records that Southwest has produced to this office.

(Exhibits B, C, D, and E were marked for identification.)

THE WITNESS: Could you repeat it? Was there a question?

BY MR. ROGERS:

Q. Yes. The question is: Why does the Newport MRI reportedly show things that aren't seen in the Steinberg MRIs?

MR. CRAFTON: Same objection.

THE WITNESS: I don't know. I didn't read these MRIs.

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BY MR. ROGERS:

Q. Is an annular tear something that would be seen on the Steinberg MRIs as well as the Newport MRI?

MR. CRAFTON: Form and foundation.

THE WITNESS: Most likely. But it does indicate here a subtle increased signal that's consistent with a subtle annular tear, so subtle findings may not have been reported out on the Steinberg.

BY MR. ROGERS:

Q. Are there some radiologists who interpret a finding as a tear, where others would call it a protrusion?

MR. CRAFTON: Form and foundation.

BY MR. ROGERS:

Q. In other words, I'm looking at the same levels here and I'm seeing different words being used, and I'm wondering why.

A. I don't think you would -- a radiologist, at least in my experience from seeing reports from the radiologists, that there's confusion and/or differences the reading between a disk bulge or a protrusion and an annular tear. Those are two different findings.

What I did imply is that on the Newport MRI it does says that these were subtle findings. Maybe these -- it wasn't as highly scrutinized on somebody's

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read.

Q. Well, can some radiologists overread a finding on a film?

A. Yes.

Q. Okay. All right. Well, when the plaintiff -- we were focusing on that March 2010 report -- when he came to see you again, did you do the trigger-point injections?

A. Yes.

Q. When Dr. McNulty sent him to you, is that what he recommended is trigger-point injections?

A. Not particularly on that visit. But again, I'm going back to April 6 of 2010 where he had seen Dr. McNulty and then being re-referred back for possible medial-branch block.

Q. Okay.

A. Looking at my evaluation there, again felt he presented in a very similar fashion; a combination of possible C4 radicular pain and some myofascial pain. On March 5th, we opted to do trigger-point injections.

Q. What happened with the medial-branch blocks that Dr. McNulty recommended?

A. It appears he ultimately had these. I just didn't happen to do it on that visit. I felt like maybe a trigger point might have been more appropriate at that

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time.
But looking on forward to April 6, 2010 --
Q. I know you did them on April 20th.
A. I don't think I have that.
THE WITNESS: But I think we saw those on your computer. That was the one.
BY MR. ROGERS:
Q. Let me give this to you. There you go.
And for the record, the doctor is looking at the April 20, 2010, records, and I believe the April 22 records are included in that stack I handed you as well.
A. It looks like just the April 20th record. It's the package of the procedure note as well as the surgery center documentation.
Q. Do you have those for April 22?
MR. CRAFTON: It's right there.
(Discussion held off the record.)
BY MR. ROGERS:
Q. All right. So the question is: What was the plaintiff's response to the medial-branch blocks?
A. Well, I have him undergoing the medial-branch blocks, left C3 through C6, April 20th, 2010.
The next note's from April 22nd, 2010, on the follow-up. It indicates the patient appreciated a 30-percent reduction in his left-sided axial neck pain,

continues to complain of left-sided neck pain and left upper trapezial pain.
Q. Okay. What do you draw from that response to the injection?
A. I consider that not a positive response. A 30 percent is not a very positive response, particularly for a diagnostic procedure like that. So he's not having relief from that. I didn't feel that a facet-mediated pain generator was in play here.
Q. Okay. But you felt what?
A. I continued to feel that he had symptoms in a C4 radicular pattern in addition to some myofascial pain in that region.
Q. And that pain is from the facet hypertrophy that you diagnosed the plaintiff with at the outset?
A. More precisely --
Q. I should probably say compression?
A. Correct.
Q. Let me rephrase that to make a clear record.
You maintain that the plaintiff's pain generator is a C4 compression caused by facet hypertrophy?
A. Correct.
Q. And I know that you weren't involved in much of the surgical workup -- well, maybe better stated, in any of it. Do you have an opinion regarding any of that

two-level fusion?
MR. CRAFTON: Object to form. Foundation.
THE WITNESS: No.
BY MR. ROGERS:
Q. All right. After the plaintiff's negative response to the medial-branch block, what did you next do?
A. I then arranged for him to have a left C3-4 transforaminal steroid injection.
Q. Okay. That's the procedure that you did back in June 2006?
A. Yes.
Q. All right. And was that the procedure that you intended to do when the plaintiff first returned to you after that March 2010 visit?
A. I'm not sure what you mean by "intended to do."
Q. Well, you did the trigger-point injection.
A. Correct.
Q. And was your plan, then, to do a C3-4 epidural?
A. No. My plan initially after the reevaluation was to do the diagnostic medial-branch block that Dr. McNulty had suggested and requested.
Q. Did you have a difference of opinion with Dr. McNulty in terms of that recommendation for the medial-branch block?

A. Yes. I didn't think this was necessarily mediated by a facet. And just looking back at his follow-up imaging, it appeared that he still had some compression of that nerve root and it was still in a C4 radicular pattern. And so I felt a left C3-4 transforaminal steroid injection would probably serve him better, recognizing that he's had some limited benefit to this in the past. But as a symptomatic standpoint, I thought we could try to provide some pain relief.
Q. I don't remember, because I just barely saw it before the deposition began, whether you did the C3-4 epidural in June of 2010, or you simply planned to do it?
A. I believe that's the one he has on his computer, a digital record.
Q. Right.
A. And it looks like our note. It looks like something we did do. And I vaguely recall seeing him and doing this procedure, but I don't have the hard copy in front of me, but that certainly looks like our note, and it's signed electronically by me, 6/10/2010.
Q. Okay. So the C3-4 epidural was done on June 10, 2010?
A. Correct.

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Q. Do you have a follow-up to know how he responded to it?
A. I don't know offhand. I'm sure he does, but I couldn't tell you today whether -- when and where he has follow-up.
Q. Okay.
A. Let's see. June 11th, this is just a procedure follow-up made by our M.A., just seeing how the patient's doing. It says, "Post-procedure call made. Spoke with patient. He's feeling a little better prior to procedure." But I wouldn't consider this a follow-up with myself or one of the providers in the clinic. It's a follow-up looking more at have you had any signs of a complication from the procedure.
Q. Okay, I see. And just for the record, the June 10 and June 11 records that you testified about, Doctor, we've read off plaintiff's counsel's computer; right?
A. Correct.
Q. Let me shift gears here. Do you have a future treatment plan for the plaintiff?
A. I don't right now in front of me.
Q. Okay. Well, will that be formulated upon determining the plaintiff's response to that epidural injection?

A. It certainly would be part of it, yes.
Q. Okay. Is there a future treatment plan, even though it's not yet formulated? In other words, is there a plan to continue seeing the plaintiff or to discharge him?
A. I don't have any particular plans to discharge him for any reason. But again, I can't comment on whether he has a follow-up right now or what date that might be. But based on what I have here, I have no reason to believe there would be.
Q. You mentioned at the outset that Dr. Arita was your former partner. Is he no longer with Southwest Medical Associates?
A. Correct, he is not.
Q. Is he still here in town?
A. I believe so.
Q. Have you discussed the plaintiff with Dr. Arita?
A. No.
Q. What's your professional opinion of Dr. Arita? Is he a competent physician?
A. Yes.
Q. How long does facet hypertrophy typically take to form?
A. I can't tell you that.
Q. You described it earlier as a degenerative

process; right?
A. Yeah. I think what -- I can tell you that this is not something that develops in a short term. This is not a one- to two-day or several-month-type process. It is a chronic condition that typically takes years to develop.
Q. I asked you earlier about whether smoking contributes to any of the findings that we saw on an MRI. I want to refine that question now. Does smoking contribute to degeneration in the spine?
A. It can.
MR. CRAFTON: I'll object to form.
THE WITNESS: It can.
BY MR. ROGERS:
Q. Do you know Dr. McNulty?
A. Yes.
Q. Do you work with him?
A. In the sense that he's one of the contracted orthopedic providers, and so I see a lot of the patients that are referred back and forth amongst ourselves, yes.
Q. What is your professional opinion of Dr. McNulty?
A. I think he's a competent physician.
Q. As I understand your testimony, the surgery was not effective in reducing the plaintiff's pain

complaints?
MR. CRAFTON: Object to form.
THE WITNESS: That would be per the patient's report. The patient returned to me telling me he had continued pain, which appeared to be in a very similar fashion that he had before.
BY MR. ROGERS:
Q. What was it you said earlier about responses to injections? You said something to the effect that 75 percent or greater is the threshold for a positive response. Did I understand that?
A. Yeah. I was referring to a diagnostic procedure in trying to infer what a positive response is to that. And in my practice, I tend to be a little more conservative. I look for a positive response of around 75 percent or greater. But then in the community, I think a 50 percent or greater mark is often construed as a positive response.
MR. ROGERS: I think I'm done. Let me just finish going through here.
MR. CRAFTON: I am going to have a few questions for you.
MR. ROGERS: Well, go ahead.
MR. CRAFTON: Do you want me to go ahead while you're looking through it?

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MR. ROGERS: Yeah.

EXAMINATION

BY MR. CRAFTON:

Q. Doctor, I introduced myself to you before the deposition. My name is Brice Crafton. I'm representing plaintiff, Mr. Simao.

And first of all, Doctor, does pain -- I'm sorry, strike that.

Does degeneration always equate to pain in your experience?

A. No.

Q. Okay. In other words, somebody can have a degenerative condition in their spine and it is an asymptomatic condition?

A. Yes.

Q. And can trauma cause an asymptomatic condition to become symptomatic, meaning that it becomes painful after trauma?

MR. ROGERS: Objection, vague as to -- well, to about four terms in the question.

But go ahead.

THE WITNESS: I think the conclusion of saying that an asymptomatic degenerative process can be somehow exacerbated by trauma is one question, which it certainly can. But a bigger picture could be just does

trauma result in people having pain that may or may not be due to the underlying degeneration they had before. I see all variations of such. They can have an underlying degenerative process and have some type of trauma and present with pain, and we are often left with how much of this is due to the underlying degenerative process and how much of this is due to trauma. It's a tough question to answer.

BY MR. CRAFTON:

Q. And let me try to simplify it a little bit, or simplify the question a little bit.

In your experience can trauma cause an asymptomatic degenerative condition to become painful -- or I'm sorry, not painful -- symptomatic?

MR. ROGERS: Same objection, and it's an incomplete hypothetical.

Go ahead.

THE WITNESS: Again, I think the conclusion was can it cause the degenerative process to become painful. It's hard to make that conclusion. I could say that, yes, a person who has an underlying asymptomatic degenerative process who has a trauma can have pain in a region that you might expect with that degenerative process. Yes, that was true.

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BY MR. CRAFTON:

Q. And you diagnosed -- or your diagnosis of Mr. Simao was a C -- correct me if I'm wrong -- a C3-4 compression resulting in a facet hypertrophy? Did I get that right?

A. I think you have it backwards. You have, radiographically, a facet hypertrophy causing some compression upon his C4 nerve root, which exits the C3-4 foramen.

Q. And you stated earlier that that is a degenerative process?

A. A facet hypertrophy is a degenerative process, yes.

Q. Is it possible for one to have a facet hypertrophy that is asymptomatic?

A. Yes.

Q. And can trauma cause that to become symptomatic?

MR. ROGERS: Same objection as earlier.

THE WITNESS: It seems like the same question as before.

Again, it can -- theoretically, can a trauma cause an asymptomatic degenerative condition, begin to cause pain now? Yes. Does it necessarily correlate to the degenerative process that's going on at that level? No.

BY MR. CRAFTON:

Q. I'm going to May 6th, 2000 -- I'm sorry, the May 10th, 2006, record, which I believe was the first time we talked about Mr. Simao receiving trigger-point injections; correct?

A. May 10th, 2006?

Q. Yes.

A. Correct.

Q. And since that discussion there was some questions and some -- I guess, some questions regarding a good response, or Mr. Simao having relief from those injections. Do you recall that discussion?

A. Yes.

Q. Can you point to me in the record, the May 10th, 2006, record, where it states that Mr. Simao was relieved at all from the trigger-point injections?

A. From the May 10th, 2006, record?

Q. Yes.

MR. ROGERS: Let's go off for a second.

(Discussion held off the record.)

THE WITNESS: For the May 10th, 2006, no.

BY MR. CRAFTON:

Q. And I think off the record you said it was a follow-up note?

A. That's correct.

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Q. And then I must have missed that. Can you point me to that follow-up note that talks about the relief from the trigger-point injections?

MR. ROGERS: I think it's in this stack right here. There's 5/10, and then going with your left hand, up.

THE WITNESS: Backwards?

MR. ROGERS: Yeah.

THE WITNESS: Off the record for a minute?

MR. ROGERS: Yeah.

(Discussion held off the record.)

THE WITNESS: This is the one. A note from June 20, 2006, in the interval history section, this is after he's had the trigger points, but also after he had the left C3-4 transforaminal steroid injection. It states: He had a good overall response to the steroid injection, noticing a decrease in his headaches. Continues to have some left pain -- or pain in the left trapezial area. And it says he did respond well to the trigger-point injections previously.

BY MR. CRAFTON:

Q. Could you state which one was more, I guess, therapeutic for him?

A. No.

Q. Was either of those diagnostic in nature?

A. No.

Q. Thank you for clarifying that.

You're not a spine surgeon; correct, Doctor?

A. No.

Q. And you would leave decisions regarding whether a person should undergo spine surgery to the spine surgeon; is that fair?

A. Yes.

Q. So whether or not Mr. Simao is a candidate for surgery, you would leave those sorts of opinions to the spine surgeons themselves; is that correct?

MR. ROGERS: Objection. I'm going to object on the reasonable -- pardon me -- relevance grounds, candidacy versus necessity.

But go ahead.

MR. CRAFTON: And I'll just state the relevancy of a proper objection. But we're not going to quibble over that.

MR. ROGERS: Right. Right.

THE WITNESS: In general, yes, I would leave that decision to the surgeon. I certainly have my perceptions of, you know, which patients I think would be better served by surgical intervention and which would not, but ultimately it's going to be up to the surgeon and the patient.

BY MR. CRAFTON:

Q. And correct me if I'm wrong, I believe you answered the question that Mr. Rogers had -- the question is: But you don't have any opinion of whether or not Mr. Simao should or should not have undergone surgery, do you?

A. No.

Q. There was some discussion about certain MRI films and why one MRI film wouldn't necessarily contain the same information that another MRI report -- and I'm talking about the reports would contain?

A. Yes.

Q. Do you remember that discussion?

A. Yes.

Q. In your experience, does that have a lot to do with who's actually reading the MRIs and preparing the report?

A. Are you referring to the variations in the report --

Q. Yes.

A. -- from one radiologist to another?

Q. Yes.

A. Yes.

Q. And, for example, in order to confirm or deny whether there are annular fissures in one MRI film

versus another, you would have to look at the actual MRI films yourself; correct?

A. I'm not sure what the question is. If I felt there was some discrepancy between two readings, certainly a third party, yourself, or whoever is involved, would want to see the films.

Q. For example, we spoke -- or we looked at an MRI film from Newport and also one from Steinberg. Do you recall that?

A. Yes.

Q. Where one referenced annular fissures and the other did not?

A. Yes.

Q. In order to confirm or deny whether or not there are annular fissures in the Steinberg MRI, you would actually want to see and interpret that MRI on your own; is that fair?

A. If I felt there was a significant variation of the two, yeah, I would like to see it myself.

Q. And you haven't seen any of the MRI films? You're relying strictly off of the -- you're relying upon the report; is that fair?

A. With regard to these particular ones --

Q. Yeah.

A. -- or in general?

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I don't know if I saw the films to his initial reports or not. Usually I'll state whether I'm seeing the actual films and/or the report, but I can't recall on the ones that were referenced here, particularly from 2008 and 2009 when I wasn't involved with him, so I didn't see the report or the film.

Q. Does the presence of annular fissures in the Newport record, did it cause you to change or modify any of your diagnoses?

A. No.

Q. Does it have any effect on your opinions whatsoever?

A. I think it certainly has to be taken into consideration. But again, going back to this, it looks like these are subtle annular tears. It looks like, I think, there's probably limited clinical significance to it, based on this report at least.

Q. With facet hypertrophy and a compression of the C3-C4 disk, what are Mr. Simao's treatment options according to the diagnosis that you've reached?

MR. ROGERS: I'm going to object. It misstates the diagnosis and the testimony.

But go ahead.

BY MR. CRAFTON:

Q. Please correct me with the diagnosis, because

I'm not reading it off the record right now.

A. I think what he's referring to is the facet hypertrophy causing compression of the C4 nerve root --

Q. I apologize.

A. -- versus the C3 disk.

His options for that are several, depending on the severity of discomfort he's having. He can do nothing. He can take a variety of medications, ranging from anti-inflammatories, opiates, anti-neuropathic medications to try to provide some symptomatic improvement. He can have interventional modalities that we've talked about before, having steroid injections at the C3-4 level, or he can consider surgical intervention.

Q. And what sort of surgical intervention could he consider?

A. That would have to be left up to the spine surgeon.

Q. Is a rhizotomy an appropriate treatment for Mr. Simao's condition?

A. A rhizotomy presumably would be referring to a medial-branch rhizotomy.

Q. I think it's also called a neuro-oblation?

A. Yeah, a medial-branch rhizotomy or a radiofrequency oblation would not have any effect on a

compressed C4 nerve root if that is truly your pain generator.

Q. What sort of condition would a -- and I'm just going to refer to it as a rhizotomy -- what sort of condition would a rhizotomy be an appropriate treatment for?

A. Rhizotomy is the appropriate treatment for facet-mediated pain.

Q. And you ruled out that facet-mediated pain in Mr. Simao?

A. I did a diagnostic medial-branch block in sometime of this year, 2010, which he did not have a response to, which would tend to rule out a facet-mediated pain; although, the responses to that are variable in my practice, that rules out a facet-mediated pain.

Q. What treatment would you recommend to Mr. Simao at this point in time to more definitively diagnose his condition and also to treat his condition?

MR. ROGERS: I'm going to object to the question about "more definitively." I don't think there's been any questions about the definiteness of the diagnosis.

But go ahead.

THE WITNESS: It seems like there's two questions. One is --

BY MR. CRAFTON:

Q. Well, let's break it down to --

A. -- diagnostic and --

Q. -- diagnostic and --

A. -- two is therapeutic.

Q. -- therapeutic. Let's talk about diagnostic first.

A. From a diagnostic standpoint, based on the last time I saw him, I would pursue again a selective nerve-root block at the C4 level.

Q. What would be the purpose of that? Would you explain?

A. To see if he's having C4 nerve-root mediated pain caused by the compression of the nerve root.

Q. Is that it? I mean, at this point in time.

A. Yes.

Q. Okay. And what -- assuming that that has a positive outcome, what would be your treatment options for -- or your treatment recommendations for him?

A. Again, from my perspective, I'm not the spine surgeon. But my job is to provide some diagnostics, but also some therapeutic interventions, which range from the modalities we mentioned before. Would it be a medication management or a repeat steroid injection? Or consider re-referral back to the surgeon to see if he

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felt there was any other surgical interventions that could help alleviate this based on those diagnostic results.

Q. And assuming the result was negative, what would be your next step?

A. If the result was negative, I'd probably continue to do myofascial treatments for him, medication management. He may not have any further interventional or surgical modalities that are available to him.

Q. At that point in time, is it foreseeable to you that he would be recommended for, say, an implant of an electronic stimulator or other type of pain-relief modality, such as the Morphine pump for --

A. I could see where some might consider that an option. I don't consider a Morphine pump or any intrathecal device right now a likely option for that.

Q. No, I understand right now. But I'm saying -- and I understand that there still has to be further workup with Mr. Simao; is that fair?

A. Yes.

Q. But those are two foreseeable options, assuming that he receives no relief from other types of therapeutic modalities, such as the ones we've discussed?

A. I could see where somebody would think that's a

reasonable option. I don't particularly think that's an option for him. But, yes, those are treatment modalities that somebody would feel is appropriate.

MR. CRAFTON: Okay. Thank you.

MR. ROGERS: Let's go off for a second.

(Discussion held off the record.)

EXAMINATION (continued)

BY MR. ROGERS:

Q. To wrap up plaintiff's line of questioning, it sounds as though you're not in a position right now to formulate a future treatment plan; but at this point you are not inclined to recommend any invasive procedures like intrathecal implantation --

A. No.

Q. -- is that correct?

A. That's correct.

Q. Something I noticed about your pain clinic was that you provide a psychologist to patients who are referred to you. What's the role of the psychologist in your clinic?

A. Currently we don't have a psychologist in our clinic, but at the time of our evaluation we did have a pain psychologist in the clinic. And the role can be variable. I think in his -- in his records here, there's a note from her on intake that's just a general

overview of the patient telling him about the clinic and what maybe he has to look forward to as far as treatment processes.

But if you speak in terms of general modalities as a pain psychologist in a clinic, you know, we often deal with a larger -- what we call a biopsychosocial model of pain, which can be very complicated and involves variables other than what we find on imaging, meaning compressed nerve roots and disk degeneration. So attempting to provide a patient with a more global pain treatment is what I think the pain psychologist adds to that.

Q. A pain psychologist can be useful in determining whether there's a nonphysiologic cause of the complaints; is that correct?

A. A pain psychologist could look to see what type of variables the patient may present with that; can predict how they may do to treatment, or how they may respond to certain physiologic -- or we'll say physiologic findings, as you might state it, such as pain, or radiographic findings such as degenerative changes in the spine. I don't think that they can necessarily sort out, "You have pain that is physiologic or nonphysiologic," but rather a global assessment of the pain of how they feel their pain has affected them

and how it may correlate with more objective findings such as an MRI of the neck or back.

Q. And, in addition, to help patients who have some psychological overlay deal with their pain?

A. Correct.

Q. Do you know whether the plaintiff has some sort of psychologic overlay?

A. No.

Q. You testified earlier that his MRI findings were subtle. You said that in reference particularly to the fissures or tears; but you said that, it seemed, generally about the physical exam and the MRI findings at Steinberg as well. But did I understand you right?

A. I said that the report from the Newport MRI indicated that there were subtle annular tears.

Q. Okay. What I mean by my question is: It goes to your earlier testimony that a person can have the same findings that the plaintiff has on diagnostic studies without having pain?

A. Correct.

Q. Do you know whether there's a nonphysiological component to the plaintiff's complaints?

MR. CRAFTON: Object to form and foundation.

THE WITNESS: I can't confirm that, no.

MR. CRAFTON: Beyond the scope.

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MR. ROGERS: All right, that's it.
(The deposition concluded at 5:09 p.m.)
-oOo-

CERTIFICATE OF DEPONENT

PAGE	LINE	CHANGE	REASON

* * * * *

I, ROSS SEIBEL, M.D., deponent herein, do hereby certify and declare that the within and foregoing transcription to be my deposition in said action; that I have read, corrected and do hereby affix my signature to said deposition, under penalty of perjury.

ROSS SEIBEL, M.D., Deponent Date

CERTIFICATE OF REPORTER

STATE OF NEVADA)
)SS:
COUNTY OF CLARK)

I, Jean M. Dahlberg, a duly commissioned and licensed Court Reporter, Clark County, State of Nevada, do hereby certify: That I reported the taking of the deposition of the witness, Ross Seibel, M.D., commencing on Friday, August 20, 2010, at 3:14 p.m.

That prior to being examined, the witness was, by me, duly sworn to testify to the truth. That I thereafter transcribed my said shorthand notes into typewriting and that the typewritten transcript of said deposition is a complete, true and accurate transcription of said shorthand notes.

I further certify that I am not a relative or employee of an attorney or counsel of any of the parties, nor a relative or employee of an attorney or counsel involved in said action, nor a person financially interested in the action.

IN WITNESS HEREOF, I have hereunto set my hand in my office in the County of Clark, State of Nevada, this ____ day of August, 2010.

JEAN M. DAHLBERG, RPR, CCR NO. 759, CSR 11715

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EXHIBIT "2"

Southwest Medical Associates, Inc.
Southwest Medical Associates, Inc. P.O. Box 15645
Las Vegas, NV 89114-5645
(702)877-8600

Patient: WILLIAM J. SIMAO
121 BEAR COAT COURT

HENDERSON, NV 89002

EMRN: 1641554
Age/DOB: 47/May 08, 1963

Home: (702)296-9275
Work:

Encounter Date: Nov 11 2010 8:15AM

Active Problems

Bulging Disc (C4 - C5) (722.0)
Cervical Postlaminectomy Syndrome (722.81)
Cervical Radiculopathy (723.4)
Cervical Radiculopathy At C4 Nerve Root; Left (723.4); Secondary to facet hypertrophy.
Cervicalgia (723.1); With LUE radiculopathy.
Common Migraine (Without Aura) (346.10)

Episodic Tension-type Headache (339.11)

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Migraine Headache (346.90)
Myalgia And Myositis (729.1)
Nicotine Dependence (305.1)

Visit For: Preoperative Exam (V72.84)

Allergies
Penicillins.

Description of Procedure
SURGEON: Nader Helmi
ANESTHESIA: Moderate Sedation
COMPLICATIONS: None

PROCEDURE: Cervical Transforaminal Steroid Injection

LEFT C3-4

EQUIPMENT:
> 25 GA 2.0 inch Spinal Needle
Number: 1
> C-Arm Fluoroscopy

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Patient: WILLIAM J. SIMAO EMRN: 1641554
Encounter: Nov 11 2010 8:15AM

DESCRIPTION OF PROCEDURE:

The patient was identified in the pre-operative holding area. A peripheral intravenous catheter was in place. The risks, benefits and alternatives were discussed in detail with the patient and written informed consent was obtained. The patient was brought to the fluoroscopy suite where they positioned themselves in the supine position on the fluoroscopy table. Standard monitors including ECG, blood pressure, and pulse oximetry were placed. The patient's cervical region was prepped and draped in a sterile fashion.

LEFT C3-4

In the right anterior oblique fluoroscopic view, the C3-4 neural foramen was identified. 1% lidocaine-MPF was used to anesthetize the skin and subcutaneous tissues overlying the target point. The posteromedial aspect of the C4 superior articulating process at the waist of the foramen was identified. Selected needle was advanced to this point under fluoroscopic guidance. When the C4 superior articulating process was contacted, the needle was gently walked ventromedially into the posterior portion of the foramen. Needle tip position confirmed on AP and lateral fluorscopic views. Negative aspiration for blood and CSF. 0.5 mL of non-ionic contrast injected easily and demonstrated outline of the C4 nerve root and spread proximally through the foramen into the lateral epidural space. This was viewed in the oblique, AP, and lateral views. After repeat negative aspiration for blood and CSF, injectate was administered without difficulty. Needle was withdrawn into subcutaneous tissue, flushed and withdrawn.

Patient tolerated the procedure well and was transferred to the PACU in stable condition.

INJECTATE:

1 mL BETAMETHASONE (CELESTONE) 6MG/ML

0.5mL 1% LIDOCAINE (preservative free)

Follow up: Arranged by Pain Management clinic.

Signature
Signed By: Nader Helmi DO; 11/14/2010 8:35 AM PST; Author.

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EXHIBIT "3"

Southwest Medical Associates, Inc.
Southwest Medical Associates, Inc. P.O. Box 15645
Las Vegas, NV 89114-5645
(702)877-8600

Patient: WILLIAM J. SIMAO
121 BEAR COAT COURT

HENDERSON, NV 89002

EMRN: 1641554
Age/DOB: 47/May 08, 1963

Home: (702)296-9275
Work:

Encounter Date: Nov 23 2010 9:20AM

INTERVAL HISTORY

S:The patient comes in today for a followup of a left C3-4 transforaminal epidural steroid injection completed by Dr Helmi on November 11, 2010. The patient states he appreciated a 75 to 80% reduction in his left upper extremity pain with this procedure. He is quite happy with the results.

He also states that he had recently been evaluated by Dr. Daniel Lee, orthopedic spine surgeon for a second opinion as it relates to his neck. He did state that he had apparently some rather severe stenosis and did discuss with him the possibilities of surgical interventions should he not get better with procedures at this office.

P:The patient is currently appreciating a 75 to 80% reduction in his left upper extremity symptoms and left-sided neck pain with this most recent transforaminal epidural steroid injection. At this time, no additional interventional treatments are required. We did however discuss the possibilities of additional procedures should his symptoms return. The patient will follow up p.r.n.

Terry Robichaud, PA-C m2/kb/apj Date:

DD: 11/23/2010
DT: 11/24/2010 10:25:41

Active Problems

Bulging Disc (C4 - C5) (722.0)
Cervical Postlaminectomy Syndrome (722.81)
Cervical Radiculopathy (723.4)
Cervical Radiculopathy At C4 Nerve Root; Left (723.4); Secondary to facet hypertrophy.
Cervicalgia (723.1); With LUE radiculopathy.
Common Migraine (Without Aura) (346.10)

Episodic Tension-type Headache (339.11)

Migraine Headache (346.90)
Myalgia And Myositis (729.1)
Nicotine Dependence (305.1)

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Patient: WILLIAM J. SIMAO EMRN: 1641554
Encounter: Nov 23 2010 9:20AM

Visit For: Preoperative Exam (V72.84)

Allergies
Penicillins.
Current Meds
Butalbital-APAP-Caff-Cod 50-325-40-30 MG Capsule;TAKE 1 CAPSULE AS NEEDED EVERY 4-6 HOURS FOR HEADACHES; Rx

Zomig ZMT 5 MG Tablet Dispersible;one tablet at migraine onset, repeat after 2 hours if needed, not to exceed 2 tabs in 24 hours; Rx
Oxycodone-Acetaminophen 5-325 MG Tablet;TAKE 1 TABLET EVERY 4 TO 6 HOURS AS NEEDED FOR PAIN.; Rx
Cyclobenzaprine HCl 5 MG Tablet;TAKE 1 TABLET 3 TIMES DAILY AS NEEDED.; Rx
PredniSONE 20 MG Tablet;take 2 po daily for 5 days; Rx

Naproxen 500 MG Tablet;TAKE 1 TABLET 3 TIMES DAILY PRN pain take with food or after meals; Rx.
Assessment
- Cervical postlaminectomy syndrome (722.81)

Orders
99213 Est Pt Limited.
Follow up PRN.
Signature
Signed By: Maliha Barikzi MA I; 11/23/2010 9:04 AM PST; Author.
Signed By: Terry Robichaud PA-C; 11/29/2010 8:05 AM PST; Author.

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EXHIBIT "4"

NEVADA ORTHOPEDIC & SPINE CENTER

P.O. Box 36550
Las Vegas, NV 89133-6550

1505 WIGWAM PKWY, SUITE 330
HENDERSON, NV 89074

(702) 878-0393

Patient Name:	WILLIAM J SIMAO
Patient ID:	316811
Date of Birth/Age:	05/08/1963 47 yrs, 9 mths
Date of Examination/Report:	02/24/2011

ORTHOPEDIC EVALUATION

CHIEF COMPLAINT: This is a 47-year-old who is status post ACDF C3 through C5. He has mostly axial neck pain. He can see pain management. There are no surgical indications at this time.

PHYSICAL EXAMINATION: Motor and sensory is satisfactory.

DIAGNOSTIC STUDIES: MRI was re-reviewed most recently because the other one was done a year and a half ago. It shows no significant stenosis within the neural foramen of C3-4.

ASSESSMENT/PLAN: As above.

Daniel D. Lee, M.D.

/tr
DD: 02/24/2011
DT: 02/28/2011
Confirmation Number: 572

Dictated, not edited.
cc: JAMES METCALF MD

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EXHIBIT "5"

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Independent Record Review Addendum # 5

DATE OF REVIEW: February 9, 2011

RE: SIMAO, William

DATE OF INJURY: 04/15/2005

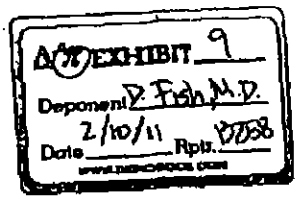
To Whom this May Concern:

I was asked by the law offices of Rogers, Mastrangelo, Carvalho and Mitchell to review the additional medical records and imaging of William Simao. I was also asked to give my opinions, based on these records, as to assessment of medical damages caused by the accident, causation, future care needs, necessity for treatment, and overall recommendations. All of my opinions below are based on a reasonable degree of medical probability.

I am currently full time faculty member at UCLA Medical Center. My position is Director of Physiatry and Interventional Pain Management at the UCLA Spine Center. I am board certified in Physiatry and Pain Management. I have provided by CV.

RECORDS REVIEWED:

1. Kathleen Hartmann, RN, BSN, CCM, CLCP Updated report 11/8/2010



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IMPRESSION AND DIAGNOSES:

Related to the motor vehicle accident of April 15, 2006:

1. Non specified myofascial pain, resolved.

Unrelated to the motor vehicle accident of April 15, 2006:

1. Migraine headaches.
2. Degenerative cervical spine disease.
3. Left shoulder subacromial bursitis.
4. Myofascial pain and muscle spasm.
5. Mandible Extraction Deformity.
6. Occipital Neuralgia.

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COMMENTARY AND MEDICAL DECISION MAKING:

I reviewed the updated LCP authored by Ms. Hartmann's on November 8, 2010 and this report addendum for Mr. Simao is only for evaluation purposes as there is no doctor patient relationship implied. Evaluation is consistent with history and previous physical examination by treating physicians. All records sent to me are reviewed for the purpose of a medical decision based upon the events of the current pain complaints. The opinions of this report are based upon examination of Mr. Simao and/or review of the medical records provided to me. All of my opinions have been rendered with a reasonable degree of medical probability but are preliminary to the extent that there is relevant information that I have not yet had the opportunity to review.

My opinions in regards to Mr. Simao are based upon my clinical experience as an active treating Physiatrist who specializes in Physiatry, Pain Medicine, and Electrodiagnostic Medicine. I am currently on staff at the UCLA School of Medicine in the UCLA Spine Center and the UCLA Medical Center. I am involved with resident and fellowship training of physicians at UCLA and must maintain updated and clinically relevant evidence-based guidelines for treatment of patients that fall within the standards of

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care. I would approach the patient as I would approach any patient with similar pain complaints as a treating physician. Based also upon my forensic review of the records, I made the following conclusions.

In summary, Mr. Simao was involved in a motor vehicle accident in which he was a restrained driver, struck from behind on April 15, 2005. The accident report noted moderate damage to the vehicles. Both were driven away. Mr. Simao was the only vehicle occupant who reported injury. He complained of headaches and neck pain. Four hours after the accident he went to the Urgent Care where he was given conservative treatment and ruled out for significant trauma. Mr. Simao had a significant history of headaches with treatment consistently for four years prior to the MVA of April 15, 2005. Post MVA, Mr. Simao did not pursue any aggressive treatment options from May 2005 to October 2005 and his care was sporadic and related to his pre-existing headaches. His first visit of May 5, 2005 to the Southwest Medical Associates had complaints of headache and no neck pain. The physical examination revealed a neck that had full range of motion as the assessment was a closed head injury and no mention of neck symptoms or pain. It was not until October 6, 2005 that his neck pain began to be an issue as he complained of shoulder pain radiating to his neck, for which he was again evaluated and underwent radiographs which were reported as normal for the cervical spine. It was not until December 12, 2005 that he was started on pain medications for neck pain assessed as a cervical strain and January 16, 2006 he began therapy for his neck, which was nine months post-MVA. It was noted on a routine follow up of May 6, 2005 that Mr. Simao was being seen only for headache complaints which was just before the CT of the BRAIN on 5/13/05 that revealed a normal unremarkable head CT. The subsequent MRI of the BRAIN on 5/23/05 was found to be a normal unremarkable MRI for age with no abnormal enhancing lesions.

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The updated life care plan (LCP) authored by Kathleen Hartmann indicates that Mr. Simao will need future medical care with a cervical spine surgery revision, therapy to accompany the surgery, and medications for the treatment of pain in the neck regions as well as additional trigger point injections, medial branch blocks, and/or transforaminal epidurals. She now notes that this will be required quarterly evaluations by Dr. Seibel for a lifetime based upon his pain complaints, increasing age, and work. It should also be noted that Mrs. Hartmann believes that therapist describe the need for 6 visits per year for a lifetime after fusion of the spine.

The LCP notes that a Dual King adjustable bed is needed for sleep improvement over 4 hours as suggested by Mr. Simao and that this bed would help with assistance for mobility and independence.

The new LCP further states that a complication can cause the need for additional surgery and a dorsal column stimulator

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As for the totals of costs when compared to her previous LCP the following is noted:

Projected evaluations is now $ 0.00

Future Medical Care Routine has been increased from $9,669.00 to $31,175.00
This is due to the quarterly visits with pain management, Dr. Seibel for a lifetime.

Future Surgical Care $249,677.00 to $427,560.00
This is due to a change in the trigger point, epidural and selective nerve root block injections from 2 in a lifetime to annual injection for 31 years of all three procedures. The visits to Dr. Seibel have been dramatically increased yearly.

Projected Modalities increased from $4,200.00 to $15,660.00
This is due to the PT visits being done annually instead of every other year need.

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Diagnostic and Laboratory needs increased from $12,096.00 to $18,565.00

Medication and Supply needs decreased from $96,068.00 to $6,754.00

A total LCP amount of $338,620 to $389,899 increased to projected $301,267 to $513,027

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SUMMARY OF NEW LCP AND OPINIONS:

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Based upon the new records and my previous opinions, the following are my opinions for Mr. Simao:

1. Mr. Simao had a significant history of headaches with treatment prior to the MVA of April 15, 2005. He had issues with headaches consistently for four years before the MVA in question. Post MVA, Mr. Simao did not pursue any aggressive treatment options from May 2005 to October 2005 for his neck and his care was sporadic and related to his pre-existing headaches. It was not until October 6, 2005 that his neck pain was advised to his health care providers and he did not start PT until January 16, 2006 that he began therapy for his neck, nine months post-MVA. The PT note at that initial visit indicated that his neck pain had been present for over six months and began after an MVA in April 2005. Furthermore, the Southwest Medical Associates progress note of December 21, 2005 indicated that his neck pain was worsening from two weeks prior or the beginning of December 2005. The LCP again has a discussion of surgery to the cervical spine but the symptoms of the cervical spine is clearly not related to the MVA of 4/15/05 as they began seven months to nine months after. I continue to disagree with the spinal injections, discograms, cervical spine surgical intervention, medications, home furnishings, and routine treatment. The treatment for the cervical spine after 5/6/2005 is not related to the MVA. The examination at SWMA had no pain in the neck with FULL RANGE OF MOTION on October 6, 2005 and therefore would be in medical probability a normal neck examination as the pain in the neck would be a referral pain from his chronic migraine headaches.

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2. Mrs. Hartmann again did not comment on the updated LCP that since the surgery to the cervical spine did not help his pain that the surgery was not a reasonable treatment for his cervical spine. She and Dr. Seibel have failed to realize and acknowledge that Mr. Simao has chronic headaches and the cervical spine surgery was not indicated for this diagnosis. Mrs. Hartmann has now indicated that even after surgery to the cervical spine, annual spine injections would be required and has increased the cost in her LCP erroneously. There is no evidence based medicine that would indicate the necessity and indications for yearly injections after surgery. Not only would this imply that the surgery did not work for the problem, but places undue risk to Mr. Simao for complications. Since Mr. Simao continues to complain of pain in his neck, shoulder, and head after both spine surgeries, it is with medical probability, the symptoms are not due to the April 15, 2005 MVA, but due to his chronic headaches. Treatment to the cervical spine is unrelated to the MVA, thus the LCP should not include such treatment.

3. The new LCP has indicated that Mr. Simao would need a life time of pain management with Dr. Seibel which is not related to the MVA, but would be related to his chronic headache condition. Any treatment to Mr. Simao after May 16, 2005 would be related to the pre-existing headaches and not to the MVA. Therefore any pain management that is being done in the LCP has no merritt for the cervical spine pain, but would be related to a pre-existing headache condition. The increase in future medical care routine is not reasonable, necessary, or related to the MVA of April 15, 2005.

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4. Mrs. Hartmann has indicated in the LCP that BOTH cervical epidurals (ESI) and selective nerve root blocks (SNRB) would be needed. What Mrs. Hartmann fails to realize is that these injections are exactly the same procedure and therefore would not be a separate entry or procedure. The difference between the SNRB and ESI is the placement of the needle location which is still in proximity to the neuroforamen of the cervical spine. Performance of both injections would not only be duplication, but unreasonable and unnecessary when treating cervical radiculopathy. The LCP should not include both of these procedures and would be used in this LCP only to increase value to the overall numbers and not have any medical merrit for use with treatment of any patient.

5. The projected modalities section has been quadrupled from $4,200.00 to $15,660.00 due to the PT visits being done annually instead of every other year in the original LCP. The use of this much PT each year is not only unrealistic and medically unreasonable, it would be considered medical fraud. PT is reserved for treatment of an acute process with defined goals. Using PT for a chronic condition not only defeats the purpose of spine surgery to cure the pain, but is unnecessary for treatment when a patient reaches a maximal medical status. The LCP indicating a lifetime of annual PT is done only to increase the value of the LCP and not with any reason for standard medical treatment.

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6. There is no cervical spine source for Mr. Simao's migraine headaches. He had a previous history of migraine headaches and a previous MVA. The cervical MRI in 2006 was reported to demonstrate C3-4 and C4-5 disc protrusions and other degenerative changes without compression effects on the C4 or C5 nerve roots. Two years later on 4/30/2008 the actual images that I reviewed were not significantly changed and show no pathology that can explain his complaints. There would be no reason to perform any more imaging as it relates to the MVA, nor is there a reason to perform a discogram between the first and second surgery. The LCP has indicated in the Diagnostic and Laboratory Needs that $15,077.00 is needed for a discogram to prepare for the second surgery after the first done on 03/25/09 by Dr. McNulty. I would not consider the first discogram done to be reasonable based upon the MVA and therefore any additional discograms or revision surgery to the cervical spine would be unnecessary based upon the April 15, 2005 MVA.

7. For home furnishings, Mrs. Hartmann has indicated that Mr. Simao requires a Dual King Adjustable Bed to help with change in position and comfort, independence in mobility transfers and safety. By this standard, every cervical spine surgery patient would need a Dual King Adjustable Bed and obviously this is not the norm or even considered a reasonable request. Mr. Simao, based upon the video Surveillance demonstrates that any injury from the MVA on April 15, 2005 recovered as there were no deficits of function or restrictions or limitations that can be seen three years after the MVA. On the video, Mr. Simao did not display any range of motion limitations, lifting precautions, or functional deficits consistent with a

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cervical spine problem that required any interventions or surgery. The LCP that continues to include a shower bench, hand held shower, front wheeled walker, cervical collar, and Dual King adjustable bed is unnecessary and unrelated to the MVA. Mr. Simao is obviously independent and safe so that he does not require an adjustable bed. The addition of this home furnishing is done merely to increase the value of the LCP and not medically relevant based on the facts.

8. The updated LCP has decreased accurately the need for Fiorinal with codine as this is treatment for chronic headaches which is what Mr. Simao is currently being treated for with pain management. The $90,000.00 projected cost for this medication was appropriately removed from the medication lists, but given that the Mrs. Hartmann and Dr. Seibel have failed to appropriately diagnose Mr. Simao's true pain complaints of chronic headache, this accurate omission is an indication that the headaches are the source of Mr. Simao's treatment needs and has nothing to do with the cervical spine.

9. Assuming the MVA caused a strain injury, the treatment before May 6, 2005 would be related to the MVA, but any treatment after this date would not be related to the MVA. Given the history of a previous MVA, his job description of a manual laborer, the reported delay in onset of pain, a previous history of migraine headaches, the MRI showing no traumatic pathology, and his lack of response to cervical spine surgery, any necessary treatment in relation to the MVA ended on May 6, 2005. All new and updated LCP references to future medical care would be unnecessary based upon the MVA. There is no indication that based upon the MVA, a dorsal column stimulator, cervical degenerative arthritis, and need for revision surgery to the cervical spine is necessary.

10. It is important to note that I have not seen any medical records from medical doctors for treatment that is included in her life care plan, such as hardware removal or adjacent segment disease.

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Physical Medicine and Rehabilitation, UCLA Spine Center
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PAST ACCIDENT HISTORY:

He reports a motor vehicle accident with a motorcycle one year prior to the April 2005 MVA. Since the motor vehicle accident, he feels he has had more headaches and migraines, which were initially diagnosed ten years ago.

PHYSICAL EXAMINATION:

General: The patient is well developed, well nourished, in no acute distress; alert and oriented x 4 with appropriate mood and affect.

Lymphatic: There are no enlarged cervical or inguinal lymph nodes.

Spine: The cervical area is symmetric without kyphosis or scoliosis. No palpable masses and no complaints of significant muscle tenderness, or point tenderness along the spine. Complains of mild discomfort with Spurling's test; into left shoulder. Leg length discrepancy not noted. Range of motion normal in all planes of the cervical and lumbar spine.

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Upper Extremities: Left shoulder evaluation: Impingement signs, Hawkins, and Neer's reportedly produce pain to the left shoulder region. Palpation tenderness is noted at the subscapularis, semispinalis capitis, trapezius and levator scapulae on palpation, which reproduces the patient's typical pain on a day-to-day basis.

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Skin: Without lesion, rash, or scar at the neck or trunk. No lesions of the hands or feet.

Neurological: Normal gait without assistive device or brace. Patient is able to walk on toes and heels without difficulty. Coordination is intact. Sensory is intact to light touch, cold, and pinprick in the upper extremities. Motor exam is 5/5 in the bilateral upper extremities. Reflexes are symmetric at 2+ in the upper extremities. No Hoffmann's or Babinski's. Muscle tone is normal without clonus or muscle atrophy. Upper extremity Tinel, Phalen, Roos, and Spurling tests were normal.

Extremities: Pulses intact distally with no cyanosis, clubbing, or edema.

IMAGING AND WORK UP:

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CT of the BRAIN 5/13/05 showed by report, but actual images were not reviewed by me personally, a normal unremarkable head CT.

MRI of the CERVICAL SPINE 3/22/06 showed by report, but actual images were not reviewed by me personally a mild broad-based disk bulge 2-3 mm with left C4 nerve root contact possible within the neural foramen. No canal stenosis is seen at the C34 and C45 levels.

MRI of the BRAIN 5/23/05 showed by report, but actual images were not reviewed by me personally, a normal unremarkable head MRI for age with no abnormal enhancing lesions.

MRI of the CERVICAL SPINE 9/24/07 showed by report, but actual images were not reviewed by me personally, negative MR of the cervical spine for age.

MRI of the CERVICAL SPINE 4/30/08

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IMPRESSION AND DIAGNOSES:

Related to the motor vehicle accident of April 15, 2006:
1. Cervical whiplash syndrome, resolved.

Unrelated to the motor vehicle accident of April 15, 2006:
1. Migraine headaches.
2. Degenerative cervical spine disease.
3. Left shoulder subacromial bursitis.
4. Myofascial pain and muscle spasm.

COMMENTARY AND MEDICAL DECISION MAKING:

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I am seeing the Mr. Simao today for evaluation purposes only. There is no doctor patient relationship implied. Evaluation is consistent with history and previous physical examination by treating physicians. All records sent to me are reviewed for the purpose of a medical decision based upon the events of the current pain complaints. The opinions of this report are based upon examination of Mr. Simao and/or review of the medical records provided to me. All of my opinions have been rendered with a reasonable degree of medical probability but are preliminary to the extent that there is relevant information that I have not yet had the opportunity to review.

My opinions in regards to Mr. Simao are based upon my clinical experience as an active treating Physiatrist who specializes in Physiatry, Pain Medicine, and Electrodiagnostic Medicine. I am currently on staff at the UCLA School of Medicine in the UCLA Spine Center and the UCLA Medical Center. I am involved with resident and fellowship training of physicians at UCLA and must maintain updated and clinically relevant evidence-based guidelines for treatment of patients that fall within the standards of care. I would approach the patient as I would approach any patient with similar pain complaints as a treating physician. Based also upon my forensic review of the records, I made the following conclusions.

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Mr. Simao was involved in a motor vehicle accident in which he was a restrained driver, struck from behind. Mr. Simao complained of headaches and neck pain, and soon after the accident went to Urgent Care where he was given conservative treatment and ruled out for significant trauma. According to the medical records, over the next seven months, Mr. Simao did not pursue any aggressive treatment options. His care was sporadic and mostly related to his pre-existing headaches. It was not until October that his pain began to get worse, for which he was again evaluated and underwent radiographs which were reported as normal for the cervical spine. It was not until December that he was started on pain medications and January of 2006 that he began therapy for his neck, nine months post-MVA.

Regarding Mr. Simao's complaints of headaches, he had a history of headaches prior to the MVA of April 15, 2005 and was treating for this complaint at the time of the MVA. Furthermore, Mr. Simao has a history of a motorcycle accident which he has admitted worsened his headaches. Therefore, it is not surprising that the chronic migraine headaches continued since the April 15, 2005 MVA. Current work up with Neurology and Imaging studies did not find an organic source for his pain; thus, with medical probability, the new worsened headaches are merely a natural history and progression of his underlying disease and not due to the April 15, 2005 MVA. Some of his initial sub-occipital symptoms may have been a part of his whiplash injury; however, his headaches after about 4-6 weeks were more consistent with migraines that he had complained for many years prior to the MVA in question.

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Regarding his cervical spine, his treating orthopedic surgeon noted that the pain pattern and the MRI did not match. In my experience, I do not see a cervical spine source for migraine headaches; especially in an individual who has a history of migraine headaches for ten years and a previous MVA. The cervical MRI in 2006 was reported to demonstrate C3-4 and C4-5 disc protrusions and other degenerative changes without compression effects on the C4 or C5 nerve roots. This MRI is age appropriate and does not demonstrate any structural changes consistent with trauma. Mr. Simao subsequently underwent pain management injections. Reportedly, his headaches improved with the epidurals. I would suggest that his improvement with injections to the C3-4 foraminal space are due to steroid and lidocaine use to relax the tension or migraine headache muscle pain. I would have expected some improvement in the headaches, but not enough of a resolution to confirm the pain generation source from the cervical spine. These symptoms of headaches pre-existed the MVA of April 15, 2005. This is why the injections did not resolve his symptoms but just temporarily improved them.

The video observations further support my initial medical opinion that the MVA on April 15, 2005 caused only a whiplash injury, which fully recovered within a few months. There are no deficits of function or restrictions or limitations of work that can be seen three years after the MVA. This would indicate that no further work up or treatment options are needed since Mr. Simao has fully recovered. He does not display any range of motion limitations, lifting precautions, or functional deficits consistent with a cervical spine problem that requires any interventions or surgery. In my experience, cervical spine surgery does not resolve or improve the pain experienced by migraine headache patients. Cervical fusion of the C34 and C45 will not help Mr. Simao's headache complaints and therefore I do not feel that a surgery is medically necessary.

Based on my physical examination today, Mr. Simao probably has a myofascial component to his pain based on his continued chronic migraine headaches. His left shoulder examination corresponds with the current pain complaints that he describes today and in reviewing the medical records, none of his physicians had suggested bursa injection to the shoulder. I do not see how the motor vehicle accident could have caused the shoulder issues since the medical records do not indicate a shoulder problem nor do they indicate that his physician's needed to address the shoulder joint as an issue. Typically significant shoulder injury after trauma causes restriction of daily activities, limited range of motion of the shoulder joint, and results in immediate need for treatment directly after the MVA. This is not the case here. Also, Mr. Simao continues to do manual labor and uses his shoulder daily to help with balancing and lifting objects. This, in medical probability, may be the cause of his left shoulder symptoms today. It is therefore my opinion that his shoulder may require future assessment and treatment, but probably not related to the MVA.

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Furthermore, given the delay in care, his current activity levels, the findings on MRI, and my current evaluation of Mr. Simao, it is my opinion that the motor vehicle accident did not cause injury to the cervical spine necessitating injection therapy or surgery. The epidural injections did not seem to last for more than two weeks according to my discussion with Mr. Simao today. This indicates that the cervical spine levels are probably not the source of his complaints. Most likely, the MVA caused a whiplash type injury that resolved around May of 2005 based on his records review. The symptoms he began to describe in October of 2005 are more likely related to his migraine headaches, myofascial pain, and shoulder issues that are unrelated to the motor vehicle accident, but more likely in medical probability a pre-existing condition. He also has arthritis of the cervical spine which can be symptomatic based upon his work, his prior MVA, and his chronic migraine history.

Mr. Simao is a smoker which further increases the likelihood of degenerative disease of his cervical spine. Furthermore, in discussing the migraine pain symptoms that he describes on the left side of his eye and head, these can be easily mistaken for cervical pain referral patterns. It is medically probable that his complaints are more likely related to the migraine headaches than to any cervical injury. Headaches such as these can give myofascial components of pain and develop into abnormal shoulder usage. This can lead to subacromial bursitis which was seen on my examination of Mr. Simao today. Thus, any surgical intervention for his cervical spine would be unindicated and medically unnecessary.

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The care Mr. Simao received directly after the MVA through the return to a routine follow up at the end of May 2005 for headache complaints was reasonable and may be related to the MVA. His care after this time frame was probably not caused by the MVA but by his pre-existing chronic medical problems. As far as his neck pain goes, I would apportion a small amount, 20% to the MVA, based on Ms. Simao's report of having neck pain directly after the MVA. However, given his history of a previous MVA one year prior, his job description of a manual laborer, the reported delay in onset of pain, and a 10 year history of migraine headaches, such apportionment would end with the treatment in May of 2005.

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FUTURE MEDICAL CARE:

At this time, based on his treatments and his pain complaints, there would be no future medical care treatment options related to the motor vehicle accident. Since there was a delay of care of up to five months, there is no way to relate any shoulder or myofascial component of pain to the motor vehicle accident. His consistent headaches and shoulder issues are more likely related to his complaints of underlying migraine headaches and bursitis, these are a pre-existing conditions that are unrelated.

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EXHIBIT "2"

DISTRICT COURT

CLARK COUNTY, NEVADA

WILLIAM JAY SIMAO, individually and CHERYL ANN SIMAO, individually, and as husband and wife, Plaintiffs, vs. JENNY RISH; JAMES RISH; LINDA RISH, DOES I through V; and ROE CORPORATIONS I through V, inclusive, Defendants.	)	Case No. A539455

DEPOSITION OF DAVID E. FISH, M.D.

Santa Monica, CALIFORNIA

Thursday, February 10, 2011

Reported by:
Gideon Choi
CSR No. 13258

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DISTRICT COURT
CLARK COUNTY, NEVADA

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

Plaintiffs,

vs.) Case No. A539455

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

Defendants.

Deposition of DAVID E. FISH, M.D., taken on behalf of Plaintiffs, at 1250 16th Street, Tower Building, Room 745, Santa Monica, California, beginning at 2:17 p.m. and ending at 4:18 p.m., on Thursday, February 10, 2011, before Gideon Choi, Certified Shorthand Reporter No. 13258.

APPEARANCES

For the Plaintiffs:
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INDEX

Witness: DAVID E. FISH, M.D.

EXHIBITS

(Continued...)

INDEX (Continued...)

INFORMATION REQUESTED

Page	Line
None.	

QUESTIONS INSTRUCTED NOT TO ANSWER

Page	Line
None.	

14:11:35
14:11:35

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DAVID E. FISH, M.D.,
called as a witness by and on behalf of the Plaintiff, and having been first duly sworn by the Certified Shorthand Reporter, was examined and testified as follows:

EXAMINATION

BY MR. WALL:

Q All right. Could you state your name for the record, please?

A David Eli Fish.

Q Dr. Fish, just to kind of walk through some things, I have a -- do you have an updated CV?

A Yeah, but before you start, what's your name?

Q My name is David Wall. Thank you. W-a-l-l.

A It's nice to meet you, sir.

Q All right. Do you have a copy of your CV?

A Yes, I do.

Q Is that updated?

A Yes, it is.

Q All right. I'm not sure mine is, so we'll make that Exhibit 1 to the deposition.

A Okay.

(Plaintiff's Exhibit 1 was marked for identification by the Certified Shorthand Reporter, a copy of which is attached hereto.)

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Q I have a list of cases, testimony history, but mine stops with 2008. Do you have a more recent one?

A Yes.

Q All right. Do you have that handy?

A I can print it up for Gideon after we're done if you want.

Q All right. We'll make that Exhibit 2. I have a fee schedule. I'm not sure whether it's updated. It shows -- actually, it says "2007 updated" in the lower left-hand corner. Is that still good?

A Probably not.

Q All right. Do you have an updated one available?

A Yes.

Q Will you be able to provide that to the court reporter as Exhibit 3?

A Yes.

Q On the list of cases since 2008, how many times do you think you've testified either in a deposition or in a trial or arbitration?

A Since 2008, and maybe 25 times.

Q And can you breakdown those 25 for me; roughly how many were on behalf of plaintiffs and how many were on behalf of the defense or as a treating doctor?

A Yes, no problem. Hold on a second. I can do that. So for 2008 --

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Q I have 2008.

A Okay. So for 2009, as a treating doctor, I did two; as an expert witness, I did seventeen; and for the plaintiff, I did nine; and for the defense -- actually, sorry -- that would be seven; and for the defense it looks like ten.

Q Do you have the records from 2010 as well?

A Yes -- oh, and of the court appearances, I have three, and they were all for plaintiff. The other ones were depositions. And for 2010, there were eleven total depositions, one as treating; and of the ten that were left over, two were plaintiff, and eight were defense.

Q Can you estimate in 2009 and 2010, how many other cases besides this one involved Mr. Rogers or his firm?

A Five.

Q Is that who initially contacted you in this case?

A I don't remember. Most likely, but I don't remember.

Q Do you have correspondence that would reflect that?

A I don't know.

Q Do you know when you were first contacted on this case?

A Sometime at the beginning of 2008, because my first report was in February of 2008.

Q I show that your first report was February of 2009. Is that incorrect?

A Yeah, I apologize. 2009 -- no. Actually, no, it was in 2008. I may not have done a report until 2009.

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Q When were you first contacted; do you know?

A Again, I'd say at the beginning of 2008.

Q Beginning of 2008?

A Correct.

Q What do you base that estimate on?

A I have my -- I have a billing statement from February 14th, 2008, and it looks like there was an expedited review of records that were needed that was dated around 2008.

Q Who did you bill?

A Rogers, Mastrangelo, Carvalho & Mitchell.

Q Your entire file, including the billing records, I'd like to have all of that provided to the court reporter and made an exhibit. I guess it would be Exhibit 4. Can you provide that after the conclusion of the deposition to the court reporter?

A Do you want it on disc or do you want it printed out or what do you want to do?

Q On disc.

A On disc?

Q On disc would be fine.

A I don't think I can get it to you today. I'd have to send it to you.

Q Okay. Do you know what your charges are to date in this case?

While you're looking for that, Doctor, you've had your

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14:25:07 1 deposition taken enough times that you'd waive all the normal
14:25:12 2 admonitions; is that right?
14:25:13 3 A Yes, sir.
14:25:14 4 MR. WALL: All right. And while you're looking for that,
14:25:34 5 Mr. Reporter, I'm going to provide to you a disc that we had
14:25:39 6 prepared that has nine previous depositions of Dr. Fish, and
14:25:47 7 that will be Exhibit 5.
14:25:51 8 THE COURT REPORTER: Okay, sir.
14:26:04 9 THE WITNESS: So I guess you did some light reading, is that
14:26:0810 true?
14:26:0811 BY MR. WALL:
14:26:1212 Q Do you have a total for me, Doctor?
14:26:1413 A I'm working on it. Okay. I got a number for
14:26:3814 you $19,200.
14:26:4115 Q That's up to, but not including today?
14:26:4616 A That is correct.
14:26:4717 Q What did you do to prepare for your deposition?
14:26:5018 A I reviewed the records that I had previously reviewed
14:26:5519 and read my reports, and I looked over the records that I
14:27:0220 thought were pertinent for the questions I hoped you would ask
14:27:0521 me.
14:27:0522 Q Anything else?
14:27:0723 A No.
14:27:0824 Q Did you have any conversations with Mr. Rogers or
14:27:1325 anyone from his firm?

14:27:14 1 A Yes.
14:27:14 2 Q What was the nature of those -- how many?
14:27:23 3 A Well, when? Last week? Last year?
14:27:28 4 Q To prepare for your deposition.
14:27:30 5 A Oh, probably just one conversation just to make sure
14:27:33 6 that I had all of the documents that I needed and to make sure
14:27:39 7 that I had all the proper records that were needed.
14:27:44 8 Q When was that conversation?
14:27:45 9 A I think it was two days ago.
14:27:4910 Q You are board certified, Doctor, is that right?
14:27:5611 A Yes, sir.
14:27:5712 Q What specialty?
14:28:0013 A Physical medicine and rehabilitation and pain medicine.
14:28:0414 Q You're not a board certified spine surgeon; is that
14:28:1115 correct?
14:28:1116 A Well, I mean, define "spine surgery". I do some spine
14:28:1617 surgeries, so you have to be a little bit more --
14:28:2018 Q Are you board certified in any orthopedic surgery or
14:28:2319 spine surgery?
14:28:2420 A Well, yeah, I am.
14:28:2821 Q Okay. In what?
14:28:3022 A Well, I do spinal cord stimulators and morphine pumps,
14:28:3523 and so we do surgery to the spine in those cases as well as
14:28:3524 vertebroplasties and kyphoplasties which are also considered
14:28:4325 spine surgeries.

14:28:43 1
14:28:45 2 Q And have you ever done a fusion?
14:28:50 3 A No.
14:28:50 4 Q Ever assisted in a fusion?
14:28:57 5 A No.
14:28:57 6 Q Do you refer patients out to spine surgeons?
14:29:03 7 A Yes.
14:29:03 8 Q Have you referred any patients to any Las Vegas spine
14:29:11 9 surgeons?
14:29:1210 A Yes.
14:29:1211 Q Who would you have referred to?
14:29:1812 A Dr. Schifini. I've referred patients to Las Vegas
14:29:2913 surgeons quite a bit. It just depends. At UCLA our catchment
14:29:3714 area is very big so we get a lot of patients from
14:29:4115 Las Vegas, and so I try to keep them in Las Vegas as opposed to
14:29:4716 having surgery done here, if that needs be
14:29:4817 Q So Dr. Schifini is not a spine surgeon; is that right?
14:29:5318 A No, no. That was the first person I thought about
14:29:5419 because I recently referred someone there. I can't tell you
14:29:5520 offhand who I did. There's a lot of surgeons in Las Vegas, so I
14:30:0021 can't tell you exactly who I referred to, but I know I've
14:30:0322 referred some patients over there.
14:30:0523 Q Do you know Dr. McNulty?
14:30:0724 A Not personally, no.
14:30:0925 Q Have you referred any patients to Dr. McNulty?

14:30:14 1 A I don't know.
14:30:14 2 Q You don't know?
14:30:16 3 A I may have. I don't know. It depends on the group
14:30:19 4 that the patients are coming from, and my office tends to try to
14:30:23 5 help them find a surgeon or find somebody in Las Vegas, so it's
14:30:27 6 possible that a referral has gone to him.
14:30:30 7 Q Are you a member of NASS, N-A-S-S?
14:30:34 8 A Yes.
14:30:35 9 Q Are you a member of ISIS?
14:30:4010 A Yes.
14:30:4611 Q I-S-I-S?
14:30:4712 A Yes.
14:30:4713 Q So are you familiar with the ISIS guidelines or
14:30:4914 criteria for pain management doctors?
14:30:5215 A Yes.
14:30:5216 Q Have you ever performed any discography?
14:31:0017 A Yes.
14:31:0118 Q I'm sorry?
14:31:0519 A Yes.
14:31:0620 Q Oh, the answer was yes. Cervical, lumbar, or both?
14:31:1021 A Cervical, thoracolumbar, and lumbar.
14:31:1922 Q Do you use those regularly?
14:31:2223 A Yes.
14:31:2224 Q When was the last time that you performed a cervical
14:31:2925 discography?

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14:31:30 1 A Two weeks ago.
14:31:32 2 Q Do you consider yourself to have expertise in the area
14:31:39 3 of biomechanics as it relates to motor vehicle accidents?
14:31:43 4 A If you mean am I certified by any governing body, no.
14:31:50 5 but do I have expertise in understanding mechanics and injuries,
14:31:54 6 yes.
14:31:55 7 Q Would it be your intention to testify as an expert in
14:31:59 8 the area of biomechanics or whether a certain type of impact
14:32:05 9 between two vehicles would be sufficient to cause a certain type
14:32:1010 of injury?
14:32:1111 A If I'm asked a question, I would answer it. I don't
14:32:1612 know if I've been asked to specifically do that as an expert.
14:32:2013 Q All right. Have you been asked to do that in this
14:32:2314 case?
14:32:2415 A Well, I mean, I think causation and the injury
14:32:3016 component and whether or not a person was injured in a specific
14:32:3317 car accident or if Mr. Simao had an injury occur from the car
14:32:4018 accident, I've been asked I've made opinions as such, but I
14:32:4319 did not measure velocities or G-force or measurements of tire
14:32:4920 skid marks or anything like that, if that's what you're asking
14:32:5221 Q So it wouldn't be your intention to offer testimony as
14:32:5622 an expert that the actual collision in this case based on --
14:33:0823 A Hello?
14:33:1124 Q -- injury, would that be correct?
14:33:1325 A You're going to have to say it again. You cut out.

14:33:18 1 MR. ROGERS: Court Reporter, I'll lodge a compound
14:33:20 2 objection, and then go ahead, Doctor.
14:33:24 3 THE WITNESS: You have to say the question again. It got
14:33:27 4 cut off.
14:33:31 5 MR. WALL: Oh, it got cut off.
14:33:33 6 MR. STEPHENS: Oh, okay.
14:33:34 7 BY MR. WALL:
14:33:34 8 Q Is it your intention in this case to offer opinions at
14:33:39 9 trial regarding whether this accident was sufficient in the
14:33:4710 magnitude of the collision to cause a particular injury?
14:33:5311 A Yes. I mean, I'm going to make opinions based on the
14:33:5812 MRI, based on the records on whether or not the accident
14:34:0213 actually caused any injury to Mr. Simao.
14:34:0614 Q That's not my question. My question is: Are you going
14:34:0915 to do that from a biomechanical perspective; that is, looking at
14:34:1316 the damage to the vehicles and the nature of the collision to
14:34:1917 determine whether it was sufficiently severe to cause a
14:34:2318 particular injury?
14:34:2619 MR. STEPHENS: I object. Compound. Doctor, go ahead.
14:34:3020 THE WITNESS: I think I've answered the question. I mean,
14:34:3221 I'm not certified as a bioengineer. I'm not certified as
14:34:3622 somebody who can measure G-forces, but I can tell what an
14:34:4123 accident and what an MRI look like and whether or not a person
14:34:4624 has been injured based on the medical records and the medical
14:34:4925 complaints.

14:34:49 1 BY MR. WALL:
14:34:49 2 Q Doctor, do you understand my question?
14:34:52 3 A Probably not because you've asked it for the third
14:34:54 4 time, so I would say no, I don't understand your question.
14:34:57 5 Q There's a difference between looking at the MRI's or
14:35:00 6 the medical records to determine certain things surrounding
14:35:04 7 causation as compared to looking at the damage to the vehicles
14:35:08 8 and determining Delta V and whether or not that particular
14:35:13 9 collision with those two vehicles was sufficient to cause a
14:35:1610 particular injury from a biomechanical perspective.
14:35:2011 Is it your intent to offer an opinion based on the
14:35:2712 biomechanics of the accident?
14:35:2913 A I don't think so.
14:35:3014 Q Are you not sure?
14:35:3515 A Well, I mean, I don't know if I understand your
14:35:3816 question.
14:35:4017 Q Have you done any analysis of the vehicles or the
14:35:4418 photographs of the vehicles or the damage estimates to the
14:35:4819 vehicles in rendering your opinions?
14:35:4920 A I've looked at them so I've done an analysis of the
14:35:5421 pictures and the amount of damage as well as the cost to fix the
14:35:5922 damage.
14:36:0023 Q Is it your opinion that the damage to the vehicles or
14:36:0424 the amount to fix the vehicles is a significant consideration in
14:36:0925 forming the basis of any of your opinions?

14:36:12 1 A I don't know if I would say significant, but it is a
14:36:16 2 factor.
14:36:18 3 Q And what training do you have to correlate the amount
14:36:25 4 of damage to the vehicle to a specific injury?
14:36:36 5 A Let me see if I got it right. Correlate the amount of
14:36:40 6 damage to a specific injury?
14:36:44 7 Q Correct, the amount of damage to the vehicle.
14:36:45 8 A Well, it's experience. It's seeing many people who
14:36:49 9 have had significant car accidents. It's seeing people who were
14:36:5410 injured and people who have had injuries as well as reviewing
14:36:5711 previous cases and my patients that come through the door as
14:37:0112 well as come through the emergency room who have had significant
14:37:0513 accidents or non-significant accidents.
14:37:0714 Q When you say "non-significant", is it your experience
14:37:1015 that an accident has to have a significant amount of damage to
14:37:1416 the vehicles in order to cause injury to one of the parties
14:37:1917 inside?
14:37:1918 A Well, again, I think that depends on the complaints of
14:37:2319 the individual, where the individual may have -- either the body
14:37:2720 struck or what kind of components of damage, where it is. I
14:37:3121 mean, obviously, if the damage was done on a rear end bumper,
14:37:3522 and a person is complaining of a wrist injury or an elbow injury
14:37:3923 on the right side, and there's nothing that the person struck,
14:37:4224 and it's a very slight injury, then obviously you make the
14:37:4625 correlation as to the medical components as well as the injury

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and the damage to the vehicle.
Q So is it your intention in this case to say, essentially, I looked at the damage to these vehicles, and it wasn't significant to cause an injury to Mr. Simao; is that your intention?
A Well, I think that's part of the whole evaluation of Mr. Simao, and looking at the records, I think that's part of it. I'm not saying that it's purely based on the actual pictures or purely based on the actual amount of damage, but it's a factor.
Q Okay. And you believe that the impact was not severe enough to cause any type of injury beyond a whiplash injury to Mr. Simao; is that your opinion?
A No. If you see in my subsequent reports, I abandon the whiplash injury as a diagnosis and felt that he had a non-specific myofascial complaint, and that based on the pain complaints from his initial visit and the subsequent six months, I don't think Mr. Simao had a significant injury to his neck.
Q Is that because the impact wasn't severe enough to cause it?
A Well, I think that's part of it. I also think it's the complaints that he had. He really was not complaining of neck pain after the May 5th -- I'm sorry -- the April 15th, 2005 accident. You know, his first visit to a provider on the 4th -- on that day, you know, he may have complained of neck pain, but

after that he didn't really complain of neck pain, so there is a component of him not being injured to his neck.
Q But my question was: Is that based on your review of the photographs and the damage estimates of the vehicle?
A That is part of it, yes.
Q And what training do you have to measure or review photographs of an accident of the vehicles or the damage estimates and then to correlate that to whether or not someone could be injured either by whiplash or by some other mechanism; what training do you have in that?
A Well, I think I answered that before, but, you know, having been in two car accidents myself and experienced them as well as seeing patients through the emergency room at UCLA, at John Hopkins, and in the military, I've got a lot of experience with accidents and with injuries that were sustained as well as treating patients who have had accidents and what kind of injuries that were sustained. So it's part of my experience, part of my training, and part of my personal experience as well.
Q All right. I have what I think is your original report which shows a date of review of February 10th, 2009. Do you have a copy of that?
A Yes.
Q I'm going to have that -- if you have a copy of that -- and ask that that it be marked as Exhibit 6. I think that's the next in order.

A I have an electronic copy I don't have the --
Q All right. Would you be able to print out a copy to make it Exhibit 6?
A Well, I was going to give him the whole disc. I really can't print everything out.
Q All right. Well, that, I want printed out and made a separate exhibit. Can you do that?
A Yes, I will try
Q All right. And then I have what we'll call Exhibit 7, "Independent Record Review, Addendum No. 1" that shows a date of review of July 13th, 2010 Do you have that available?
A Electronically, yes
Q All right. I would ask that that be printed out after the deposition and made Exhibit 7. And then I have "Independent Record Review Addendum No. 4".
A Yes.
Q Which appears to have a date of October 18th, 2010. Do you have that available?
A Yes.
Q I would ask that that be made as Exhibit 8 to the deposition and printed out. Is there an Addendum 2 and 3?
A That's what I was trying to clarify. I think it was a clerical error, and that's why it came out to Addendum 4.
Q The answer is no, there is not?
A There is not.

Q All right. Do these three reports contain a complete statement of all of your opinions that you have in this case?
A No. There's an Addendum 5.
Q Where is Addendum 5?
A Right here. (Indicating.)
Q Has that been produced to anyone? The record should reflect that you're showing me a copy over Skype?
A Yes. I've given it to Mr. Rogers.
Q I have not received No. 5.
MR. WALL: Mr. Rogers, have you received No. 5?
MR. ROGERS: I have not. When did you send it, Dr. Fish?
THE WITNESS: Yesterday.
MR. STEPHENS: Okay.
BY MR. WALL:
Q All right. I'm going to ask that a copy be made of that and made Exhibit 9. I guess that would be the next in order.
(Plaintiff's Exhibit 9 was marked for identification by the Certified Shorthand Reporter, a copy of which is attached hereto.)
I won't be able to see that, obviously, so I'm going to reserve now the opportunity, once I review No. 5, to reconvene the deposition in order to do that.
Let me ask you this. In No. 5, does it list the records that you reviewed since No. 4?

14:44:14 1 A Yes.
14:44:17 2 Q What records are listed?
14:44:18 3 A The updated report of Kathleen Hartman dated 11/8/2010.
14:44:24 4 Q Is that it?
14:44:25 5 A Yes.
14:44:26 6 Q All right.
14:44:30 7 MR. STEPHENS: Dated what?
14:44:33 8 THE WITNESS: 11/8/2010.
14:44:39 9 BY MR. WALL:
14:44:3910 Q All right. Do all of those four reports which we've
14:44:4511 marked as 6, 7, 8, and 9 contain all the complete opinions you
14:44:5312 intend to express in this case?
14:44:5513 A Well, I tried to be as complete as possible. Since my
14:44:5914 review of the records in preparation for this deposition, I may
14:45:0315 make some other statements or opinions, so I'm hoping that it
14:45:0716 contains a lot of them, but I may have more.
14:45:1017 Q All right. Does it – do the reports contain a
14:45:1418 complete statement of the basis for your opinions?
14:45:1819 A I don't know because I just got new records as well,
14:45:2420 and so that may not contain some of the records that I've
14:45:2821 received recently. Actually, in fact –
14:45:3022 Q At least as of the date of the report, does it?
14:45:3423 A As of the – no, because I was not able to add the new
14:45:3924 records in on a new report, so it's probably missing some
14:45:4525 reports that I do not have. And I can list them for you, if you

14:45:49 1 want.
14:45:50 2 Q What are you listing for me?
14:45:53 3 A Well, I know I have not made any opinions or referenced
14:45:56 4 some records that I received. And so you said does this
14:46:04 5 report, No. 5, include all the things that I had, and I actually
14:46:06 6 have some records, but I have not made any opinions on them.
14:46:10 7 Q What records are those, and when did you receive them?
14:46:18 8 A This week or last week. Oh, I have them on disc.
14:46:27 9 Q February 2011?
14:46:2810 A Yeah. I forgot. I have a whole set of discs that I
14:46:3311 have. They're in my office, so I can bring them in if you want.
14:46:3712 I can show them to you on the Skype if you want.
14:46:4013 Q What records did you receive within the last two weeks?
14:46:4314 That's what I'm asking.
14:46:4415 A No, I know. I just realized that I had these other
14:46:4716 records. I apologize. The depositions of Britt Hill,
14:46:5817 Dr. Seibel, Officer Hagstrom, Dr. Rossler, Dr. Grover,
14:47:0518 Dr. McNulty, Jenny Rish – R-i-s-h; a report from Dr. Winkler, a
14:47:1219 report from Dr. Wang, W-a-n-g; cervical spine X-rays, 4/15/05,
14:47:3020 10/18/05, 6/17/08, 1/11/10; a CT of the cervical spine,
14:47:3421 8/8/08, 08/11/09; a CT of the brain, 5/14/2005; MRI of the
14:47:4522 cervical spine, the actual images, 3/22/2010.
14:47:5023 Q Let me stop you for a minute. These are things that
14:47:5324 you just received in the last two weeks?
14:47:5525 A Well, I didn't have the actual images and so they were

14:47:59 1 sent to me, so I don't know if I've actually reviewed the images
14:48:03 2 in my previous reports and so – I may have received them
14:48:07 3 beforehand, but I haven't had a chance to actually look at them
14:48:10 4 until the last two weeks.
14:48:11 5 Q And so all of those – well, I'll let you finish the
14:48:17 6 list. Finish the list.
14:48:18 7 A Okay. MRI of the cervical spine, 9/24/2007; MRI of the
14:48:24 8 cervical spine, 4/30/2008; MRI of the cervical spine, 8/11/2009;
14:48:30 9 brain MRI of 5/23/2005, actual images. Oh, and vehicle photos.
14:48:3710 Sorry. I didn't have those before.
14:48:3911 Q And all of those things that you just listed you just
14:48:4412 received within the last two weeks?
14:48:4613 A I may have received them before, but I have not had a
14:48:4914 chance to look at them until the last two weeks, so in my mind I
14:48:5315 just received them in the last two weeks.
14:48:5616 Q Including those depositions? Did you receive those
14:48:5917 depositions within the last two weeks?
14:49:0318 A I believe so, yes.
14:49:0519 Q I didn't hear that Mr. Simao's deposition was listed in
14:49:1120 that group; is that correct?
14:49:1321 A I might not have seen that one. If I listed it on my
14:49:1922 reports, I may have had them, but I might not have seen his
14:49:2323 actual deposition.
14:49:2424 Q Well, Exhibit 6 which is your original report lists no
14:49:3025 depositions. Exhibit 7 which is your Addendum No. 1 lists the

14:49:35 1 deposition of Dr. Adam Arita, A-r-i-t-a, and no others. And
14:49:43 2 Addendum No. 4 doesn't list any depositions.
14:49:45 3 So would you have listed all of the documents that you
14:49:49 4 reviewed in preparation of your reports in that particular
14:49:53 5 report or addendum?
14:49:57 6 A Which particular report or addendum?
14:50:00 7 Q All of them as you did each one.
14:50:04 8 A I'm not sure I understand your question.
14:50:06 9 Q All right. When you did your original report in
14:50:1010 February of 2009, it listed records reviewed. Is that all of
14:50:1411 the records that you reviewed in preparation for that report?
14:50:1612 A Yes.
14:50:1713 Q Same thing for Addendum No. 1 where it lists records
14:50:2314 reviewed?
14:50:2315 A Yes.
14:50:2316 Q Same thing for Addendum No. 4?
14:50:2617 A Yes.
14:50:2718 Q And Addendum No. 5 apparently as well; is that right?
14:50:3119 A Correct.
14:50:3220 Q Same answer?
14:50:3421 A Correct.
14:50:3522 Q So you had – the only deposition that you had that you
14:50:4123 reviewed until the last two weeks was the deposition of
14:50:4524 Dr. Arita; is that right?
14:50:4725 A I believe so, yes.

Q And have you -- when did you review the depositions of Dr. Hill, Dr. Seibel, Dr. Rossler, Dr. Grover and Dr. McNulty?
A Over the last two weeks.
Q I'm sorry?
A Over the last two weeks.
Q And is that because you've just received them?
A Like I said, I might have received them beforehand, but I did not know that I had them until the last couple of weeks in preparation for the deposition that was happening today.
Q If you had them, why wouldn't you have known that you had them?
A I'm a busy man. I don't know what to tell you. I have a lot of things going on on my plate. I've got research projects that need to be taken care of. I have grants that I'm submitting. You know, I've got a lot of things going on besides this case, so it's possible that they were there, and I just didn't have a chance to get to them.
Q How many --
A I hope you can appreciate that.
Q I'm sorry. Go ahead.
A I hope you can appreciate that.
Q How many depositions of Dr. McNulty did you have?
A What do you mean? From this case?
Q Yes.
A I think it's just one. Is there another? Oh, he had

two; right?
Q Well, tell me how many transcripts you have?
A I believe I recall just one, but, actually, in thinking about it, I think it wasn't completed, and he had to have a second one.
Q So all of these documents that you've listed here that you say you either didn't receive or at least didn't review until the last two weeks, are any of those mentioned in Addendum No. 5?
A I don't believe so.
Q Did any of those depositions that you reviewed or the medical records that you've reviewed change any of your opinions in this case?
A It reinforced them. The deposition by Dr. Seibel in conjunction with the deposition of Mr. Hill and Dr. Arita really enforced the -- a lot of my opinions and allowed me to actually get a better grasp and picture of the case in general.
Q Your Addendum No. 1 -- I'm sorry -- Addendum No. 4 from October of 2010, do you have access to that?
A Yes, sir.
Q On Page 4 in Paragraph No. 3, it says, "I have reviewed the deposition testimony from Mr. Simao's treating physicians," and then it goes on to reference portions of Dr. Arita's deposition.
When you said, "I have reviewed the deposition

testimony of Mr. Simao's treating physicians," at that time was Dr. Arita the only one that you had reviewed?
A I believe so, yes.
Q If, in fact, all of those other depositions were not sent to you until the last two weeks, did you ever request them previously?
A Well, I mean, I requested all the records, but they may have come in earlier, and I just didn't look at them or I didn't see them. There may have been a lot of different factors.
Q You would have wanted to see the deposition testimony of the treating physicians and the surgeon who performed the surgery; is that right?
A Well, I would want to see all the records.
Q What period of time do you understand that Dr. Arita actually treated Mr. Simao?
A Do you think we could take a quick break? I just want to get a drink. I'm starting to get dry here; okay?
MR. WALL: Sure.
(Recess taken from 2:55 p.m. to 2:57 p.m.)
MR. WALL: All right. Let's go back on the record.
BY MR. WALL:
Q Doctor, do you remember the question that was asked before we took a break?
A Yes, I do.
Q What was the period of time that you understand

Dr. Arita to have treated Mr. Simao?
A I think it's between 8/24/2006 to 3/22/2007.
Q Let me ask you: That list of things that you read to me that you had just reviewed within the last two weeks, where does that list come from? What were you reading from?
A Oh, well, I realized that I didn't have some of the records, and so I just quickly put it together in my -- it's just a summary, just a page.
Q When did do you that?
A In preparation for the deposition I realized that there was records that I didn't have listed there so I wanted to make sure that I had them.
Q And so did you contact Mr. Rogers's office to obtain that information?
A No. I think I might have had them already, but I just didn't -- I don't know if they, you know, sent everything to me in the last couple of weeks or whether I had them already. I mean, there's a lot of records for this case. That's the thing.
Q A lot of the X-rays and CT scans that you talked about seem to be referenced in your Addendum No. 1 as films that you actually reviewed?
A Correct, but he's had some more since that time so I wanted to make sure -- well, I received some more since that time so I wanted to make sure that I was getting everything for

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you
Q Your Addendum No. 4 on Page 3 says that "the accident report noted moderate damage to the vehicles and both were driven away." Is that a significant basis for any of your opinions in this case?
MR. STEPHENS: I'm going to object. Vague as to "significant", but go ahead, Doctor.
THE WITNESS. I don't see where you're at. What page?
BY MR. WALL:
Q Page 3 of Addendum No. 4 in the first full paragraph.
A The first full paragraph, so it's the top of Page 3? Right. Okay. Well, at the time I don't think -- that was basically from the reports, but I don't know if I can really say that I had the actual images of the pictures or the estimates of the damage at the time, so it may have just been taken from the reports.
Q My question was: Did it play a part in forming your opinions in this case?
A Maybe.
Q Could you elaborate on that a little bit?
A Well, I'm not really sure exactly how you want me to determine this. I guess it's, you know, all the factors that go into this case. It's seeing the initial records and seeing his complaints at the time as well as looking at the photographs and the actual damage of those photographs, and so it definitely

played a factor in the overall review of the case.
Q On the same page further down under Paragraph 1 it says, "Mr. Simao had a significant history of headaches with treatment prior to the motor vehicle accident of April 15th, 2005."
Did you review any records which predated -- medical records which predated the accident?
A No.
Q Do you have any knowledge of the character or location of those headings based on any medical records?
A Just from the recent records with his new neurologist that he's been seeing in 2010 and him describing the history of longstanding migraines as well as the other records that he described to the Southwest Medical Associates when he presented after the accident about his pre-existing migraines.
Q So what were Mr. Simao's presenting complaints on the day of the motor vehicle accident?
A Neck pain, headache, left elbow pain.
Q Anything else?
A That's what the records say.
Q In Addendum No. 4 -- well, let me ask you this. Addendum No. 4 -- you testified previously that since the time of your original report until at least Addendum No. 4 or No. 5, that you had abandoned certain conclusions; is that right?
A I modified them. I don't know if "abandoned" is the

right word, but I changed them.
Q I thought "abandoned" was the word you used earlier.
A Oh, was it? Okay. Abandon.
Q Should I disregard the first report and Addendum 4 or Addendum 1?
A I wouldn't disregard any of the reports. I just was looking at the diagnosis that I came up with, and I modified it or abandoned it from the previous reports, but the opinions that are in the earlier reports may not have been extended to the next report.
Q In Addendum 4 you state that "Mr. Simao's care between May and October of 2005 was sporadic and related to his pre-existing headaches"; do you see that?
A No, but I that's what I recall writing.
Q What basis do you have to determine that any treatment between May and October of 2005 was related to the pre-existing headaches as opposed to something different that occurred in the accident?
A Well, his admission on 5/4/2005, that he had a history of migraine headaches; no change in the mental status, if you will; and no weakness into his legs based on the examination; there's no neurological complaints; the MRI of the brain being unremarkable showing no structural abnormalities from 5/23/2005; the treatment for migraine type headaches with standard medication such as Topamax and Carisoprodol.

Q So my question was --
A I'm listing -- hold on. I'm not done. The listing of X-rays of the cervical spine in the left shoulder from 10/8/2005; and the inconsistencies of him following up where he doesn't have consistent follow-up on a weekly or bi-weekly basis, but actually had gaps in care. That, to me, is consistent with a pre-existing migraine condition.
Q Did you understand that Mr. Simao described any headaches he had post-accident during that period as being different from the migraines he may have suffered prior to the accident?
A Yes, I read that.
Q And have you disregarded that?
A No, I didn't disregard it. That's fine. I understand where he's coming from. I'm going by the records, and this is my opinion based on the simplicity of the records and his pre-existing condition, as well as if you look at the records from 2010, that really kind of starts talking about only migraine headaches.
Q You write in Addendum No. 4, Exhibit 8, that it was not until October 2005 that his neck pain began to be an issue, but in fact he presented with neck pain at the hospital; is that correct?
A Yeah, but you have to understand the neck pain that he

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presented with was not something that he continued to complain about. You know, if somebody has neck pain related to a significant trauma, in my experience at a Level I trauma center at UCLA, Johns Hopkins, and in the military, these individuals have continuous pain complaints every single day, and they will show up the following week.

I mean, he showed up on multiple visits between then and October and had no neck pain. And, actually, if you look at the physical exam, the range of motion of the neck was full without any pain. So just because he had it on the first day, obviously, doesn't mean that he had significant pain later on.

Q Well, that's a significant basis for your opinions in this case, isn't it, that there wasn't neck pain from May to October of 2005 documented in the records?

A It's not a significant basis. It's a portion of the basis of my opinions. I have other opinions. The MRI's actually being normal, reported as normal on subsequent MRI's after the first one. The fact that Mr. Simao had no improvement with his surgery for his neck condition, and the fact that he's been complaining of headaches, not neck pain, for consistently the last four years, five years.

Q Are you saying that the records suggest that he hasn't been complaining of neck pain over the last four or five years?

A No, but what I'm saying is that the consistency of his complaints appear to be related to a headache condition. The

other factor being -- and Dr. Arita has already established this -- that there may be no basis for his pain complaints. He doesn't understand where the pain is coming from. The MRI's are appearing normal. The discograms don't seem to make a concordance sense. And Dr. Seibel and Dr. Arita both seem to think that there may be no trauma that can explain the pain that he has -- or I'm sorry -- no pathology that can explain the pain that he has.

Q So if he had, hypothetically, constant pain complaints in his neck from May to October of 2005, you're saying that wouldn't change your opinions in this case?

A That's not what I'm saying. What I'm saying --

Q Does it change your opinion?

A No.

Q The hypothetical?

A No, it wouldn't change my opinions. You know, the MRI's are normal. It doesn't explain his symptoms. It may show a degenerative condition which is pre-existing, but his complaints based on the records show that it's a headache that he was complaining of, not neck pain, and the exam showed a normal neck examination so I don't see how hypothetical can fit in this case.

Q Okay. In your practice, do you ever see patients who have multiple injuries or issues going on, issues of primary and secondary pain?

A Yes.

Q Have you ever seen it when the main focus of a pain generator is addressed and treated and all of a sudden the secondary pain generator becomes apparently where it hadn't been thought of as symptomatic previously?

A I mean, we talk about that. I think as practitioners we like to focus on one problem and try to solve it to go to the next one, but I don't believe that. You know, if you're going to have significant trauma, and it happens to a significant portion of your body, you're going to complain of all of those things, not just focus and pick and choose. So if it's significant enough, you're going to complain of all the issues, not just the one and forget the other.

Q Do you remember testifying a little bit contrary to that previously in a deposition?

A Well, it depends on the case, you know. I think that the issue may be that that case presented that the person was having significant issues in one area and may not have thought about the other areas, so it's a case-by-case basis. It's not that it's unheard of, but, you know, it's something that you got to consider when you're looking at all the facts in the case in general.

Q In fact, you previously testified that -- and I quote -- "A lot of times in the patient population that I see, the main focus of the pain generator, once that's taken away, all of

a sudden you kind of see the forest from the trees, you know, and so things kind of open up and you start seeing the other areas that you haven't -- haven't been noticed before." And then you go on to say, "Yeah, there's a primary and a secondary pain." Do you recall testifying to that?

A Which case?

Q I believe it was the Gilbert case.

A I don't remember. When was it?

Q I believe 2007, and it was referenced again in a Schultz case in June of last year.

A I think you have to look at the context of the question. There's definitely issues like that. I'm not saying that Mr. Simao couldn't have that as well. What I'm saying is it depends on the case by case and what the question was. I mean, you can pull out any quote you want, but unless you show the flow of that questioning, I don't really understand the relevance of your question.

Q Well, ultimately, is it your opinion that he doesn't have neck pain or that he doesn't have neck pain that was caused by the motor vehicle accident in April of 2005?

A My opinion is that he does not have neck pain that's significant from the accident itself, and that he may have presented on the first day with neck pain, but that had resolved within the first two weeks. The MRI's are completely normal in follow-ups, and you cannot relate any of the cervical spine

15:14:27 1 pathology since there is none to any of the accident which is
15:14:30 2 why I decided to call this a non-specific muscle pain that had
15:14:36 3 resolved.
15:14:38 4 Q You had in your earlier reports in this case discussed
15:14:43 5 a whiplash injury, and you had indicated that you're abandoning
15:14:48 6 that theory; is that correct?
15:14:50 7 A Yeah. You have to look at all the records in general,
15:14:52 8 and based on that and based on Dr. Arita's testimony as well as
15:14:57 9 Dr. Seibel's testimony of possibly a secondary gain and possibly
15:15:01 10 not finding the source of the pain, that there has to be some
15:15:05 11 questions as to whether or not there was truly an injury to the
15:15:09 12 neck significant enough to warrant surgery.
15:15:12 13 Q Well, I'm not asking if you relate any whiplash injury
15:15:19 14 to the surgery.
15:15:20 15 I'm saying: Did he suffer, in your expert opinion, a
15:15:24 16 whiplash injury at the time of the accident?
15:15:26 17 A No.
15:15:26 18 Q You reference in your reports a prior motorcycle
15:15:37 19 accident suffered by Mr. Simao; do you recall that?
15:15:40 20 A Yes
15:15:40 21 Q Do you know when it was?
15:15:44 22 A 2005.
15:15:45 23 Q The motorcycle was 2005?
15:15:49 24 A Oh, I'm sorry. I think it was the year before, 2004.
15:15:54 25 Q Are you aware of any facts surrounding the accident?

15:15:56 1 A Not other than what he had said to his providers.
15:16:02 2 Q Have you reviewed any records of any medical treatment
15:16:05 3 as a result of that particular accident?
15:16:07 4 A No.
15:16:07 5 Q It's your opinion that any treatment after the end of
15:16:18 6 May of 2005 is not related to the motor vehicle accident; is
15:16:21 7 that right?
15:16:21 8 A Correct.
15:16:22 9 Q You go on to criticize treatment that Mr. Simao
15:16:28 10 received for cervical issues in 2006 and beyond; is that right?
15:16:37 11 A Well, I'm asked to give an opinion on those treatments
15:16:40 12 and whether or not they are treatments that I would consider
15:16:44 13 performing and so -- I was also asked whether or not they were
15:16:48 14 reasonable, necessary, and related to the accident, so I made
15:16:52 15 opinions on them.
15:16:53 16 Q Once you determined that nothing after May of 2005 is
15:16:57 17 related to the motor vehicle accident, you went on to state
15:17:02 18 whether you thought treatment in 2006 and beyond was reasonable
15:17:07 19 and necessary?
15:17:09 20 A As it relates to the accident.
15:17:12 21 Q But you've already determined that it wasn't related to
15:17:16 22 the accident.
15:17:17 23 My question is: Taking out any question of causal
15:17:21 24 relationship, if you already determined that nothing beyond
15:17:26 25 May 2005 is related to the accident, why is it necessary to

15:17:30 1 render an opinion as to whether the subsequent treatment was
15:17:34 2 reasonable and necessary?
15:17:35 3 A Because I'm sure you're going to ask me about it
15:17:39 4 Q And so that's why you rendered the opinion?
15:17:43 5 A Well, I mean, I'm asked to give an opinion on the
15:17:45 6 records, I'm asked to give an opinion on the procedures so --
15:17:50 7 I'm asked to give an opinion, so I gave an opinion.
15:17:53 8 Q The MRI from March of 2006, you have reviewed both the
15:17:58 9 report and the film; is that right?
15:18:02 10 A That is correct.
15:18:03 11 Q And do you agree that it showed a mild narrow left
15:18:09 12 neural foramina at C3 and C4?
15:18:13 13 A No, I don't.
15:18:14 14 Q Do you agree that it showed a small central disc
15:18:18 15 protrusion at C4 and 5?
15:18:21 16 A No, I don't.
15:18:22 17 Q If Dr. McNulty had -- well, assume that he disagreed
15:18:38 18 with you, would you agree that it was appropriate to send the
15:18:41 19 plaintiff for pain management treatment at that point?
15:18:47 20 A Well, you know, it's always appropriate to send someone
15:18:50 21 to pain management because I don't think there was a surgical
15:18:53 22 issue. So if the individual is -- if you're trying to figure
15:18:57 23 out where the source of the pain is coming from, you're going to
15:19:00 24 want to try to determine that on a more concrete basis as
15:19:05 25 opposed to trying to solidify and fix a disc, and so I think it

15:19:09 1 was definitely reasonable for Dr. McNulty to pass him on to
15:19:14 2 someone else for a second opinion and maybe even an evaluation
15:19:19 3 to determine where the source of the pain is coming from.
15:19:19 4 Q Do you agree that by the time Dr. McNulty saw Mr. Simao
15:19:23 5 again in September of 2007, that there was evidence of a pain
15:19:27 6 generator at C3-4 and/or C4-5?
15:19:31 7 A No, I don't agree with that.
15:19:35 8 Q Do you believe it was appropriate for Dr. McNulty to
15:19:39 9 order a new MRI in September of 2007?
15:19:43 10 A Appropriate, because he's trying to further determine
15:19:47 11 what's going on, sure. I mean, I don't think that that's
15:19:50 12 unreasonable for him to make a decision because he was confused.
15:19:54 13 There was no real good source for the pain, and yet he was still
15:19:58 14 complaining of pain, and Dr. McNulty's a spine surgeon so he
15:20:01 15 wants to try and fix the spine. Whether it's relevant and
15:20:05 16 related to the motor vehicle accident, no, it's not.
15:20:08 17 Q The September 2007 MRI, you reviewed both the report
15:20:14 18 and the film?
15:20:16 19 A Yes. I have it right here on my computer.
15:20:19 20 Q Do you see any differences between that and the
15:20:22 21 March 2006 MRI?
15:20:26 22 A You know, in general, it looks like it's improved which
15:20:42 23 is what happened in 2008 in August. It was reported as normal.
15:20:46 24 I mean, it looks like a very normal MRI for age
15:20:51 25 appropriateness.

15:20:51 1 Q I'm just asking you about September 2007 as compared to
15:20:56 2 March 2006, you're saying there's an improvement between those
15:20:59 3 two?
15:21:00 4 A Well, in my mind, it looks like it's about the same. I
15:21:04 5 mean, I don't know if you can really quantify it as improved,
15:21:07 6 but it's still considered, to me, to be an age-appropriate,
15:21:11 7 normal MRI.
15:21:13 8 Q Dr. McNulty testified in his deposition that it showed
15:21:17 9 the same findings, the September of 2007 one as the March 2006
15:21:2510 one. You may disagree with the findings, but do you disagree
15:21:2911 that they are essentially the same?
15:21:3112 A My feeling is that they're essentially the same
15:21:3913 Q All right. Following that MRI, Dr. McNulty either did
15:21:5114 or ordered a left C3-4 and C4-5 transforaminal epidural
15:21:5815 injections. Do you agree or disagree with that process to
15:22:0116 determine the pain generator?
15:22:0317 A I disagree. I don't think it's necessary to perform
15:22:0618 those injections. He wasn't having pain in that distribution
15:22:0919 pattern, and when it was done, he didn't have any improvement
15:22:1320 either, so it was --
15:22:1521 Q Actually -- I'm sorry
15:22:1722 A Well, again, that's the problem with the reports of
15:22:2123 pain. You know, you're going by a subjective report. Mr. Simao
15:22:2624 said he felt better, but obviously he didn't because he was
15:22:3025 still having symptoms afterwards.

15:22:33 1 Q He reported 80 percent relief. You think that that's
15:22:39 2 placebo or what do you think?
15:22:40 3 A Well, I don't know. That's the problem. I mean, it
15:22:43 4 could be placebo. It also could be that we're just not clear
15:22:46 5 because the pain generator has not really been established, and
15:22:51 6 it appears to me that it was more related to a migraine headache
15:22:56 7 cause.
15:22:59 8 Q In your Addendum No. 4 you state that "I agree with
15:23:10 9 Dr. Arita that cervical spine surgery was not necessary based
15:23:1710 upon the images and Mr. Simao's pain complaints." Do you recall
15:23:2111 that?
15:23:2112 A Yes.
15:23:2213 Q You understand that Dr. Arita didn't have any records
15:23:2714 post-June of 2007 and never saw Mr. Simao after June of 2007; is
15:23:3615 that right?
15:23:3616 A I don't know. You'd have to ask Dr. Arita.
15:23:4417 Q Well, we did.
15:23:5118 A So --
15:23:5319 Q Is that -- the period of time we already established
15:23:5720 from you is that that was the period of time that you believe
15:24:0021 Dr. Arita saw Mr. Simao; is that right?
15:24:0522 A Do you want to go over it again because I'm not sure I
15:24:0923 understand the dates.
15:24:1124 Q All right. Dr. Arita treated Mr. Simao roughly from
15:24:1825 October of 2006 until June of 2007; is that consistent with your

15:24:23 1 understanding?
15:24:23 2 A That's about right.
15:24:24 3 Q When do you understand that the surgery actually was
15:24:28 4 performed? Do you understand that the surgery was in the spring
15:25:46 5 of 2009?
15:25:48 6 A I'm looking. March 25th, 2009.
15:26:29 7 Q All right. So that would have been almost two years
15:26:33 8 after Dr. Arita stopped seeing Mr. Simao; is that right?
15:26:36 9 A Yes.
15:26:3710 Q There was a discography performed in this case in
15:26:4611 August of 2008 by Dr. Rossler. Are you aware of that?
15:26:4912 A Yes.
15:26:4913 Q Do you know Dr. Rossler?
15:26:5214 A No.
15:26:5215 Q Did you review his records?
15:26:5516 A Yes.
15:26:5517 Q Did you review his deposition?
15:26:5818 A Did I list it?
15:27:0419 Q You read it to me today. You listed it when you read
15:27:0720 off a list of things that you received within the last two
15:27:1021 weeks.
15:27:1122 A Well, if I read it and I listed it off, then yes, I
15:27:1623 reviewed it.
15:27:1624 Q It's not listed in any of your reports. It's just what
15:27:1925 you told me today.

15:27:20 1 A That's what I'm saying. That's why I got the list so I
15:27:25 2 could expound with you.
15:27:26 3 Q During a discography procedure, it's generally blind to
15:27:32 4 the patient; is that right?
15:27:34 5 A The level that's being tested is blind, yes.
15:27:37 6 Q Any reason that you would conclude that Dr. Rossler
15:27:41 7 would tell Mr. Simao what levels he's injecting?
15:27:44 8 A No, I have no reason to believe that.
15:27:47 9 Q And the result, according to Dr. Rossler, was positive
15:27:5210 at C3-4 and C4 and 5; is that your understanding?
15:27:5611 A Based on the report, yes.
15:27:5812 Q Do you have any reason to believe that the procedure
15:28:0113 was not properly performed?
15:28:0214 A No.
15:28:0315 Q Any reason to believe that it was a false positive?
15:28:0816 A Yes, I do have reason to believe that.
15:28:1117 Q And what is that reason?
15:28:1318 A He has a normal MRI. Normal discs do not usually give
15:28:1919 pain that are considered pathological. A disc that has pain
15:28:2720 that's a normal appearance on an MRI is not a disc that you want
15:28:3121 to replace or do surgery for, so that would be considered a
15:28:3422 positive control, so if you think it's positive and you do
15:28:3923 surgery and it doesn't help him, which it didn't, then it's
15:28:4324 considered a false positive.
15:28:4625 Q So since -- let me just make sure I understand this,

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and please correct me if I'm wrong. Since you view the MRI to be normal, and the discogram was positive for C3 and C4 – or C3-4 and C4-5, then you're rejecting the discogram and relying on the MRI and, therefore, the discogram must be a false positive?

A Almost. You're almost there. It's a little more complex than that. I think, as you know – I know you've probably read up on discograms in general and whether or not there's false positives, especially in cases of litigation and secondary gain, and cervical discograms are noted to be even more controversial and more considered to be false positives.

And you have to look at a lot of different factors. You have to look at the MRI. You have to look at the previous treatment. You have to look at the pain complaints. You have to look at where the patterns of pain travel. You have to look at the legitimacy of those complaints and what was previously treated as well as the discogram and the confines of that discogram and the MRI. So you're looking at a lot of different factors in conjunction with this. And based on what appears to be the pattern of pain for Mr. Simao as well as the disc appearance on the MRI, he was not a candidate for discograms to determine whether or not surgery was necessary or surgery would be done because he was never a surgical candidate for a cervical spine.

Q Which – what's a more valuable tool to see, for

instance, an annular tear in a disc, an MRI or something else?

A Well, annular tears can happen with any kind of degenerative component. Annular tears can be present and we have no pain component of it. How do you determine what's a more significant way of evaluating that annular tear? It's a very difficult question, and we have not really found a positive way of determining that.

Now, you can put contrast in a disc with discogram and do a CT myelogram and see a tear or fissure, but that still may not mean anything clinically. You could look at an MRI and see that on the MRI, and it still may not make sense. So I don't know if we have really great imaging components to say what is the best way of looking at it.

Q Well, an annular tear can exist and not show up on an MRI; is that correct or no?

A No, I don't believe that. I think you have to show something on an MRI. If the MRI's our gold standard, you know, you're hoping that you see something. And this idea of a microtear or a microscopic tear that is only seen by you placing a needle and shoving a bunch of fluid in there doesn't make much sense to me.

Q Well, if it's your conclusion that it was a false positive, but there's no reason to believe the procedure wasn't properly performed or that the equipment malfunctioned, then what would cause the false positive?

A Well, many factors. You know, I don't know if you've undergone a procedure or have actually seen a procedure, but they're not the funnest things to have done to you, and they are quite traumatic. You're placing a very long needle into the anterior part of your neck, and you're partly awake because you have to give a response. It's not a pleasant procedure by any means. And so just the sheer fact of placing the needle is a component of pain, and people may misinterpret that.

The fact that you're pressurizing a disc, and if it's not in the center of the disc and it's in the annulus or if it's not in the nucleus, but somewhere off to the side, there's a possibility that you get a false read, especially if you have a higher pressure. The pressure component of that disc – I wasn't there, so I can't tell you exactly, but if you look at it – performing a disc, some of the times these discs are positive for individuals, and we don't exactly know why they're positive, but they can be, and the MRI is completely normal. That definitely confuses you. So if you're seeing a positive disc with an MRI that appears to be normal, you've got to conclude that it's potentially a false positive disc

Not only that, but you also have the psychological components that need to be addressed, the secondary gain, the components of where the pain is located, and where does the pain travel? You know, are you saying that the disc is painful because it's painful or are you saying that it's concordant with

the pain of where you normally have pain on a day-to-day basis? That can also give you a false positive.

Q So is it your testimony and your opinion to a reasonable degree of medical probability that the discography in August of 2008 rendered a false positive?

A Yes.

Q And you obviously disagree with Dr. Rossler on that; is that right?

A Well, he called it positive, so I guess I disagree.

Q And do you believe that under Propofol, that Mr. Simao gave a response to a blind discogram that rendered the false positive?

A Well, I think that's also a component. I didn't even address that, but yes. I mean, if the person's out, and they're on Propofol, and they can't really think clearly, and they don't remember the treatment at all, absolutely anything can cause pain. You could just pinch their skin on the side and that could cause pain, so that's another component that I had not brought up, but thank you for bringing that up.

Q Well, what do you use when you perform that? Do you use Propofol? Do you use Versed? What do you use?

A Yeah, we use – you know, we try to make the patient as comfortable as possible. I've done it without any sedation, and we've gotten through it. You know, patients have to be able to tolerate this procedure. We can give a little Fentanyl to make

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15:35:14 1 sure they're somewhat comfortable, and then we give a little bit
15:35:18 2 of Versed to again make them relax. The way I perform these
15:35:22 3 tests is that I tell them up front that this is not going to be
15:35:26 4 a fun test to perform, and there's going to be some pain aspect
15:35:28 5 to it, but I need you fully awake so you can participate with
15:35:30 6 me. When you knock somebody out with Propofol and then try to
15:35:33 7 wake them up, it's a harder test.
15:35:37 8 Q Dr. Rossler testified in his deposition that the
15:35:41 9 procedure he used followed the guidelines from ISIS. Do you
15:35:46 10 agree with that or disagree?
15:35:49 11 A I have no reason to disagree that he didn't follow a
15:35:52 12 guideline, but like any guideline, it's a guide I mean, it's
15:35:55 13 not the standard of care. It's not the way that everyone does
15:35:59 14 it. Everyone has a little different component of performing a
15:36:03 15 discogram
15:36:07 16 Q In your fourth addendum, Addendum No. 4 which is
15:36:13 17 Exhibit 8 – and I understand this was commenting on the life
15:36:23 18 care plan, but you wrote on Page 4: "To a medical probability,
15:36:31 19 injections were not necessary based on the motor vehicle
15:36:34 20 accident. The injections that were done did not resolve his
15:36:38 21 pain and did not confirm cervical involvement."
15:36:44 22 Is it your position – setting aside the issue of
15:36:49 23 whether it's related to the accident, is it your position that
15:36:53 24 all of the injections that Mr. Simao has undergone were
15:37:01 25 unnecessary?

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15:37:03 1 A Well, it's hard for me to make a blanket statement like
15:37:07 2 that. I guess what I was saying is that I didn't feel, based on
15:37:13 3 his pattern of his pain, that he needed to have selective nerve
15:37:19 4 root block and facet injections as well as facet rhizotomies.
15:37:24 5 His pain was obviously related to his migraine headaches in my
15:37:28 6 opinion.
15:37:28 7 Now, I'm not faulting Dr. Arita, but based on the –
15:37:30 8 and you told me not to base it on the accident, but I don't
15:37:33 9 think I would have done those procedures. I don't think they
15:37:36 10 would have really determined anything because the MRI was
15:37:38 11 appearing normal, so you're not going to get these kind of need
15:37:43 12 for an injection based on a normal appearing MRI and the pattern
15:37:48 13 of pain that he described.
15:37:50 14 Q So is that yes, you believed that the injections were
15:37:54 15 unnecessary?
15:37:55 16 A Again, I didn't want to make a blanket statement so I
15:37:58 17 tried to clarify that.
15:38:00 18 Q Well, you did make a blanket statement in your report.
15:38:04 19 That's why I'm asking.
15:38:05 20 A Well, I'm trying to hone it in on today's visit.
15:38:11 21 Q So is it yes, they were necessary; or no, they were
15:38:14 22 unnecessary – strike that. Wait a minute. Let me – I think I
15:38:18 23 just gave you a heads I win, tails you lose.
15:38:21 24 Is it your testimony that the injections were necessary
15:38:27 25 or unnecessary setting aside the issue of causation?

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15:38:31 1 A Hey, is Rogers there?
15:38:37 2 MR. STEPHENS: Are you soliciting an objection?
15:38:41 3 THE WITNESS: Well, I mean, he corrected himself, so I
15:38:44 4 thought you might have at least known what he was saying.
15:39:01 5 THE WITNESS: Can you read the question back?
15:39:01 6 (The record was read by the reporter.)
15:39:04 7 THE WITNESS: Yeah, I don't think the injections were
15:39:06 8 necessary based on his pain complaints and based on what I saw
15:39:09 9 from the MRI, so no, it's not necessary.
15:39:13 10 BY MR. WALL:
15:39:13 11 Q Is it your opinion that none of the injections
15:39:18 12 confirmed cervical involvement?
15:39:22 13 A Yeah, I don't think any of the injections actually gave
15:39:25 14 him the relief that we're looking for to determine the source of
15:39:29 15 the pain, and I think that's why all the doctors were ordering
15:39:33 16 so many MRI's trying to figure out what was going on. I think
15:39:37 17 Dr. Arita was scratching his head trying to figure out why he
15:39:39 18 wasn't getting any better and why he wasn't improving.
15:39:39 19 Dr. Seibel is pretty much doing the same thing now. And
15:39:43 20 Dr. McNulty did surgery, and he's still not better and still has
15:39:48 21 pain. So I don't think the actual generator has been found
15:39:53 22 within the cervical spine. It's somewhere else.
15:39:56 23 Q All right. Do you believe that the surgery performed
15:40:00 24 was unnecessary?
15:40:00 25 A I don't want to say that it was unnecessary. I think

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15:40:03 1 it was unreasonable. It didn't make sense based on the MRI.
15:40:08 2 Q If you used the word "unnecessary" in your report, are
15:40:16 3 you changing that opinion?
15:40:16 4 A You know, you guys have your lawyer thing about it, so
15:40:22 5 yes, I'll stick with what's in my report.
15:40:26 6 Q Do you believe the treatment by Dr. McNulty fell below
15:40:37 7 the standard of care?
15:40:38 8 A I was never asked to look at standard care. I have no
15:40:41 9 comments to make on standard of care so –
15:40:44 10 Q Would an unnecessary surgery be below the standard of
15:40:48 11 care?
15:40:48 12 A I was not asked to look at standard of care. I'm not
15:40:52 13 going to be able to comment on that question.
15:40:54 14 Q Well, do you have an opinion as to whether an
15:40:57 15 unnecessary surgery would be below the standard of care?
15:41:02 16 A I have no opinion on that topic.
15:41:04 17 Q You write in your – I guess I'm looking at Addendum 1
15:41:17 18 now. Is Addendum 1 still valid or have we sort of moved on to
15:41:23 19 something else? Are your conclusions – let me ask that a
15:41:26 20 better way.
15:41:27 21 Are your conclusions and statements in Addendum No. 1
15:41:31 22 still some of your opinions?
15:41:34 23 A We can go through them if you want.
15:41:39 24 Q You write on Page 8: "The lack of response by the
15:41:44 25 procedures done with Dr. Arita calls into question why the

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injections done by the spine surgeon, Dr. McNulty, were more successful."

Let me break that down. Is it your belief that the selective nerve root blocks done by Dr. Arita in October of 2006 evidenced a lack of response?

A Well, I think there's just inconsistencies with his response, and that's kind of the point of what I was saying is that how come you can have a good response with one provider and not with the other. I mean, you should be consistent. You know, you want to do a procedure by anybody and have the same result. Since you didn't get good success with these things, and then all of a sudden you get to another provider and you have good success, it doesn't make much sense. Plus, if you inject in different areas by one provider and you get results, and by another provider you don't, it just calls into question the inaccuracies and the inconsistencies of reporting by Mr. Simao.

Q So if Dr. Arita testified that there was a 50 to 75 percent improvement according to Mr. Simao from the selective nerve root blocks in October of 2006, what conclusion might you reach from that particular fact?

A I don't know. That's the problem. I don't think I can make one.

Q Well, would it be the lack of response by the procedure done by Dr. Arita? There was a response, and a positive

response, wasn't there?

A Well, that's what's reported, but I think it's inconsistent, you know. I mean, from the pattern of pain that he described, the response that was the response, it confuses me. It doesn't make sense. The MRI being normal and having no compression of any nerves. I mean, you're blocking a nerve that you assume is being compressed somewhere, and the MRI is not showing any compression anywhere, so it's -- why is it getting better? You just don't know.

Q Dr. Arita also did on at least two occasions a pulse radio frequency in the end of 2006, spring of 2007; do you recall that?

A Yes.

Q And Mr. Simao reported a temporary reduction of pain for several months from each procedure; is that your understanding?

A From the records, yes.

Q Well, given those, why would you say that it was a lack of response by the procedures done by Dr. Arita?

A Maybe I just wasn't making myself clear. There was a lack of any long term response, any clinically significant response. And, you know, Mr. Simao is saying that he's better for a couple of months, but he's still not improved. He never made progressive improvement. And an MRI that actually shows improvement to where you have an MRI in August of 2008 being

normal -- that's not how it works. I mean, that's not how you typically see these kind of patients.

Patients who get worse have MRI findings. They have findings that are consistent with what you expect the pain to be, and this is not what you see in this case, and that's why it's confusing. I mean, even Dr. McNulty did a secondary set of discograms to see if he could further anesthetize the disc and make it better so in his mind he knew what was going on, but, you know, obviously, Mr. Simao didn't even get relief from the surgery either. Nothing was working, so then you have to call into question why is that, especially when you have a normal MRI.

Q Is it your opinion that the pulse radio frequency should work for a long period of time, longer than a few months?

A Yeah. The pulse radio frequency should work for anywhere between six months to twelve months. If you look at the literature, it can actually last up to twelve months so you're expecting a long term benefit from it.

Q There's a difference between the pulse radio frequency that Dr. Arita did and a rhizotomy, right?

A You know, the rhizotomy is going to be a radio frequency ablation, and so a rhizotomy can be a pulsed rhizotomy or a continuous heat rhizotomy. I mean, your question doesn't really make sense to me in terms of the difference between the two. They're still rhizotomies.

Q Well, if Mr. Rossler testified that the pulse radio frequency procedure that he performed he expected to normally last for two to three months, would you disagree with that or have some question about what procedure he actually performed?

A No, I'm not disagreeing. What I'm saying is if you look at the literature, and you look at the procedure itself, the expected results are going to be six to twelve months is what you're hoping for, especially when you're performing those procedures. If Dr. Rossler --

Q And --

A I'm sorry. I apologize. If Dr. Rossler felt it only lasted for three months, maybe that's his experience. I'm just going by what the literature shows.

Q In your report that is Addendum No. 1, Exhibit 7, you say that "there is a possibility of a placebo effect with all injections and a bias by the performing injectionist who eventually performs surgical spine surgery." Do you recall writing that?

A Yes.

Q Is that still your opinion today?

A Well, I mean, I think Dr. Arita put it very eloquently in his deposition, and he said that, you know, if you're going to be doing a surgery, you may want an independent person performing the injections so that they're not biased, because if you know that you're going to be doing the surgery at that site,

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15:48:04 1 and you're hoping to get some kind of positive response so you
15:48:09 2 can perform the surgery, there is a maybe unconscious bias that
15:48:14 3 can happen in that case.
15:48:15 4 Q So do you believe that there is a bias by Dr. McNulty
15:48:23 5 resulting in him either ignoring a placebo effect or creating
15:48:38 6 out of cold cloth the need for the surgery that he performed?
15:48:42 7 MR. STEPHENS: Objection. Compound. Go ahead, Doctor.
15:48:45 8 THE WITNESS: Yeah, you're going to have to rephrase it.
15:48:49 9 BY MR. WALL:
15:48:49 10 Q Is it your opinion to a reasonable degree of medical
15:48:53 11 probability that Dr. McNulty was biased and performed a surgery
15:49:00 12 that wasn't medically necessary?
15:49:04 13 MR. STEPHENS: Again, compound. Go ahead
15:49:06 14 THE WITNESS: You're going to have to be more specific.
15:49:11 15 He's done many procedures. Which procedure are you talking
15:49:14 16 about?
15:49:14 17 BY MR. WALL:
15:49:14 18 Q All right. The one you wrote about when you said,
15:49:17 19 "There's a bias by the performing injectionist," tell me that
15:49:21 20 bias that Dr. McNulty had to a reasonable degree of medical
15:49:25 21 probability?
15:49:25 22 A Well, now I got to back up. Which procedure was I
15:49:29 23 talking about because he had performed multiple procedures? Are
15:49:32 24 we talking about the discogram? Are we talking about the
15:49:35 25 surgery? What exactly are we talking about?

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15:49:38 1 Q You wrote: "The lack of response by the procedures
15:49:40 2 done by Dr. Arita calls into question why the injections done by
15:49:45 3 the spine surgeon, Dr. McNulty, were more successful. There is
15:49:50 4 a possibility of a placebo effect with all injections and a bias
15:49:54 5 by the performing injectionist who eventually performed cervical
15:50:00 6 spine surgery." Does that give you the context?
15:50:05 7 A Maybe, but now ask your question again? I'm not sure
15:50:09 8 what we're talking about.
15:50:10 9 Q Explain to me the bias that you see, to a reasonable
15:50:14 10 degree of medical probability, from Dr. McNulty?
15:50:17 11 A I thought I just did. I said that, you know, when
15:50:20 12 you're expecting a specific result, that you have an expectation
15:50:26 13 in your mind that this is where I'm going to be performing
15:50:30 14 surgery, so I hope this is where it works in terms of the pain,
15:50:33 15 so there's a possibility of a bias. That's what I'm saying.
15:50:39 16 You know, I'm bringing that up.
15:50:42 17 Q Well, is it your opinion to a reasonable degree of
15:50:44 18 medical probability, based on everything you've reviewed in this
15:50:48 19 case, that there was a bias on the part of Dr. McNulty when he
15:50:55 20 performed that surgery?
15:50:56 21 A Well, I think based on my statement, that's what I
15:50:59 22 said, that there's a possibility of a bias.
15:51:02 23 Q And you described it previously as -- I don't remember
15:51:06 24 if you said "unconscious" or "subconscious", but do you believe
15:51:10 25 that it's a conscious bias on the part of Dr. McNulty or not?

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15:51:15 1 A I don't know. I'm just bringing it up.
15:51:18 2 Q You write one sentence later that "Dr. McNulty chose to
15:51:24 3 perform a surgery with very limited chance of success." Is that
15:51:29 4 also a result of the bias that you discuss?
15:51:34 5 A I don't know. It's hard to know. I mean, that's the
15:51:36 6 confusing part with the case. I mean, Dr. McNulty had a normal
15:51:41 7 appearing MRI, and he obviously had the patient in his office,
15:51:44 8 and he was trying to do something proactive for him. I just
15:51:47 9 don't think you're going to have success with that kind of
15:51:51 10 surgery. And low and behold, you didn't. He didn't get any
15:51:56 11 better, especially when he's complaining of these migraine
15:51:59 12 headaches. That's really where his complaint was. He didn't
15:51:59 13 really have a pattern of neck pain complaints.
15:52:01 14 You know, again, we go back to the original thing that
15:52:04 15 you had said to me earlier which is that if everything after May
15:52:08 16 of 2005 is not related to the accident, then why am I even
15:52:13 17 giving an opinion anyway? And my response is exactly as before,
15:52:15 18 because I knew you were going to ask me about it.
15:52:18 19 Q Do you believe that choosing to perform a surgery with
15:52:24 20 a limited chance of success is below the standard of care?
15:52:29 21 A I think I've already told you that I've not got an
15:52:32 22 opinion on that. I was not asked to review the standard of
15:52:35 23 care.
15:52:35 24 Q Do you believe that you're qualified to give an opinion
15:52:38 25 on the necessity of spine surgery?

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15:52:42 1 A Yes.
15:52:42 2 Q More so than a spine surgeon?
15:52:46 3 A I don't know if more so, but I'm qualified to give an
15:52:51 4 opinion because I see a lot of patients that come through my
15:52:55 5 door who either had surgery, will have surgery, need surgery,
15:52:59 6 want surgery, don't want surgery, or are not candidates for
15:53:01 7 surgery, and I make that decision every day.
15:53:03 8 Q Now, your original report talked about myofascial pain?
15:53:09 9 A Right.
15:53:10 10 Q Define that for me?
15:53:13 11 A Well, I mean, that's just it. You're describing a
15:53:17 12 muscle in the connective tissue surrounding the muscle or where
15:53:23 13 the muscle connects as the source of the pain.
15:53:23 14 Q Do you --
15:53:26 15 A I hate to cut you off. So we only have fifteen more
15:53:30 16 minutes. I mean, I know we started a little bit late, but we're
15:53:33 17 sticking to two hours?
15:53:35 18 Q Myofascial pain doesn't appear in your No. 1 and
15:53:42 19 No. 4 Addendum. Is that a change in your opinion?
15:53:46 20 A What do you mean "doesn't appear", appear where?
15:53:51 21 Q It doesn't appear in your two subsequent reports as
15:53:55 22 being one of your opinions as to what Mr. Simao suffered from.
15:54:03 23 Do you believe now that he suffered -- well, what is your
15:54:04 24 opinion today?
15:54:06 25 A Well, as I said before, I thought it was -- I believe

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15:54:11 1 in medical probability that it's a non-specific myofascial pain.
15:54:14 2 It's just -- we don't know where it's coming from and that --
15:54:19 3 Q Is that --
15:54:20 4 A Say that again?
15:54:21 5 Q Is that non-specific myofascial pain from his
15:54:25 6 migraines?
15:54:26 7 A Well, I don't know. It's not quite clear. You know,
15:54:28 8 that's the problem. It's possible, in my mind, that it's coming
15:54:33 9 from his migraines, his pre-existing migraines. It's not quite
15:54:3710 clear where his pain's coming from, and I think that's the
15:54:4111 issue. You know, you've got questions from his treating
15:54:4312 providers, two of them, that call into question whether or not
15:54:4613 these are legitimate complaints so, you know, I'm not really
15:54:4914 sure where the pain is coming from. It doesn't make sense.
15:54:5215 But looking at the records from the initial six months,
15:54:5416 it's not a neck pain issue. Any treatment for his neck, any
15:54:5917 surgery, any injections, it's not from the car accident.
15:55:0218 Q What about his shoulder or trapezius?
15:55:0519 A Again, I don't think it's coming from the car accident.
15:55:0820 I mean, he was complaining -- he wasn't really complaining of
15:55:1121 that component at the time of the accident, and I just don't
15:55:1622 feel it's related to the accident, and I don't believe in
15:55:1923 medical probability that it is.
15:55:2124 Q And you believe that -- well, is it your opinion that
15:55:2525 he suffers from left shoulder or trapezial pain?

15:55:31 1 A Well, again, I think that's the problem. I'm not sure
15:55:33 2 what he suffers from. It's not quite clear. No one's been able
15:55:37 3 to clarify the actual pain generating source, so it's not clear.
15:55:43 4 Q You wrote in your report -- in fact, your initial
15:55:46 5 report, you refer to or reviewed surveillance video from, I
15:55:52 6 think, 2008; is that right?
15:55:54 7 A Yeah. You know, what I find interesting is that we
15:55:56 8 haven't brought that up, but he saw Dr. Kabins around that
15:56:00 9 timeframe, and Dr. Kabins was saying that he was at his wits end
15:56:0410 in terms of his pain, and yet on these video surveillance you
15:56:0611 see him moving his neck around with no pain behaviors
15:56:1012 whatsoever. It's a very inconsistent appearance based on the
15:56:1413 surveillance and based on what Dr. Kabins is noting.
15:56:1814 Q Mine is just a yes or no question. By the way, I don't
15:56:2115 think he ever saw Kabins, but if you want to produce a record
15:56:2316 for me, I'd appreciate that.
15:56:2517 A Oh, it wasn't Kabins? Maybe it was Grover. I
15:56:2918 apologize.
15:56:3019 Q The surveillance video, did you see any indication in
15:56:3320 the surveillance video of any pain Mr. Simao suffered in his
15:56:3721 neck or left shoulder?
15:56:5022 A It was Dr. Grover, not Dr. Kabins, I apologize.
15:56:5423 Q Did you hear my next question?
15:56:5824 A No. I was trying to figure out which surgeon I had
15:57:0025 talked about, and I misspoke, and I apologize. It was

15:57:02 1 Dr Grover, not Dr. Kabins.
15:57:05 2 Q Did you see in a surveillance video in 2008 any
15:57:08 3 indication of pain in Mr. Simao's neck on the left side or in
15:57:12 4 his left shoulder?
15:57:13 5 A No.
15:57:13 6 Q Never saw him wincing from pain from his left shoulder
15:57:21 7 area?
15:57:22 8 A No.
15:57:23 9 Q During the same period in time, that 2008, in your
15:57:2910 original report you were claiming that Mr. Simao had a variety
15:57:3411 of symptoms that weren't related to the motor vehicle accident,
15:57:3812 like myofascial pain, degenerative cervical spine disease, left
15:57:4313 shoulder subacromial bursitis, and migraines, is that right?
15:57:4814 A That's what I authored at the time, yes
15:57:5115 Q So has your opinion changed on those?
15:57:5516 A Well, now that I've got to see a better picture of the
15:57:5917 records and have a more broader scope of what's been going on
15:58:0418 since I've been preparing for this deposition, yeah, it's
15:58:0819 obviously changed. I mean, he has multiple pain complaints
15:58:0820 It's not quite clear where it's coming from, and none of these
15:58:1221 are related to the motor vehicle accident
15:58:1322 Q Is your opinion on the subacromial bursitis being the
15:58:1823 cause of his left shoulder pain, have you abandoned that
15:58:2224 conclusion?
15:58:2325 A Well, I mean, I'm trying to come up with a reason for

15:58:26 1 him to have the symptoms, but I don't think it's quite clear.
15:58:29 2 You know, I mean, what he displays on the videos, what he's
15:58:34 3 saying to his providers, it's just not clear, so I was trying to
15:58:34 4 come up with a diagnosis that makes sense.
15:58:38 5 But, you know, related to the motor vehicle accident
15:58:41 6 itself, I don't think he had any of these symptoms -- or any of
15:58:46 7 these diagnoses. Excuse me.
15:58:48 8 Q My question was have you abandoned or retreated from
15:58:55 9 your conclusion in your original report that he suffered from
15:59:0010 subacromial bursitis in his left shoulder?
15:59:0311 A Well, he may, so I don't know if I've abandoned it. He
15:59:0612 may, but it's not related to the motor vehicle accident.
15:59:0813 Q Do you believe or do you agree that there are
15:59:1114 degenerative changes in Mr. Simao's cervical spine?
15:59:1515 A Well, again, I think before I actually had a chance to
15:59:1916 see the reports -- I mean, Dr. Arita didn't really get a chance
15:59:2217 to see the films. He only went by reports. And now that I've
15:59:2618 actually seen the films, I disagree with that. I don't think he
15:59:2919 has degenerative changes. In fact, in 2008 of August, the MRI
15:59:3420 was reported as normal, so there aren't any degenerative
15:59:3721 changes.
15:59:3922 Q So you've reviewed the films, the MRI's from March of
15:59:4423 2006, September of 2007, and I want to say November of 2008, but
15:59:5024 I'm not sure of the exact date, and it's your testimony to a
15:59:5425 reasonable degree of medical probability that they do not show

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any degenerative changes in his cervical spine?
A Correct. There's an authored report on the very first film that there may be a change at the C2-3 level, but on the subsequent MRI's you can see that that actually improved, so it may be the technique of the MRI, a larger magnet. But the November -- or whatever the 2008 film -- I thought it was August, but if it's November of 2008, the film is normal. There is no degenerative change, so it may just be an incidental image variance on that first MRI.
Q So you disagree with any physician who has reviewed that and determined that there were degenerative changes in his cervical spine?
A I don't know if I disagree. My opinion is that there aren't any degenerative changes. If that's in disagreement, I guess, but I'm just telling you what I see personally.
Q All right. Are you aware of any record or any evidence that Mr. Simao suffered any cervical or neck pain prior to April 15th, 2005?
A Just from the reports of what he said to his providers. I don't think there's a record that I had been able to review.
Q Are you saying that he reported to a provider that he had left shoulder or neck pain prior to the accident?
A Well, he had that motorcycle accident, and he had a history of migraines, so he may have said to his providers that he may have had some symptoms in the shoulder, but I don't have

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a specific record.
Q Are you aware of any complaint that Mr. Simao made to any medical provider indicating that he had left shoulder or neck pain prior to April 15th, 2005?
A Not offhand.
Q Do you feel that it's appropriate for a patient to follow a doctor's advice?
A Well, that's what it is, it's a doctor's advice. It's a recommendation, and I think it's important for a patient to understand what those recommendations are and make an informed decision.
Q Are you aware of any evidence of Mr. Simao during the course of his treatment being noncompliant?
A Noncompliant in what way?
Q With his doctor's advice?
A Well, you know, the doctors may recommend certain things, and he may not have followed them. I don't know how to answer that question.
Q Well, are you aware of any instances where he was noncompliant?
A I don't think there's evidence of him being noncompliant, but there may be recommendations that he did not follow. In your strict definition of noncompliant, it may be noncompliant.
MR. WALL: I don't have any other questions.

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EXAMINATION
BY MR. STEPHENS:
Q Hello, Doc. I've got a few.
A Oh, great.
Q Dr. Seibel -- I may be --
MR. STEPHENS: Court Reporter, I may be mispronouncing it, Seibel. I believe it's S-i-e-b-e-l -- scratch that. S-e-i-b-e-l.
THE COURT REPORTER: Thank you.
BY MR. STEPHENS:
Q So let's start with the question. Dr. Seibel testified that in his opinion 50 percent relief from a diagnostic injection is not positive. Do you agree with that?
A That's a fair statement.
Q Okay. And you testified earlier in your deposition that you received films a week or two ago that in fact are cited in your July 13, 2010 report. If you look on Page 2 of that July 2010 report --
A Okay.
Q -- the first line reads, "Imaging and work up which I have personally reviewed the images."
A Okay.
Q Now, did you review those images when preparing this July 2010 report?
A Yes.

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Q Okay. I want to walk through the bases for your opinions.
A Hey, you know what, you look older on video.
Q You want to see the other guy instead?
A Yeah.
Q All right. Do the diagnostic films show evidence of neck trauma?
A No.
Q Can the MRI findings be characterized as normal given the plaintiff's age?
A Yes.
Q You were asked just a few moments ago by Mr. Wall whether there were any degenerative findings in the MRI's. Would it be fair to say that those MRI's show age appropriate degeneration for the plaintiff?
A They may be age appropriate, but if you look at subsequent films, you're seeing a more normal picture. So the reason why I'm saying there's no degeneration is because by definition, each film should get worse and worse and worse or degenerated, and the fact that you're seeing a normal appearing MRI two years after the accident, in my mind, looking at the entire thing, well, it might make a change on the first film in terms of a degenerative appearance -- it's not what you're seeing. It should be consistent all through. That's why I was saying that there's really no evidence of degeneration on these

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films
Q Well, there is a comment by the radiologist relating to C3-4 facet hypertrophy Is that a traumatically induced condition or a product of a degenerative process?
A Well, it's not in a traumatic condition, but you may have a large or hypertrophied facet because that may be genetically how that facet started to develop. It may not be a degenerative process. It could just be a larger facet.
Q Okay. Are there any findings in any of the MRI's or CT scans or X-rays that, to a medical probability, result only from a single traumatic event like a car accident?
A No.
Q In your medical opinion, would plaintiff's complaints to his provider be consistent with traumatic injury to the cervical spine?
A No.
Q Now, you commented a few times in today's deposition about your work at the emergency room at UCLA. Do they have a Level 1 trauma center there?
A Yes
Q Do you work in that trauma center?
A I'm not in the trauma center, but I've been asked to evaluate patients who come through the trauma center, and I have on occasion been asked to evaluate a patient who's in the trauma room or the ER

Q Okay. Where, other than UCLA, have you worked in a trauma center?
A Johns Hopkins and the U.S. military as an officer at the Army, U.S. Army.
Q Did you treat traumatically induced neck injuries in the trauma centers where you've worked?
A Yeah. I was stationed at the M.A.S.H during the Iraq -- I'm sorry -- not the Iraq. I'm glad I'm not there -- in the Bosnian conflict in '96. I was stationed in the forward M.A.S.H. component, and we had a lot of injuries that had occurred from trauma ranging anywhere -- believe it or not -- from basketball injuries to shell injuries, so there was a wide range of traumatic events that happened in this M.A.S.H..
Q Okay. And in your experience treating traumatically induced cervical injuries, you've observed or reached the opinions that the plaintiff's clinical presentation doesn't match a trauma presentation?
A Correct.
Q Okay
A Hey, we got to go.
Q Okay. Just give me one minute, Doctor. I'll go fast.
MR. STEPHENS: Court reporter, did he leave or go to the restroom?
THE WITNESS: There's another meeting here at 4:00, so we got to go.

BY MR. STEPHENS:
Q Okay. Let me just get through a couple of more points. What time is it right now?
A It's 4:10. We could probably sucker through another couple of minutes.
Q Okay. Then I'll move fast. Did the neck injections reveal traumatic injury?
A No, not at all.
Q Did the neck injections reveal a cause of the symptoms?
A No.
Q Is there a concern in the medical field about a surgeon doing neck injections and making surgical decisions on the injections?
A I don't know if it's in the medical -- well, I don't know how to answer that question. I just think that it's definitely a concern when you're performing injections to find a result when you're going to be doing surgery on that result
Q Is it medically probable that the plaintiff's pre-existing migraines were aggravated by the accident?
A I don't think so. The evidence doesn't seem to show that. I think it's just his pre-existing migraines. There's a normal MRI. There's no evidence of a CT scan showing any trauma. There was maybe a little bruising -- or I'm sorry -- a little pain in the back of his occiput, but there does not appear to be a laceration or a contra coup injury, so I don't

see how the migraines would have been worsened by the accident.
Q Okay. Next, take the vehicle photos out of the equation altogether, does it change your opinion in any way about the plaintiff's condition?
A No, uh-uh.
Q All right. Now, next, you were asked questions about the discogram, and the plaintiffs average report of pain was seven of ten, yet at the discogram the reproduction was logged as one of ten. Is that concordant?
A Well, you know, obviously, you have to ask the patient, "Is this like your normal everyday pain?" I actually use the word "concordant" because I want to make sure that that's what we're relying on in saying that that's your concordant and equivocal pain. So I'm not so concerned about the numbers, but it's hard for me to say that the numbers one, three, seven, or five, whether or not it's concordant. It's really asking them, "Hey, is this like your normal pain in terms of the pattern of where it goes and where it generates?"
Q All right. You mentioned earlier that you prepared a supplemental report -- I haven't yet seen it -- on a Hartman report. I believe you said it was dated sometime in 2010. There's been a more recent report. Will you prepare a reply to her most recent supplemental report?
A Are you asking me?
Q I am now.

16:13:02 A Yes, I'd be happy to.
16:13:04 Q And if the plaintiffs produce records additional
16:13:10 injections or any other treatment, will you prepare a reply to
16:13:13 that treatment?
16:13:14 A Yes.
16:13:14 Q Okay. Now, finally, the plaintiff testified he's been
16:13:22 referred to a hand specialist who diagnosed carpal tunnel
16:13:26 syndrome, and he's been referred to a shoulder specialist. Have
16:13:33 you been supplied with any of those records?
16:13:35 A This is the first I've heard of it.
16:13:38 Q All right. All of your opinions that you and I have
16:13:42 discussed have been given to a reasonable degree of medical
16:13:46 probability; correct?
16:13:46 A Yes.
16:13:46 Q Thank you, sir.
16:13:46
16:13:46 FURTHER EXAMINATION
16:13:46 BY MR. WALL:
16:13:49 Q Doctor, just a follow-up. I need about 60 seconds of
16:13:52 your time. Let me just kind of compartmentalize this. You
16:13:57 believe that the only pain that Mr. Simao suffered post-accident
16:14:03 – let's even say after June or July of 2005 – is the same
16:14:10 migraines that he had before the accident?
16:14:14 A Based on the pattern of that pain, I would say yes.
16:14:19 Q And so there is no pain generator at C3-4 or C4-5 in

16:14:27 your opinion?
16:14:28 A Correct.
16:14:28 Q And the auto accident didn't even exaggerate or
16:14:36 exacerbate his migraine pain passed maybe two months; is that
16:14:41 your testimony?
16:14:42 A I don't know if I would say two months, but, you know,
16:14:55 from May 26th, 2005, was the last time he was seen until
16:15:01 October. I mean, that's five months. It wouldn't be anything
16:15:07 – you know, he didn't have any other problems at that point
16:15:12 related to any headaches, so yeah, I don't think it caused
16:15:15 anything.
16:15:16 Q And he doesn't have any cervical condition that should
16:15:20 be causing him pain?
16:15:22 A Well, again, I think we discussed that. I mean, it's a
16:15:25 normal MRI. They're not sure where the pain's coming from.
16:15:29 It's just not clear, you know.
16:15:32 Q So the answer is there is no objective reason for him
16:15:39 to be having pain?
16:15:40 A I don't see any objective evidence. The injections
16:15:43 don't seem to be helping him, and the surgery didn't help, and
16:15:46 the MRI was normal, so I don't see an objective component of
16:15:50 where the pain is coming from. There's no pain generator
16:15:53 that's been determined at this point.
16:15:58 Q Okay. That's all I have.
16:15:59 MR. STEPHENS: All right, Doc. Thanks for giving us the

16:16:02 extra time.
16:16:03 THE WITNESS: No problem.
16:16:58 MR. STEPHENS: Mr. Court Reporter, do you have my
16:16:58 information?
16:16:58 THE COURT REPORTER: Yes. I got it off the caption from my
16:16:58 office.
16:16:59 MR. STEPHENS: I want a copy with E-trans.
16:18:41 (Discussion was held off the record.)
16:18:41 MR. WALL: Okay. We'll stipulate to the doctor waiving
16:18:47 signature.
16:18:50 MR. STEPHENS: That's fine.
16:18:50 (Plaintiff's Exhibit 2, 3, 4, 5, 6, 7, and 8 were
16:18:50 marked for identification by the Certified Shorthand Reporter, a
16:18:50 copy of which is attached hereto.)
16:18:50 (Whereupon, the deposition of DAVID E. FISH, M.D.
concluded at 4:18 p.m.)
(Declaration under penalty of perjury on the
following page hereof.)

***

I do solemnly declare under penalty of perjury that the foregoing is my deposition under oath; that these are the questions asked of me and my answers thereto; that I have read same and have made the necessary corrections, additions, or changes to my answers that I deem necessary.

In witness thereof, I hereby subscribe my name this_____ day of _____, 20_____.

_____
DAVID E. FISH, M.D.

CERTIFICATION
OF
CERTIFIED SHORTHAND REPORTER

I, the undersigned, a Certified Shorthand Reporter of the State of California do hereby certify.

That the foregoing proceedings were taken before me at the time and place herein set forth; that any witnesses in the foregoing proceedings, prior to testifying, were placed under oath; that a verbatim record of the proceedings was made by me using machine shorthand which was thereafter transcribed under my direction; further, that the foregoing is and accurate transcription thereof.

I further certify that I am neither financially interested in the action nor a relative or employee of any attorney of any of the parties.

IN WITNESS HEREOF, I have this date subscribed my name. Gideon Chen

Dated:_____

Certificate Number 13258

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EXHIBIT "3"

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Independent Record Review Addendum # 5

DATE OF REVIEW: February 9, 2011

RE: SIMAO, William

DATE OF INJURY: 04/15/2005

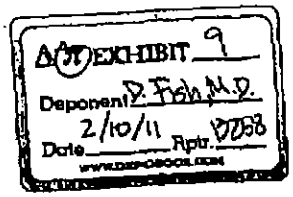
To Whom this May Concern:

I was asked by the law offices of Rogers, Mastrangelo, Carvalho and Mitchell to review the additional medical records and imaging of William Simao. I was also asked to give my opinions, based on these records, as to assessment of medical damages caused by the accident, causation, future care needs, necessity for treatment, and overall recommendations. All of my opinions below are based on a reasonable degree of medical probability.

I am currently full time faculty member at UCLA Medical Center. My position is Director of Physiatry and Interventional Pain Management at the UCLA Spine Center. I am board certified in Physiatry and Pain Management. I have provided by CV.

RECORDS REVIEWED:

1. Kathleen Hartmann, RN, BSN, CCM, CLCP Updated report 11/8/2010



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IMPRESSION AND DIAGNOSES:

Related to the motor vehicle accident of April 15, 2006:

1. Non specified myofascial pain, resolved.

Unrelated to the motor vehicle accident of April 15, 2006:

1. Migraine headaches.
2. Degenerative cervical spine disease.
3. Left shoulder subacromial bursitis.
4. Myofascial pain and muscle spasm.
5. Mandible Extraction Deformity.
6. Occipital Neuralgia.

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COMMENTARY AND MEDICAL DECISION MAKING:

I reviewed the updated LCP authored by Ms. Hartmann's on November 8, 2010 and this report addendum for Mr. Simao is only for evaluation purposes as there is no doctor patient relationship implied. Evaluation is consistent with history and previous physical examination by treating physicians. All records sent to me are reviewed for the purpose of a medical decision based upon the events of the current pain complaints. The opinions of this report are based upon examination of Mr. Simao and/or review of the medical records provided to me. All of my opinions have been rendered with a reasonable degree of medical probability but are preliminary to the extent that there is relevant information that I have not yet had the opportunity to review.

My opinions in regards to Mr. Simao are based upon my clinical experience as an active treating Physiatrist who specializes in Physiatry, Pain Medicine, and Electrodiagnostic Medicine. I am currently on staff at the UCLA School of Medicine in the UCLA Spine Center and the UCLA Medical Center. I am involved with resident and fellowship training of physicians at UCLA and must maintain updated and clinically relevant evidence-based guidelines for treatment of patients that fall within the standards of

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care. I would approach the patient as I would approach any patient with similar pain complaints as a treating physician. Based also upon my forensic review of the records, I made the following conclusions.

In summary, Mr. Simao was involved in a motor vehicle accident in which he was a restrained driver, struck from behind on April 15, 2005. The accident report noted moderate damage to the vehicles. Both were driven away. Mr. Simao was the only vehicle occupant who reported injury. He complained of headaches and neck pain. Four hours after the accident he went to the Urgent Care where he was given conservative treatment and ruled out for significant trauma. Mr. Simao had a significant history of headaches with treatment consistently for four years prior to the MVA of April 15, 2005. Post MVA, Mr. Simao did not pursue any aggressive treatment options from May 2005 to October 2005 and his care was sporadic and related to his pre-existing headaches. His first visit of May 5, 2005 to the Southwest Medical Associates had complaints of headache and no neck pain. The physical examination revealed a neck that had full range of motion as the assessment was a closed head injury and no mention of neck symptoms or pain. It was not until October 6, 2005 that his neck pain began to be an issue as he complained of shoulder pain radiating to his neck, for which he was again evaluated and underwent radiographs which were reported as normal for the cervical spine. It was not until December 12, 2005 that he was started on pain medications for neck pain assessed as a cervical strain and January 16, 2006 he began therapy for his neck, which was nine months post-MVA. It was noted on a routine follow up of May 6, 2005 that Mr. Simao was being seen only for headache complaints which was just before the CT of the BRAIN on 5/13/05 that revealed a normal unremarkable head CT. The subsequent MRI of the BRAIN on 5/23/05 was found to be a normal unremarkable MRI for age with no abnormal enhancing lesions.

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The updated life care plan (LCP) authored by Kathleen Hartmann indicates that Mr. Simao will need future medical care with a cervical spine surgery revision, therapy to accompany the surgery, and medications for the treatment of pain in the neck regions as well as additional trigger point injections, medial branch blocks, and/or transforaminal epidurals. She now notes that this will be required quarterly evaluations by Dr. Seibel for a lifetime based upon his pain complaints, increasing age, and work. It should also be noted that Mrs. Hartmann believes that therapist describe the need for 6 visits per year for a lifetime after fusion of the spine.

The LCP notes that a Dual King adjustable bed is needed for sleep improvement over 4 hours as suggested by Mr. Simao and that this bed would help with assistance for mobility and independence.

The new LCP further states that a complication can cause the need for additional surgery and a dorsal column stimulator

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As for the totals of costs when compared to her previous LCP the following is noted:

Projected evaluations is now $ 0.00

Future Medical Care Routine has been increased from $9,669.00 to $31,175.00
This is due to the quarterly visits with pain management, Dr. Seibel for a lifetime.

Future Surgical Care $249,677.00 to $427,560.00
This is due to a change in the trigger point, epidural and selective nerve root block injections from 2 in a lifetime to annual injection for 31 years of all three procedures. The visits to Dr. Seibel have been dramatically increased yearly.

Projected Modalities increased from $4,200.00 to $15,660.00
This is due to the PT visits being done annually instead of every other year need.

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Diagnostic and Laboratory needs increased from $12,096.00 to $18,565.00

Medication and Supply needs decreased from $96,068.00 to $6,754.00

A total LCP amount of $338,620 to $389,899 increased to projected $301,267 to $513,027

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SUMMARY OF NEW LCP AND OPINIONS:

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Based upon the new records and my previous opinions, the following are my opinions for Mr. Simao:

1. Mr. Simao had a significant history of headaches with treatment prior to the MVA of April 15, 2005. He had issues with headaches consistently for four years before the MVA in question. Post MVA, Mr. Simao did not pursue any aggressive treatment options from May 2005 to October 2005 for his neck and his care was sporadic and related to his pre-existing headaches. It was not until October 6, 2005 that his neck pain was advised to his health care providers and he did not start PT until January 16, 2006 that he began therapy for his neck, nine months post-MVA. The PT note at that initial visit indicated that his neck pain had been present for over six months and began after an MVA in April 2005. Furthermore, the Southwest Medical Associates progress note of December 21, 2005 indicated that his neck pain was worsening from two weeks prior or the beginning of December 2005. The LCP again has a discussion of surgery to the cervical spine but the symptoms of the cervical spine is clearly not related to the MVA of 4/15/05 as they began seven months to nine months after. I continue to disagree with the spinal injections, discograms, cervical spine surgical intervention, medications, home furnishings, and routine treatment. The treatment for the cervical spine after 5/6/2005 is not related to the MVA. The examination at SWMA had no pain in the neck with FULL RANGE OF MOTION on October 6, 2005 and therefore would be in medical probability a normal neck examination as the pain in the neck would be a referral pain from his chronic migraine headaches.

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2. Mrs. Hartmann again did not comment on the updated LCP that since the surgery to the cervical spine did not help his pain that the surgery was not a reasonable treatment for his cervical spine. She and Dr. Seibel have failed to realize and acknowledge that Mr. Simao has chronic headaches and the cervical spine surgery was not indicated for this diagnosis. Mrs. Hartmann has now indicated that even after surgery to the cervical spine, annual spine injections would be required and has increased the cost in her LCP erroneously. There is no evidence based medicine that would indicate the necessity and indications for yearly injections after surgery. Not only would this imply that the surgery did not work for the problem, but places undue risk to Mr. Simao for complications. Since Mr. Simao continues to complain of pain in his neck, shoulder, and head after both spine surgeries, it is with medical probability, the symptoms are not due to the April 15, 2005 MVA, but due to his chronic headaches. Treatment to the cervical spine is unrelated to the MVA, thus the LCP should not include such treatment.

3. The new LCP has indicated that Mr. Simao would need a life time of pain management with Dr. Seibel which is not related to the MVA, but would be related to his chronic headache condition. Any treatment to Mr. Simao after May 16, 2005 would be related to the pre-existing headaches and not to the MVA. Therefore any pain management that is being done in the LCP has no merritt for the cervical spine pain, but would be related to a pre-existing headache condition. The increase in future medical care routine is not reasonable, necessary, or related to the MVA of April 15, 2005.

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4. Mrs. Hartmann has indicated in the LCP that BOTH cervical epidurals (ESI) and selective nerve root blocks (SNRB) would be needed. What Mrs. Hartmann fails to realize is that these injections are exactly the same procedure and therefore would not be a separate entry or procedure. The difference between the SNRB and ESI is the placement of the needle location which is still in proximity to the neuroforamen of the cervical spine. Performance of both injections would not only be duplication, but unreasonable and unnecessary when treating cervical radiculopathy. The LCP should not include both of these procedures and would be used in this LCP only to increase value to the overall numbers and not have any medical merritt for use with treatment of any patient.

5. The projected modalities section has been quadrupled from $4,200.00 to $15,660.00 due to the PT visits being done annually instead of every other year in the original LCP. The use of this much PT each year is not only unrealistic and medically unreasonable, it would be considered medical fraud. PT is reserved for treatment of an acute process with defined goals. Using PT for a chronic condition not only defeats the purpose of spine surgery to cure the pain, but is unnecessary for treatment when a patient reaches a maximal medical status. The LCP indicating a lifetime of annual PT is done only to increase the value of the LCP and not with any reason for standard medical treatment.

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6. There is no cervical spine source for Mr. Simao's migraine headaches. He had a previous history of migraine headaches and a previous MVA. The cervical MRI in 2006 was reported to demonstrate C3-4 and C4-5 disc protrusions and other degenerative changes without compression effects on the C4 or C5 nerve roots. Two years later on 4/30/2008 the actual images that I reviewed were not significantly changed and show no pathology that can explain his complaints. There would be no reason to perform any more imaging as it relates to the MVA, nor is there a reason to perform a discogram between the first and second surgery. The LCP has indicated in the Diagnostic and Laboratory Needs that $15,077.00 is needed for a discogram to prepare for the second surgery after the first done on 03/25/09 by Dr. McNulty. I would not consider the first discogram done to be reasonable based upon the MVA and therefore any additional discograms or revision surgery to the cervical spine would be unnecessary based upon the April 15, 2005 MVA.

7. For home furnishings, Mrs. Hartmann has indicated that Mr. Simao requires a Dual King Adjustable Bed to help with change in position and comfort, independence in mobility transfers and safety. By this standard, every cervical spine surgery patient would need a Dual King Adjustable Bed and obviously this is not the norm or even considered a reasonable request. Mr. Simao, based upon the video Surveillance demonstrates that any injury from the MVA on April 15, 2005 recovered as there were no deficits of function or restrictions or limitations that can be seen three years after the MVA. On the video, Mr. Simao did not display any range of motion limitations, lifting precautions, or functional deficits consistent with a

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cervical spine problem that required any interventions or surgery. The LCP that continues to include a shower bench, hand held shower, front wheeled walker, cervical collar, and Dual King adjustable bed is unnecessary and unrelated to the MVA. Mr. Simao is obviously independent and safe so that he does not require an adjustable bed. The addition of this home furnishing is done merely to increase the value of the LCP and not medically relevant based on the facts.

8. The updated LCP has decreased accurately the need for Fiorinal with codine as this is treatment for chronic headaches which is what Mr. Simao is currently being treated for with pain management. The $90,000.00 projected cost for this medication was appropriately removed from the medication lists, but given that the Mrs. Hartmann and Dr. Seibel have failed to appropriately diagnose Mr. Simao's true pain complaints of chronic headache, this accurate omission is an indication that the headaches are the source of Mr. Simao's treatment needs and has nothing to do with the cervical spine.

9. Assuming the MVA caused a strain injury, the treatment before May 6, 2005 would be related to the MVA, but any treatment after this date would not be related to the MVA. Given the history of a previous MVA, his job description of a manual laborer, the reported delay in onset of pain, a previous history of migraine headaches, the MRI showing no traumatic pathology, and his lack of response to cervical spine surgery, any necessary treatment in relation to the MVA ended on May 6, 2005. All new and updated LCP references to future medical care would be unnecessary based upon the MVA. There is no indication that based upon the MVA, a dorsal column stimulator, cervical degenerative arthritis, and need for revision surgery to the cervical spine is necessary.

10. It is important to note that I have not seen any medical records from medical doctors for treatment that is included in her life care plan, such as hardware removal or adjacent segment disease.

David E. Fish, MD, MPH
Chief, Division of Interventional Pain Physiatry
Associate Professor, UCLA Department of Orthopaedic Surgery
Physical Medicine and Rehabilitation, UCLA Spine Center
Electrodiagnostic Medicine, Pain Medicine
David Geffen School of Medicine at UCLA

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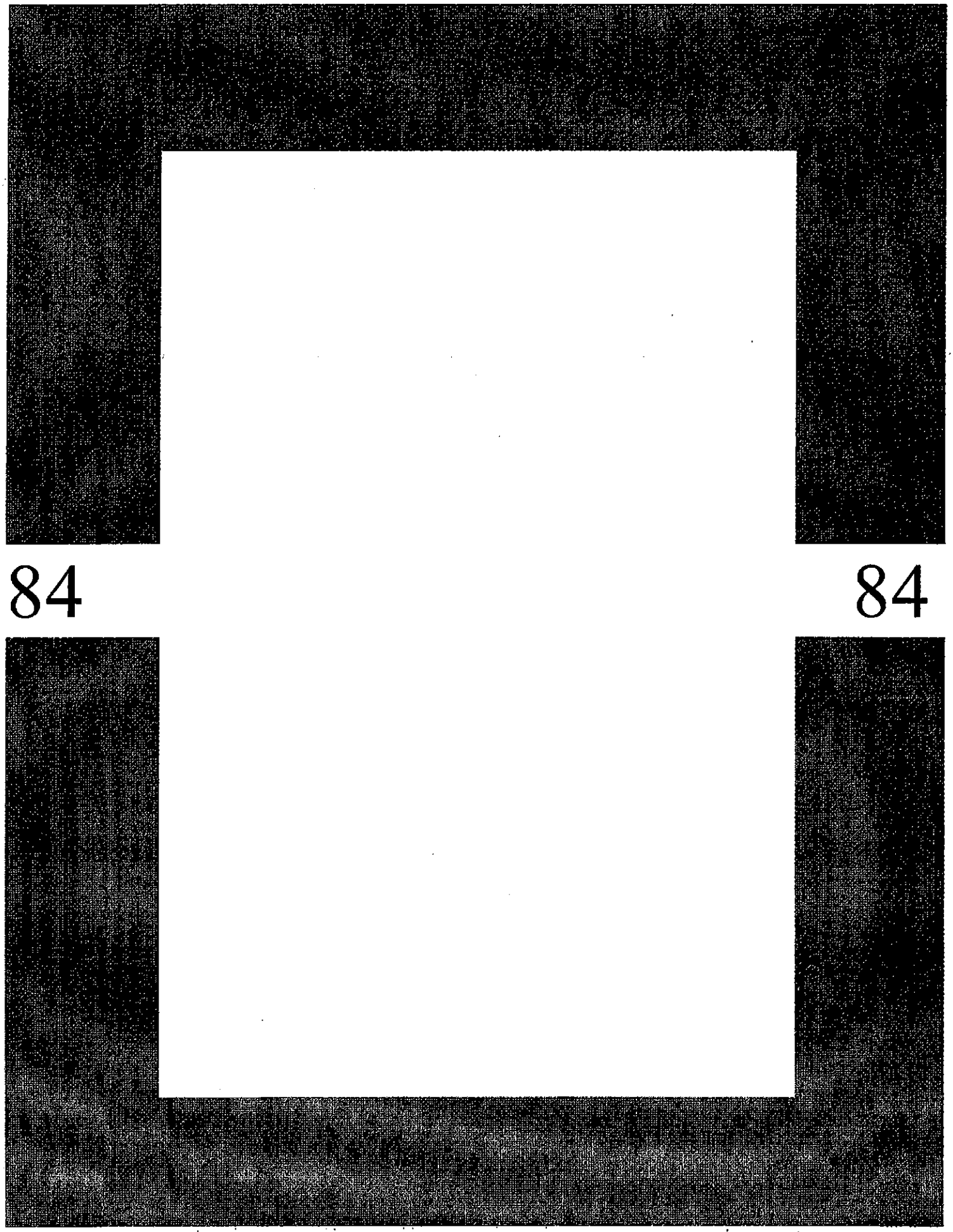

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DISTRICT COURT
CLARK COUNTY, NEVADA

WILLIAM JAY SIMAO, individually and CHERYL ANN SIMAO, individually, and as husband and wife, Plaintiffs, v. JENNY RISH; JAMES RISH; LINDA RISH; DOES I through V; and ROE CORPORATIONS I through V, inclusive, Defendants.	CASE NO.: A539455 DEPT. NO.: X **PLAINTIFFS' SECOND SUPPLEMENT TO THEIR CONFIDENTIAL TRIAL BRIEF TO PERMIT DR. GROVER TO TESTIFY WITH REGARD TO ALL ISSUES RAISED DURING HIS DEPOSITION**

This Trial Brief is served pursuant to Eighth Judicial District Court Rule 7.27 which specifically states:

> Unless otherwise ordered by the court, an attorney may elect to submit to the court in any civil case, a trial memorandum of points and authorities prior to the commencement of trial by delivering one unfiled copy to the court, without serving opposing counsel or filing the same, provided that the original trial memorandum of points and authorities must be filed and a copy must be served upon opposing counsel at or before the close of trial.

I.

ARGUMENT

A. Although Dr. Grover Was Named as an Expert, He Must Be Permitted To Testify Regarding All of the Issues that Were Raised During His deposition.

Jaswinder S. Grover, M.D., is an Orthopedic Spine Surgeon and one of Plaintiff, William Simao's, **treating physicians**. As a treating physician, Dr. Grover's testimony would normally be limited to his medical records and treatment together with any medical records and treatment of other physicians in which Dr. Grover relied on or utilized in providing treatment of Mr. Simao. The reason for this is that treating physicians typically do not review the entirety of Plaintiff's medical treatment. However, due to a bizarre move made by defense counsel during the discovery of this case, Dr. Grover's testimony must no longer be constrained to his own medical records and treatment.

On April 16, 2009, Dr. Grover was deposed by Stephen Rogers, Esq. (*See* Deposition of Dr. Grover, **Exhibit "1"**). The deposition transcript of Dr. Grover's deposition is comprised of fifty-two (52) pages. (*See Id.*). Of these fifty-two (52) pages, Mr. Rogers spends the first seven (7) pages going over Dr. Grover's background, and approximately thirty (30) pages questioning Dr. Grover regarding the medical treatment that he provided to William Simao.[1] (*See Id.*).

However, in a bizarre turn of events, defense counsel spent the remainder of the deposition questioning Dr. Grover about the opinions of Dr. Fish (defendant's medical expert).

[1] Importantly, at page 5, lines 22-25 thru 6, line 1-5, Dr. Grover testified that he was not an expert in this case but was simply a treating physician. **(Exhibit "1")**

Specifically, half was through his deposition, Dr. Grover was given and asked to read Dr. Fish's Expert Medical Report. (Expert Report of Dr. Fish, **Exhibit "2"**). Dr. Fish's report not only contained his opinions, but also contained a medical records review, summarizing **all** of Plaintiff's medical treatment. In other words, this report contained medical records and information that Dr. Grover had never seen before.

After reading Dr. Fish's report, Mr. Rogers extensively questioned Dr. Grover regarding the opinions contained therein. By doing so, Defense counsel transcended Dr. Grover from a treating physician to a medical expert. Under the unique circumstances that occurred during Dr. Grover's deposition, Dr. Grover must now be permitted to offer a full and complete opinion regarding Dr. Fish's expert report. Simply put, when Defense counsel asked Dr. Grover to interpret Dr. Fish's DME report, including all of the medical records summarized therein, Dr. Grover shed the limitations of his own medical records and treatment.[2] (*See* **Exhibit "1,"** at 37:6-51:13).

Certainly, the defense intends to cross-examine Dr. Grover at trial regarding the opinions set forth in his deposition. It would be patently unfair to Plaintiff, however, to allow the defense to question Dr. Grover regarding Dr. Fish's, or any of Defendant's experts' opinions, unless on direct examination Dr. Grover is permitted to testify regarding the same material relied upon by Dr. Fish.

In opposition, the defense will likely argue that Dr. Grover is simply a treating physician and not a retained medical expert, and as such should not be able to expand his testimony in areas outside of the medical treatment that he provided. Moreover, they may argue that they are being unfairly surprised at trial by the expanded opinions of Dr. Grover.[3] However, it would be

---

[2] Dr. Grover must be permitted to testify regarding each piece of information relied upon by Dr. Fish when Dr. Fish authored his report.

[3] Any anticipated argument made by the defense concerning surprise is unfounded since Defendant is well aware and has been on notice since Dr. Grover's deposition in April 2009, that Dr. Grover will be offering testimony at

improper to limit Dr. Grover to his status as a treating physician after the defense invited, and elicited critiques and opinions of him regarding Dr. Fish's report. This would, in essence, allow the defense to "have their cake and eat it too." Such a scenario would create substantial prejudice against Plaintiffs and preclude William from introducing to the jury the full breadth of the medical evidence that supports his claims for damages. In the interest of fair play, Dr. Grover must be allowed to testify regarding the same information relied upon by Dr. Fish, lest Dr. Grover's opinions are incomplete and the information shared with the jury lacking.

Accordingly, Plaintiffs request that Dr. Grover be permitted upon direct examination to testify fully and completely regarding the opinions set forth by Dr. Fish, including being allowed to testify regarding the same information reviewed and relied upon by Dr. Fish in the formulation of his opinions.

DATED this 24th day of March, 2011.

MAINOR EGLET

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trial regarding Dr. Fish's opinions.

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EXHIBIT "1"

DISTRICT COURT

CLARK COUNTY, NEVADA

* * * * *

WILLIAM JAY SIMAO, individually, and CHERYL ANN SIMAO, individually, and as husband and wife, Plaintiffs, vs. JENNY RISH; JAMES RISH; LINDA RISH; DOES I through V; and ROE CORPORATIONS 1 through V, inclusive, Defendants.	Case No. A539455 Dept. No. X

DEPOSITION OF JASWINDER S. GROVER, M.D.

Taken on Thursday, April 16, 2009
At 6:05 P.M.

At Nevada Spine Clinic
7140 Smoke Ranch Road
Las Vegas, Nevada

Reported by: CAMEO KAYSER, RPR, CCR No. 569

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APPEARANCES:

For the Plaintiffs:
JOHN E. PALERMO, ESQ.
Aaron & Paternoster, Ltd.
2300 West Sahara Avenue
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For the Defendants:
STEPHEN H. ROGERS, ESQ.
Rogers, Mastrangelo, Carvalho & Mitchell
300 South Fourth Street
Suite 710
Las Vegas, Nevada 89101

I N D E X

E X H I B I T S

****Exhibits B and C to be provided by Dr. Grover*****

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(Thereupon, Rule 30(b)(4) was waived prior to the commencement of the deposition proceedings.)

Thereupon --

JASWINDER S. GROVER, M.D.

was called as a witness by the Defendants, and having been first duly sworn, testified as follows:

EXAMINATION

BY MR. ROGERS:

Q. Would you state your name, please.

A. Jaswinder Grover.

Q. Let's start with some of the normal admonitions. You know, of course, having been deposed before, that the oath that you just took is the same oath you would take in court. It carries with it the obligation to tell the truth and penalties if you do not?

A. That is correct.

Q. Do you have a copy of your CV?

A. I do, yes.

Q. We will attach that as A. Do you have a testimony history with you?

A. Not with me, but my medical assistant can get that for you.

Q. We will attach that as B, and your file

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is in front of you?

A. Yes.

Q. We will attach that as C.

(Defendants' Exhibit A was marked for identification.)

(Defendants' Exhibits B and C were identified for the record.)

BY MR. ROGERS:

Q. Let's go over some of the broad strokes. Are you board certified?

A. Yes.

Q. And in what field?

A. Orthopedic surgery, and I'm also reboard certified in orthopedic surgery having been board certified for originally approximately ten years.

Q. Are you fellowship trained?

A. Yes. I'm fellowship trained in spinal cord injury and spinal reconstructive surgery.

Q. What did you do to prepare for this deposition?

A. Well, I took a peek at the chart before I came into the room today to refresh my memory as to Mr. Simao.

Q. Have you reviewed any records other than those contained in your chart?

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A. No.

Q. Does your chart contain records from other providers?

A. I believe it does have some records that I noticed from Nevada Orthopedic Center & Spine Center, Dr. McNulty.

Q. Any others?

A. I see here a note from the University Medical Center.

Q. McNulty did an epidural there?

A. Siena Adult Medicine, Southwest Medical Associates. There were some studies that were done there. I think the date of these studies is October 2007, and I think that is about it.

Q. And is Dr. Rosler your partner?

A. Yes, he is.

Q. And do you have records from him as well?

A. I do. I have his notes, yes.

Q. You did not meet with any attorneys to prepare for this deposition?

A. No, I did not.

Q. Will you be an expert in this case?

A. If I'm asked to be an expert, I would consider that. I was the treating physician for Mr. Simao, so at this point, I would classify myself

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as a treating physician.

Q. You have not been asked then by Mr. Simao's counsel to serve as an expert at the trial?

A. That is correct.

Q. How many times have you been deposed in the capacity of a treating provider for a personal injury claim?

A. Many hundreds of times.

Q. What percentage of your practice involves patients who are making personal injury claims?

A. Our practice is a fairly diverse practice where we take care of mostly patients that are just having general degenerative or neuropathic problems, but in the nature of taking care of spinal disorders, there are many patients who are injured in a motor vehicle collision or a workers' comp type of a situation.

I would say the personal injury claims of patients that we have probably represents 20 percent of our practice.

Q. Have you represented patients involved in personal injury claims who were represented by Mr. Simao's counsel.

A. Who is Mr. Simao's counsel.

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MR. PALERMO: Aaron & Paternoster.

THE WITNESS: Yes, I have.

BY MR. ROGERS:

Q. How many?

A. Gosh, I don't know how many. You know, we have a very large practice, and I cannot tell you how many. I would say occasionally.

Q. Give me an estimate then. Is it 100 all told? Something less than that?

A. I do not know. I have been in practice for 15 years. We see many, many patients here. I would say I have been in the clinic two days a week seeing patients. I might see an Aaron & Paternoster client, patient, so to speak, once every two or three weeks. Maybe once a month. Maybe twice in one week, but it is not -- we see patients, you know, that are represented with all kinds of attorneys in this community if they are involved in a personal injury case.

Q. Who referred Mr. Simao to your office?

A. I do not have -- let me see who referred him. I'm not certain who referred him. It does not have anything filled out in the referral section. Usually we make a note of who referred the patient, but we do not have that information in this

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particular case.

Q. Was your treatment done on a lien?

A. I'm not sure if the treatment was done on a lien or not. Usually when I answer that question I'm not right. We have a policy here that patients are advised that we would like to bill their health insurance, unless they specifically direct us not to bill their health insurance. I am looking here. He does have a lien signed in the chart, so I see that we probably have a lien as a precaution as a source of payment and I also see here that he is a member of HPN, Health Plan of Nevada. I can tell you that we're not providers for Health Plan of Nevada. It is an HMO product. So it is possible that he is being treated on a lien, but that information can be confirmed quite easily by checking with Danette in our billing department.

Q. Can you spell her name?

A. D-a-n-e-t-t-e.

Q. What is Danette's last name?

A. Gosh, I do not know. But she can quite easily provide that information as to the insurance source of the patient.

Q. When was the last time you spoke with the plaintiff, Mr. Simao?

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A. My notes reflect that the last time I saw him was September 2nd, 2008.

Q. You have not spoken with him since?

A. No.

Q. When was the first time you saw him?

A. I saw him on March 28th, 2008.

Q. And you took a history from him at that time?

A. I did, yes.

Q. What history did he give you?

A. He gave me a history. His chief complaint was neck pain, left parascapular pain, and lower back discomfort, and he presented at that time as a 44-year old gentleman who stated that about two or three years prior to seeing me had been involved in a rear-end type motor vehicle collision. He stated that he hit the back of his head on the metal cage of his vehicle. And since then had been suffering from pain in the back of his head, left parascapular area, meaning the area around the left shoulder blade or scapula, and the area between the shoulder blades.

Occasionally pain radiating into the left arm, and he advised me that he had been treated to that point through physical therapy, some medical

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management, some injections, and he had seen Dr. McNulty, who he stated had recommended surgery for him, and he was reporting an intensity of pain and discomfort occasionally after a ten out of ten, but essentially at a level of three out of ten on an ongoing basis, and he described aching penetrating, occasionally an unbearable symptomatology.

Q. Did he describe the car accident with any more detail than what you have just testified about?

A. He may have, but I do not have any recollection of it, other than what is documented in my notes.

Q. Well, after reading your notes, does it refresh your recollection at all as to what he told you about the force of this impact?

A. No.

Q. Is it fair to say you do not know anything about this car accident other than what the plaintiff told you?

A. That is correct.

Q. Did he tell you whether he lost consciousness?

A. No. All I can tell you is what is in the records, and I have no record of whether he did or did not lose consciousness.

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Q. Did he tell you whether he had any cuts or bumps or bruises?

A. No. I can only recall what is noted in my notes, and as you can read just as well as I can, it does not make any reference to whether he did or not did have any of those type of things.

Q. Did he tell you about any car accidents that he had before April 2005?

A. No. I do not have any reference to any previous injuries or car accidents or whatnot. He did deny any previous history of symptoms around the neck, shoulder blade area, and the left arm prior to that event.

Q. Did he tell you about any other symptoms that he had before April 2005?

A. No.

Q. Did he tell you about any car accidents he was involved in after April 2005?

A. No.

Q. Did he tell you about any aggravations of injury that he had after April of 2005?

A. No.

Q. At the time that he saw you was the plaintiff disabled?

MR. PALERMO: Which time? He may have

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seen him more than once. I will issue an objection as to vague and ambiguous as to the time frame.

BY MR. ROGERS:

Q. We are talking about that initial visit in March of 2008.

A. Well, what do you mean by disabled? Specifically, what would you like me to comment upon by his level of activities or his abilities in my opinion?

Q. Let's start with was he unable to work when he came to see you in March of 2008?

A. It depends on the type of work that he would be doing. I certainly felt that he was able to walk, move around, he was complaining of pain in his neck, left shoulder blade area, and he felt that at times it was quite significant, and unbearable to him, but he was able to talk, walk, speak, move his arms and legs. He could certainly work in some capacity in all likelihood.

Q. I don't mean in a generic sense. I mean, was this patient unable to do his work?

A. I do not know. I don't know what work he was doing. I do not have a reference to that in the chart.

Q. He was a carpet cleaner.

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A. It would be unlikely that I would return him back to carpet cleaning. Depending on what the work requirements specifically were, but it sounds to me like a relatively physically endearing job, and I think that would potentially aggravate his neck.

If he wanted to return to work, I would not tell him necessarily not to, but I would certainly probably have advised him to not perform strenuous activities that resulted in prolonged posturing or strain on his neck or his back, but, you know, he could work in some capacity. He could probably perform a clerical position or office space type position that was not physically demanding.

Q. Did you ever ask him about whether he was working when he was treating with you?

A. My notes reflect that he was married. He was apparently the owner and manager of a cleaning company. I don't have anything to the effect of whether or not he was working or able to work.

Q. Well, were his complaints to you inconsistent with his work as a carpet cleaner?

MR. PALERMO: Objection. Vague as to form. Ambiguous.

BY MR. ROGERS:

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Q. Go ahead.

A. Can you ask me specifically or maybe you can rephrase it, so I can answer it?

Q. Mr. Simao comes to you and he says, These are my problems. This is my level of pain. Were his presenting complaints inconsistent with working as a carpet cleaner? Not just clerical work, but actual labor?

MR. PALERMO: Same objection. Also misstating.

THE WITNESS: I'm not sure what you are trying to ask me, but being he had symptoms of neck pain and shoulder blade pain and arm pain.

BY MR. ROGERS:

Q. Well, you testified earlier that you, I believe you said you would have given him a work release, and that his condition was consistent or compatible with clerical work, but probably not labor?

A. No, I did not say I would give him a work release. I answered your question that you asked me broadly was disabled.

Q. Okay.

A. And I believe I stated that I would probably preclude him or advise him not to perform

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any strenuous activities that resulted in sprain/strain or stress around his neck, but that if he wanted to work and felt that he could, I would tell him not to work because we routinely encourage our patients to try to remain as active as possible as long as it is not unreasonable to do so, and I would not have thought it was unreasonable in this case. But if he told me that his pain was really aggravated and worsened by those type of activities I would probably advise him not to do it.

Q. Did he ever tell you that?

A. Well, I can only tell you what is in the notes. I do not see anything in the notes stating that.

Q. Now, can the symptoms that the plaintiff complained of result from something other than trauma?

A. Yes, they can.

Q. You said you reviewed some records from Southwest Medical. How far back in time do those records go?

A. Well, I just noticed these records here. I'm looking here. There are some records in the chart dating back to a note from October 5th, 2007, Southwest Medical Associates from a physician

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assistant, his assessment is, History of migraine headaches, cervical radiculopathy pending cervical spine surgery with Dr. McNulty. I think they are all around that time of October of 2007 from Southwest Medical Associates.

Q. Now, that is roughly two and a half years after this car accident. You have not seen any of the records in the two and a half years immediately following this car accident?

A. That is correct.

Q. Let's shift gears to your physical exam. What did you find?

A. When I examined him, he was demonstrating tenderness to palpations above the left parascapular area, discomfort with left cervical rotation as compared to right, was independently ambulatory otherwise without orthotics or assistive devices. He had no evidence of gross spinal deformity.

He was neurologically otherwise focally intact without evidence of any focal neurologic deficit and his reflexes were otherwise symmetric. He did not have a positive Spurling sign on the left whereby upon lateral bending and rotation of his neck, we were able to reproduce pain in the neck and the shoulder blade area, possibly the arm and also

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reproduction of pain, left-sided shoulder blade pain in the back of the head upon active compression of his head. Those were the pertinent findings.

Q. Did you do any orthopedic tests other than the axial compression and Spurling's?

A. Not specifically that I can recall or see evidence of in the notes.

Q. What about his range of motion?

A. I don't have his range of motion documented here as to the degrees of range of motion that he had. I simply have a note that he had discomfort upon left cervical rotation as compared to the right.

Q. Was there any indication of ligament injury in the cervical spine?

A. Clinically or based on my evaluation of his imaging studies?

Q. Let's start with your physical exam. We will get into the radiology studies.

A. Well, no. I do not think I could state that clinically he had a ligamental injury simply by looking at it and examining it. That is not necessarily possible to do that, as far as I'm aware.

Q. Did you perform Waddell's signs?

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A. No, I did not.

Q. Why not?

A. We do not routinely document the Waddell's signs, but if a patient demonstrates sort of a presentation that is perhaps nonorganic or if a patient appears to me to be embellishing his symptoms, then I think we would perhaps perform Waddell's signs, but this is not a forensic medical exam where we are examining medical patients. In that sense, we are evaluating and treating patients who have complaints.

Q. Did you review any films?

A. Yes, I did.

Q. What films?

A. I looked at an MRI scan of the cervical spine dated September 2007.

Q. Is that the only cervical spine film that you saw?

A. At that time, I believe so.

Q. Did you see any films of any other body part?

A. No.

Q. Well, what did you see in the September 2007 film?

A. My notes reflect that I felt that this

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was a marginal quality study or not a good quality study, let's say. And I did not see a clear cervical disc herniation, but I did see a suggestion of that facet tropism in the proximal segments of C3-4 and C4-5.

Q. Do you know Dr. Arita from Southwest Medical?

A. No.

Q. He is a pain management physician that Dr. McNulty referred the plaintiff to. We deposed him a little while ago and, in his opinion, the plaintiff had facet hypertrophy in the cervical spine. Do you agree with that opinion?

A. I think he had some facet anomalies. He may very well have had some facet hypertrophy. He had some facet problems at C3-4 and C4-5, as far as my notes reflect. Included with that may have been some hypertrophy, but I'm not completely sure.

Q. At C3-4 --

A. And C4-5.

Q. Did you review reports of radiology studies done other than the September 2007 MRI?

A. My records reflect that on that last date. That is all I looked at.

Q. Now, there was a cervical MRI done on

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March 2nd, 2006. Did you ever review the film or the report?

A. No. My notes do not reflect that I did so. I might have, but I cannot tell you that I did. My notes reflect that specifically I looked at an MRI scan dated September 2007.

Q. Well, did you order the April 2008 cervical MRI?

A. I probably did, yes.

Q. And you have a copy of that in your chart?

A. Yes. Well, I have actually just the final report. I do have that yes.

Q. Is there a change between the April 2008 cervical MRI and the September 2007 cervical MRI?

A. I could not tell you that without directly comparing the studies myself. I mean this MRI scan also reveals a potential annular tear of the left-sided protrusion at C2-3 as well as a disc problem as C3-4 and C4-5, and I don't recall a history of identification of a C2-3 problem in September.

Q. Can the condition seen on the MRIs that we have discussed result from causes other than a car accident?

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A. Yes.

Q. Is it fair to say that those MRIs demonstrate age appropriate degeneration?

MR. PALERMO: Objection as to form.

THE WITNESS: I would say that it is not unusual to see patients of Mr. Simao's age with abnormalities or some subtle disc compromise in the MRIs scan, but when we see the MRI scan, it does not allude to the asymmetry or abnormality of the facet joints at C3-4 and C4-5, and I would say that is less commonly seen. It is not as common of a finding as the subtle disc compromise.

BY MR. ROGERS:

Q. What is the less common finding?

A. The facet asymmetry at C3-4 and C4-5, but can that be seen in patients as it is related to the age-related degeneration, and the answer to that is yes, it can be.

Q. What is the cause of that asymmetry?

A. Well, we do not always know. There is some inflammation in the facet joints in that area that is either causing or a result of the anatomy there.

Q. Can the cause be something other than trauma?

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A. Yes, it can.

Q. What was your impression after this initial visit with the plaintiff?

A. I felt that he had persistent neck left parascapular, left upper extremity symptoms, symptoms that obviously had been present for up to three years prior to his presentation to me, and I made a note that apparently he had been recommended for surgery by Dr. McNulty, but I felt that at that point was not able to fully evaluate his condition satisfactorily or fully understand his pain syndrome, and I wanted to obtain a better quality updated MRI scan of his cervical spine and some electrodiagnostic studies of the upper extremities.

Q. So did your partner, Dr. Rosler, do those?

A. No.

Q. Who did those studies?

A. That is the MRI scan that we talked about that was performed in April of 2008.

Q. Did anyone do an EMG or a nerve conduction study?

A. I do not see one in the chart when it was done. I don't recall either. I also recommended that he proceed with some C3-4, C4-5 selective nerve

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root blocks on the left side, possibly facet blocks on a therapeutic and diagnostic basis, and I also recommend that is the last time.

Q. Did anyone do the facet blocks?

A. I see that he had underwent the left sided C-5 and C-4 selective nerve blocks on May 10th, 2008, so I think Dr. Rosler ended up doing selective nerve root blocks as opposed to facet blocks.

Q. Do you know why he chose the nerve root blocks instead of the facet injections?

A. I think he probably felt that that was -- he wanted to see if he could isolate some of the pain to that area. I mean, the C-4 and C-5 selective nerve root blocks go right by the facet joints so if there is facet inflammation, it would irritate the nerve roots, but some of that medication would get into the area of the facet joint too.

Q. If you were trying to isolate the pain generator, wouldn't a facet block be more precise?

A. Not necessarily. You're isolating the pain generator by anesthetizing a segment that produces pain within the motion segment, so if you do a C-4 selective nerve root block, you're

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injecting the C3-4 area. And if you do a C-5 selective nerve root block, you are injecting the C4-5 area.

Similarly, if you do a facet block in that area, you're anesthetizing the facet in that motion segment, so you can certainly further isolate problems by injecting into the specific areas, whether it is the facet, nerve root foramen that travels by the facet and the disc.

I cannot answer for Dr. Rosler. He might have felt that is what he wanted to do at the time.

Q. And, of course, I am not going to ask you to speak for Dr. Rosler, but as the surgeon for a patient, if the question is whether to perform surgery on the disc or the facet joint, wouldn't you want to know whether a facet injection alleviated all of the pain before you performed either kind of surgery?

MR. PALERMO: Objection as to form.

THE WITNESS: No, not necessarily. It is not quite that simple, because we would not be operating on the disc or the facet, because if we were to operate on him to fix a facet problem, we would remove the disc and fuse the segment. So it is more helpful to get a selective nerve root block

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than to get a cervical facet block if we were to choose one or the other, but it is not unreasonable to do both to better understand the pathology.

BY MR. ROGERS:

Q. Are you saying that if the problem is the facet tropism, that the remedy is a fusion?

A. That is correct. Well, let me answer that a bit more specifically. In general, the more definitive remedy would be a fusion, but if the problem is that the nerve root is irritated by the facet tropism or inflammation, in some cases, we will perform what is called a foraminotomy and remove part of the facet to unpinch the nerve in the hope that that relieves the pain without fusing the segment, so there are other alternatives other than fusion, but they are directed towards release of pressure from the nerve root.

Q. Well, the records I have show that you saw the plaintiff on May 6th.

A. That is correct.

Q. And this was before the injections were done?

MR. PALERMO: I will object as to form as to injections that were done.

MR. ROGERS: Okay. The injections done

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by Dr. Rosler.
BY MR. ROGERS:
Q. I have in my records, Doctor, a May 10th, 2008 left-sided C-4 and 5 selective nerve root block. That was the first one that I'm aware of.
A. I believe that is correct.
Q. Well, did you learn anything then at the time of this May 6th visit that you had with the plaintiff that you did not know before?
A. No.
Q. Do you know why the EMG studies which you again recommended on May 6th were never done?
A. No, I do not. I know sometimes patients are told not to do anything. Other times there is a clerical hiccup in getting it coordinated. I cannot tell you I know the answer why.
Q. Did your impression change between that initial visit and the May 6th visit?
MR. PALERMO: Objection as to form. Vague and ambiguous.
THE WITNESS: No. I do not think so. I think we're still working on the same working diagnosis.
BY MR. ROGERS:
Q. And then the next visit I have is

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June 17th. Is that the same that your records show?

A. Yes.

Q. Were there any changes then at that visit?

MR. PALERMO: Same objection as to form.

THE WITNESS: That visit I looked again at the MRI scan, which suggested some subtle disc protrusions at C3-4 and C4-5. I obtained a flexion-extension X-ray. It did not reveal gross instability, although I felt there may be a subtle subluxation at the C4-5 level. He was significantly symptomatic. Left parascapular pain, pain in the back of the head, symptoms which he felt were quite severe at times, and I felt that he had ongoing symptoms related to disc and facet pathology going across those areas.

BY MR. ROGERS:

Q. Were the diagnostic findings in any way inconsistent with his subjective complaints?

A. No.

Q. What was his chief complaint?

A. Neck pain and left shoulder pain, parascapular pain.

Q. And there are places in your records I believe where it is described as axial neck pain?

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A. That is correct.

Q. Was the parascapular pain related to the neck pain?

A. Yes. Pain in the cervical spine frequently radiates into the area around the shoulder blade or in the back of the head.

Q. And what was causing his headaches?

A. Suboccipital headaches or pain in the back of the head are commonly a result of cervical facet pathology or cervical root irritation.

Q. Which level?

A. Usually the upper cervical segments result in pain in the back of the head, C3-4, C4-5.

Q. Do you know whether he had headaches before this accident? I mean, substantial enough that he treated for them?

A. No, I do not know.

Q. And you ordered cervical discography for the patient on this visit?

A. I did, yes.

Q. And that was performed by your partner?

A. Yes.

Q. What did it show?

A. It showed compromise and reproduction of symptomatology of my injection at the C3-4 and C4-5

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areas.

Q. In your opinion, what is the reliability or potential for false positives in cervical discography?

A. Well, I think that you know there is always a possibility of false positives of discography in the cervical or lumbar spine. We use discography in our practice or in my practice here far more commonly in the lumbar spine.

Most commonly when we recommend or perform cervical spine surgery, we do it without the need to resort to cervical discography, but I think in his particular case, given the not so typical nature of his pathology whereby a lot of his pain was potentially mediated through the facet joints, with some subtle disc compromise. I felt a discography would be somewhat helpful.

Q. Well, that explains then why you thought it was appropriate. But what are the potentials for false positives with cervical discography?

A. I think there is potential for false positives and false negatives.

Q. Is there a greater potential for false positives with cervical discography then with lumbar discography?

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A. I think it depends on which article you read. I think for spine surgeons in practice you use discography, which is most sophisticated spine surgeons use it judicially in context with other diagnostic imaging studies, and at least in our practice and I believe in most other spinal practices, lumbar discography is relied upon more so than cervical discography as a rule, in general, but there are selective cases, such as this where cervical discographies is helpful, but certainly there is a chance of a false positive in the cervical discography.

Probably I find it to be less useful in my assessment, and my assessment of lumbar discography is useful, for instance, in lumbar pathology, disc pathology.

Q. Is there a reliable study, in your opinion, out there, regarding the correlation between positive cervical discography and positive surgical outcome based on that discography?

A. Well, I don't think you can just take one article.

Q. A series then?

A. I cannot give you a name of a specific article at this time that will give you that result,

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but discography, I don't use discography, and I do not think most surgeons do use them whether it is lumbar or cervical in a vacuum, so to speak, as an isolated study whereby one can then make a determination for the need for surgery. It is really just one more part in the whole diagnostic assessment of a patient, so I do not think I would say, Well this guy has positive discograms. You need surgery. It is not quite so simple. If it were that simple, you would not need the experience of many years of education.

Q. Well, I would imagine that the majority of spine surgeons would not perform a neck surgery based on a single study. Like you, they are taking into account the patient's complaints, their history, MRIs, and cervical discography.

With that basis, knowing, of course, that you recommended surgery on this plaintiff, is there a study anywhere out there, that provides some basis for determining whether that discography was helpful in determining whether this patient needed a fusion surgery in the neck?

A. Oh, sure. There are studies that clearly show that discography in the cervical as well as lumbar spine are helpful in determining the outcome

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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.

APPEAL

from the Eighth Judicial District Court, Clark County
The Honorable JESSIE WALSH, District Judge
District Court Case No. A539455

APPELLANT'S APPENDIX
VOLUME 14
PAGES 3156-3406

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Defendant reserves the right to supplement her list of documents as additional documents become known.

DATED this 8th day of September, 2008.

ROGERS, MASTRANGELO, CARVALHO & MITCHELL

By: _____

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Attorneys for Defendant Jenny Rish

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CERTIFICATE OF MAILING

I, the undersigned, hereby certify that on the 10th day of September, 2008, I mailed a true and correct copy of the foregoing **DEFENDANT JENNY RISH'S FIRST SUPPLEMENT TO THE 16.1 EARLY CASE CONFERENCE PRODUCTION OF DOCUMENTS AND/OR WITNESSES** in a sealed envelope with postage fully prepaid addressed to the following:

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Attorneys for Plaintiffs William Jay Simao and Cheryl Ann Simao

An Employee Of
Rogers, Mastrangelo, Carvalho & Mitchell

M:\Rogers\Rish adv. Simao\Pleadings\1st Supp to ECC.wpd

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EXHIBIT "8"

IN THE SUPREME COURT OF THE STATE OF NEVADA

VICTORIA KINSTEL AND MILTON KINSTEL, INDIVIDUALLY, AND AS HUSBAND AND WIFE,
Petitioners,
vs.
THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA, IN AND FOR THE COUNTY OF CLARK, AND THE HONORABLE VALORIE J. VEGA, DISTRICT JUDGE,
Respondents,
and
WAYNE L. WILSON; AND AUTOZONE, INC., A NEVADA CORPORATION,
Real Parties in Interest.

No. 48191

WRIT OF MANDAMUS

TO: The Honorable Valorie Vega, Judge of the Eighth Judicial District Court:

WHEREAS, this Court having made and filed its written decision that a writ of mandamus issue,

NOW, THEREFORE, you are instructed to vacate the order excluding the supplemental reports and related testimony, in the case entitled Kinstel vs. Wilson, Case No. A501221.

WITNESS The Honorables James W. Hardesty, Ron Parraguirre, and Michael L. Douglas, Associate Justices of the Supreme Court of the State of Nevada, and attested by my hand and seal this 30th day of January, 2007.

Bruce A. Horstmanshoff
Chief Assistant Clerk

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IN THE SUPREME COURT OF THE STATE OF NEVADA

VICTORIA KINSTEL AND MILTON KINSTEL, INDIVIDUALLY, AND AS HUSBAND AND WIFE,
Petitioners,
vs.
THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA, IN AND FOR THE COUNTY OF CLARK, AND THE HONORABLE VALORIE J. VEGA, DISTRICT JUDGE,
Respondents,
and
WAYNE L. WILSON; AND AUTOZONE, INC., A NEVADA CORPORATION,
Real Parties in Interest.

No. 48191

FILED

JAN 30 2007

JANETTE M. BLOOM
CLERK OF SUPREME COURT
BY
CHIEF DEPUTY CLERK

ORDER GRANTING PETITION FOR WRIT OF MANDAMUS

This original petition for a writ of mandamus or prohibition challenges a district court order granting a motion in limine to exclude supplemental expert reports and testimony. We directed an answer to the petition, which has been filed.

A writ of mandamus is available to compel the performance of an act that the law requires as a duty resulting from an office, trust, or station,[1] or to control a manifest abuse of discretion.[2] The counterpart to a writ of mandamus, a writ of prohibition is available when a district court

[1]See NRS 34.160.

[2]See Round Hill Gen. Imp. Dist. v. Newman, 97 Nev. 601, 637 P.2d 534 (1981).

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acts without or in excess of its jurisdiction.[3] Both mandamus and prohibition are extraordinary remedies, and it is within this court's discretion to determine if a petition will be considered.[4] Further, a writ of mandamus or prohibition may issue only when there is no plain, speedy, and adequate legal remedy.[5]

In the challenged order, the district court ruled that expert reports produced after the discovery cutoff set forth in the scheduling order would not be admitted at trial, and likewise, that no testimony concerning these reports would be admitted. The reports at issue were supplemental expert reports submitted under NRCP 26(e)(1), which imposes a duty upon litigants to supplement any expert disclosures and reports made in accordance with NRCP 16.1(a)(2)(B), and states that any such supplements are due "by the time the party's disclosures under NRCP 16.1(a)(3) are due." NRCP 16.1(a)(3) provides that, unless otherwise ordered by the court, such information is due "at least 30 days before trial."

The rules' language is plain: supplemental reports are due at least 30 days before trial, unless otherwise ordered by the court. The reports at issue were produced over 40 days before the trial date set at the time they were provided. The scheduling order set a discovery cutoff of May 12, 2006, but it did not alter the date set in NRCP 26(e)(1) for

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[3]State of Nevada v. Dist. Ct. (Anzalone), 118 Nev. 140, 146-47, 42 P.3d 233, 237 (2002); NRS 34.320.

[4]See Smith v. District Court, 107 Nev. 674, 818 P.2d 849 (1991).

[5]See NRS 34.170 and 34.330.

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supplemental expert reports, and in fact, it echoed NRCP 16.1(a)(3)'s deadline for pretrial disclosures: 30 days before trial. Therefore, petitioners' supplemental reports were provided within the time required and were not subject to exclusion as untimely.[6]

Accordingly, we grant the petition and direct the clerk of this court to issue a writ of mandamus instructing the district court to vacate its order excluding the supplemental reports and related testimony.

It is so ORDERED.

_____, J.
Hardesty

_____, J.
Parraguirre

_____, J.
Douglas

cc: Hon. Valorie Vega, District Judge
Aaron & Paternoster, Ltd.
Allan P. Capps
Mainor Eglet Cottle, LLP
Alverson Taylor Mortensen & Sanders
Eighth District Court Clerk

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[6]We note that the two-month period between the supplemental report and the firm preferential trial setting provided ample opportunity for supplemental depositions of petitioners' experts, if necessary.

CLERK OF THE SUPREME COURT
By _____
Deputy Clerk

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EXHIBIT "9"

FILED
FEB 17 2011
CLERK OF COURT

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DISTRICT COURT
CLARK COUNTY, NEVADA

WILLIAM JAY SIMAO, individually and CHERYL ANN SIMAO, individually, and as husband and wife. Plaintiffs, v. JENNY RISH; JAMES RISH; LINDA RISH; DOES I through V; and ROE CORPORATIONS I through V. inclusive. Defendants.	CASE NO.: A539455 DEPT. NO.: X **PLAINTIFFS' MOTION IN LIMINE TO (1) PRECLUDE DEFENDANT FROM RAISING A "MINOR" OR "LOW IMPACT" DEFENSE; (2) LIMIT THE TRIAL TESTIMONY OF DEFENDANT'S EXPERT, DAVID FISH, M.D. AND; (3) EXCLUDE EVIDENCE OF PROPERTY DAMAGE**

COME NOW, Plaintiffs, WILLIAM and CHERYL SIMAO, by and through their attorneys of record, ROBERT T. EGLET, ESQ., DAVID T. WALL, ESQ. and ROBERT A. ADAMS of the law

firm of MAINOR EGLET, and hereby file this Motion in Limine to (1) Preclude Defendant from Raising a "Minor" or "Low Impact" Defense; (2) Limit the Trial Testimony of Defendant's Expert, David Fish, M.D., and; (3) Exclude Evidence of Property Damage.

This Motion is made and based upon the pleadings and papers on file herein, the attached Points and Authorities, and any argument made by counsel at the hearing of this matter.

DATED this 16 day of February, 2011.

MAINOR EGLET

DAVID T. WALL, ESQ.

ORDER SHORTENING TIME

It appearing to the satisfaction of the Court, and good cause appearing therefore, IT IS HEREBY ORDERED that the time for hearing on **MOTION IN LIMINE TO (1) PRECLUDE DEFENDANT FROM RAISING A "MINOR" OR "LOW IMPACT" DEFENSE; (2) LIMIT THE TRIAL TESTIMONY OF DEFENDANT'S EXPERT, DAVID FISH, M.D., AND; (3) EXCLUDE EVIDENCE OF PROPERTY DAMAGE** for hearing on the 1 day of MARCH, 2011, at the hour of 9:30 a.m., in Department X, in the above-entitled Court, or as soon thereafter as counsel can be heard.

DATED this _____ day of February, 2011.

DISTRICT COURT JUDGE

Respectfully submitted by:

DAVID T. WALL, ESQ.

AFFIDAVIT OF DAVID T. WALL, ESQ. IN COMPLIANCE WITH EDCR 2.47 AND IN SUPPORT OF PLAINTIFFS' MOTION ON AN ORDER SHORTENING TIME

STATE OF NEVADA)
) ss.:
COUNTY OF CLARK)

DAVID T. WALL, ESQ., being first duly sworn, under oath, deposes and says that:

1. Affiant is an attorney licensed to practice law in the State of Nevada and a partner with the law firm of **MAINOR EGLET**, counsel for Plaintiffs in this matter;

2. That pursuant to EDCR 2.47, Affiant and defense counsel, Steve Rogers, Esq., discussed the merits of the instant Motion on February 15, 2011 in good faith, but have been unable to resolve this matter satisfactorily, thereby necessitating the filing of the instant Motion.

3. Trial of this matter is currently set to go forward on March 14, 2011;

4. Plaintiffs took the deposition of Dr. Jeffrey Fish on February 10, 2011, during which Dr. Fish opined regarding matters outside his area of expertise, prompting the instant Motion;

5. That because the trial date is quickly approaching and because the instant Motion concerns matters that are central to trial, this matter cannot be heard in normal course and it is respectfully requested that it be heard on an Order Shortening Time, pursuant to Court order.

FURTHER, AFFIANT SAYETH NAUGHT.

DAVID T. WALL, ESQ.

SUBSCRIBED AND SWORN to before me
This 16th day of February, 2011.

NOTARY PUBLIC

Ashley M. Conine
Notary Public, State of Nevada
My Commission Expires: April 3, 2014
Certificate No: 10-3978-1

MEMORANDUM OF POINTS AND AUTHORITIES

I.

FACTUAL BACKGROUND

On or about April 15, 2005, Plaintiff, WILLIAM SIMAO, was driving his vehicle on southbound Interstate 15 in the #1 travel lane near the Cheyenne interchange in Las Vegas, Nevada. William had slowed his vehicle to a complete stop for congested traffic when Defendant, JENNY RISH, failed to decrease her speed and collided with the rear end of William's vehicle. As a result of the crash, William suffered severe and debilitating injuries.

II.

RELIEF REQUESTED

Plaintiffs file this Pre-trial Motion and respectfully moves this court as follows:

1. To instruct Defendant and Defendant's attorneys not to mention, refer to, comment upon or bring before the jury directly or indirectly, upon voir dire examination, reading of the pleadings, statement of the case, opening statement, interrogation of witnesses (i.e. questions and/or responses to questions) introduction of exhibits, written discovery or any other documents, arguments, objections before the jury, closing argument, or in any other manner, any of the matters set forth below, unless and until such matters have first been called to the Court's attention, out of the presence and hearing of the jury, and until a favorable ruling has been received regarding the admissibility and relevance of such matters;

2. To instruct Defendant's counsel to inform Defendant and all witnesses called by Defendant not to mention in the presence or hearing of the jury any of the below –enumerated matters, unless and until specifically permitted to by ruling of the Court.

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3. To instruct counsel for Defendant that failure to abide by such order of the Court may constitute contempt of the court and result in sanctions.

4. Plaintiffs' Motion is made on the ground that violation of any or all of these instructions would cause great harm to Plaintiffs' cause and would deprive Plaintiffs of a fair and impartial trial.

5. Counsel for defendant, defendant, defendant's expert, Dr. Fish, and all other witnesses will refrain from referencing or insinuating that 1) the subject motor vehicle crash as a "low" or "minor impact 2) that the dynamics of the crash were insufficient to result in the injuries or medical care of Plaintiff.

III.

LEGAL AUTHORITY

The primary purpose of a motion in limine is to prevent prejudice at trial. *Hess v. Inland Asphalt Co.*, 1990 U.S. Dist. Lexis 6465, 1990-1 Trade Cases (CCH) P68, 954 (E.D. Wash., Feb. 20, 1990). The court has authority to issue a preliminary ruling on the admissibility of evidence. The decision to do so is vested to the sound discretion of this court. *See State v. Teters*, 2004 MT 137, 91 P.3d 559, 563 (Sp. Ct. Mont. 2004). The court's discretion will not be overturned on appeal absent a showing of a clear abuse-of-discretion. *See Gagan v. American Cablevision, Inc.*, 77 F.3d 951, 966-67 (7th Cir. 1996); *United States v. Brady*, 595 F.2d 359, 361 (6th Cir.), cert. denied, 444 U.S. 862, 100 S.Ct. 129, 62 L.Ed.2d 84 (1979); *United States v. Robinson*, 560 F.2d 507, 513-515 (2d Cir. 1977), cert. denied, 435 U.S. 905, 98 S.Ct. 1451, 55 L.Ed.2d 496 (1978); *United States v. Hall*, 565 F.2d 1052, 1055 (8th Cir. 1977); *Texas Eastern Transmission v. Marine Office-Appleton & Cox Corp.*, 579 F.2d 561, 567 (10th Cir. 1978); *Rozier v. Ford Motor Co.*, 573 F.2d 1332, 1347 (5th Cir. 1978);

Longenecker v. General Motors Corp., 594 F.2d 1283, 1286 (9th Cir. 1979); *United States v. D'Alora*, 585 F.2d 16, 21 (1st Cir. 1978); *United States v. Juarez*, 561 F.2d 65, 70-71 (7th Cir. 1977).

Such motions are designed to simplify the trial and avoid prejudice that often occurs when a party is forced to object, in the presence of the jury, to the introduction of evidence. *Fenimore v. Drake Construction Co.*, 87 Wn.2d 85, 549 P.2d 483 (1976).

NRS 48.035 states that "[a]lthough relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence. *Nevada Revised Statutes 48.015; & 48.035.*

When the proffered testimony or evidence is not relevant, its prejudicial effect outweighs its relevance, the substance of the proffered testimony or evidence is collateral to the issues of this trial and would only serve to confuse and mislead the jury, the evidence must be excluded. *See e.g., Uniroyal Goodrich Tire Co. v. Mercer*, 111 Nev. 318, 890 P.2d 785 (1995); *Larsen v. State*, 102 Nev. 448, 725 P.2d 1214 (1986).

IV.

ARGUMENT

Nothing in the accident report of April 15, 2005 indicates that the impact was minor. In fact, the responding officer listed that the damage to each vehicle was "moderate." *See* Traffic Accident Report, dated April 15, 2005, attached hereto as **Exhibit "1."** As mentioned above, Defendant failed to decrease her speed and rear-ended Plaintiff's vehicle while he was stopped for traffic. Defendant was cited for failure to use due care. *See* **Exhibit "1."** Clearly, it was Defendant's own negligence that caused the subject crash.

As a result of the incident, William sustained serious and disabling personal injuries that resulted in years of ongoing medical care.

A. **DEFENSE PHYSICIAN EXPERTS ARE NOT QUALIFIED TO TESTIFY TO THE SEVERITY OF THE ACCIDENT AND MUST BE PRECLUDED FROM DOING SO**

Medical doctors are not qualified to testify regarding the nature of the impact.

Nevada Revised Statute 50.275, "Testimony by experts," provides that:

> If scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by special knowledge, skill, experience, training or education may testify to matters ***within the scope of such knowledge***.

Medical professionals who are qualified as experts with special knowledge in the field of medicine may testify to matters within the scope of that medical knowledge. This does not include the nature of the impact, how they believe the accident occurred by their review of the accident report, or what they believe happened at the time of impact. Their testimony must be limited to Plaintiff's medical history and medical examination of the Plaintiff, if applicable.

B. **THE DEFENSE AND HER EXPERTS SHOULD BE PRECLUDED FROM PRESENTING TESTIMONY OR ARGUMENT THAT THE SUBJECT CRASH WAS MERELY A "MINOR IMPACT" NOT SUFFICIENT ENOUGH TO CAUSE PLAINTIFF'S INJURIES**

The defense must be precluded from commenting upon the dynamics of the motor vehicle crash and from arguing, suggesting or insinuating at trial that the crash was a "minor impact" or "low impact" collision, and not significant enough to cause Plaintiff's injuries.

Only a qualified expert in the area of biomechanical engineering may offer opinions regarding the nature and extent of the forces imparted to a body and how those forces may or may not cause trauma. The defense has not designated **any** expert qualified in the field of biomechanics to testify

with regard to the forces that may have been imparted upon Plaintiff in the subject crash and whether those forces could have caused his injuries. Consequently, without any scientific evidence, the defense may not argue or suggest that this motor vehicle crash was simply a "minor-impact" and that William could not have been hurt by the impact. There is simply no evidence to support such an argument.

Biomechanical engineers are commonly retained in motor vehicle cases to offer expert testimony relating to the effect of the forces that were imparted upon a plaintiff's body in a collision. Biomechanical engineers typically rely upon the accident reconstructionist's data and calculations relating to impact speeds and Delta V. However, in this case, the defense has failed retain an accident reconstructionist, let alone submit any scientific evidence that the impact speeds and Delta V(s) involved in this crash could not have caused William's injuries. Now that discovery has closed and the defense's medical experts have submitted their reports, the defense, including their experts, must be precluded from introducing evidence at trial which suggests or insinuates that William could not have been injured in the subject crash because it was a purported "minor-impact" collision. The defense has no foundation in the evidence from which to suggest that the forces imparted upon William's body in the crash were not significant enough to cause his injuries. As such, because there is no foundation in the evidence to support such arguments, and especially because no qualified expert has expressed such an opinion, Plaintiff would be unfairly prejudiced if the defense were permitted to argue that the collision in this case was a "minor impact" collision. NRS 48.035. To allow the defense to argue as such would be to permit an argument outside the evidence.

"There is no rule of trial practice more universally accepted and applied than the rule that counsel may not introduce into his argument to the jury, statements unsupported by evidence produced

on the trial . . ." *State of Nevada v. Kassabian*. 69 Nev. 146, 149 (1952). While counsel may enjoy wide latitude in arguing facts and drawing inferences from the evidence during closing argument, (*Silver v. McFarland*, 109 Nev. 465, 476 (1993)), counsel "may not state facts which are not in evidence." *Williams v. State of Nevada*, 103 Nev. 106, 110 (1987). Counsel is limited to arguing "any reasonable inferences from the evidence the parties have presented at trial." *Silver*. 103 Nev. at 476. However, "Courts will ban closing arguments which go beyond the inferences the evidence in the case will bear." *Wickliffe v. Sunrise Hospital, Inc.* 104 Nev. 777, 781 (1988). The Nevada Supreme Court has ruled in multiple cases that it is reversible error for an attorney to make statements of fact beyond the scope of the records in closing arguments. *Kassabian*, 69 Nev. at 151.

Accident reconstruction and biomechanical issues **are not common sense issues within the common knowledge of lay persons**. In fact, the Nevada Supreme Court has set forth stringent foundational requirements with respect to expert testimony relating to these areas of expertise. *See Hallmark v. Eldridge*, 189 P.3d 646 (Nev. 2008); *Levine v. Remolif*, 80 Nev. 168, 390 P.2d 718 (1964) and *Choat v. McDorman*, 86 Nev. 332. 468 P.2d 354 (1970). These cases hold that expert testimony cannot be based upon speculation. *Id.* Rather, such testimony must come from a qualified expert and must be based upon hard data, such as the speed of the vehicles, the depth of the crush damage based upon a visual inspection of the vehicles, and the weight and height of the vehicles, to name a few. *Id.*

In *Levine*, the case arose as the result of a motor vehicle accident and was a wrongful death action. The accident occurred when one of the drivers failed to yield the right of way to another vehicle at an intersection. At the accident scene, various photographs were taken and a diagram of the scene was drawn to show the intersection, place of impact, skid marks and where the two cars came to rest. This diagram was prepared by two (2) police officers.

At trial, one of the parties offered the expert testimony of an accident reconstructionist. The expert testified as to the speed of the vehicles involved in the accident and his testimony was based entirely upon the exhibits in evidence, which included photographs of the scene and of the vehicles after they had come to rest and a diagram made by the two police officers. The accident reconstructionist did not inspect either of the vehicles and relied upon the diagram prepared by the police officer. The trial court granted the motion to strike the reconstructionist's testimony with respect to his conclusion as to the speed of either vehicle. The Nevada Supreme Court upheld the exclusion of the accident reconstructionist's testimony because he had not inspected the vehicles, but rather relied upon photographs and a diagram made by an inexperienced police officer.

In *Choat*, the Choat car struck the rear of the McDorman vehicle and drove it approximately 85 to 90 feet. Both vehicles were severely damaged and the McDormans were injured in the accident. Choat died a few days later as a result of the accident, and an action was filed against the McDormans as a result of the collision. At the trial, the court allowed an officer who had investigated the accident to testify as to the relative impact speed of the Choat vehicle at the time of the accident. The investigating officer was a former highway patrolman who had arrived at the scene approximately ten minutes after the collision occurred. He investigated the accident, determined the point of impact, and assisted local police with some measurements.

Upon voir dire examination, he admitted that he had made no measurement of the skid marks made by the Choat vehicle, had made no measurement of the road grade or any particular computations, and did not know if the brakes were set on the McDormans car or if it was in gear when it was struck. He further testified that he did not know the weight of the vehicles involved, but believed that their weight would have had some bearing on the resulting damage, and that the speed

estimate was based on the resulting damage to the vehicles and his experience as a patrol officer. The court held that "[o]pinion evidence as to the speed of a car at the time an accident occurred, based on the appearance or condition of the car and the locus after the accident, is inadmissible, upon the ground that the conclusion if given would amount to a mere guess." *Choat*, 86 Nev. 332, 336. The court further stated:

> Just because a witness may be qualified as an expert does not automatically qualify him to give an opinion necessarily based on facts beyond his knowledge even though the opinion may be within the range of his expertise. In *Levine v. Remolif*, 80 Nev. 168, 390 P.2d 718 (1964), this court held that the testimony of an expert who had never examined the wrecked vehicles, as to their speed at the time of the accident, was properly stricken when based entirely on photographs of vehicles and certain diagrams made after the accident because the photographs could not disclose damage to the frames of the cars.

Id., at 335-36.

Changed conditions and lack of physical inspection of the vehicles can also invalidate the testimony of an expert witness. In the case of *Powers v. Johnson*, 92 Nev. 609, 555 P.2d 1235 (1976), Plaintiff presented an expert who had conducted his investigation:

> . . . [N]early three and one-half (3 1/2) years after the accident. Photographs taken in the interim showed that the street had been resurfaced, rendering the relied upon coefficient of friction test irrelevant. One witness had described tree limbs as being in visual obstruction when the accident occurred; [the expert] concluded that the limbs were in a completely different condition when he made his 'investigation' on August 6, 1973. Additionally, he had not ascertained the vehicles' weights; and, he had not viewed the vehicles. Indeed, it was doubtful that he had even viewed pictures of the vehicles. Upon stronger facts, this court has held it to be prejudicial error to allow such testimony. *Gordon v. Hurtado*, 91 Nev. 641, 541 P.2d 533 (1975); *Choat v. McDorman*, 86 Nev. 332, 468 P.2d 354 (1970). Cf. *Levine v. Remolif*, 80 Nev. 168, 390 P.2d 718 (1964). (emphasis added).

Powers, 92 Nev. at 610, 555 P.2d at 1236.

Courts have long excluded speculative testimony regarding the speeds of vehicles at the time of accidents. The case of *Bailey v. Roads*, 276 P.2d 713 (Or. 1954), involved a Plaintiff's attempt to have a

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state police officer testify as to the speed of the vehicle at the time of the accident. The trial court allowed the officer to testify as to the speed of the vehicle at the time it left the roadway. Though the officer had arrived at the accident scene shortly after the accident, he had investigated all of the physical facts including debris, marks on the roadway, and the location of the vehicles following the accident. the Oregon Supreme Court reversed the decision of the trial judge and found admission of the officer's opinion testimony as to speed to be prejudicial error. The court described the officer's testimony as "pure speculation and conjecture." The court further pointed out that, though speculative, the testimony of a police officer would tend to have a decided affect upon the jury. *Id.* at 718. Where all the facts upon which the police officer based his opinion were clearly presented by the evidence, the jury was in a position to determine whether or not the vehicle in question was traveling at an excessive rate of speed under the circumstances and did not need the assistance of an expert. *Id.* at 719.

In the case of *Montgomery v. Hyatt*, 282 P.2d 277 (Wash. 1955), the Plaintiffs again attempted to introduce testimony from a police officer as to the speed of the vehicles at the time of the collision. As in the *Bailey* case, supra, the court held that the officer's testimony as to speed was simply opinion and was not based upon sufficient facts and investigation to qualify the testimony as expert in nature. *Id.* at 280. Admission of the officer's testimony regarding speed was found to be prejudicial error and the matter was reversed and remanded for a new trial.

Finally, an investigating police officer offered testimony with regard to speed of the vehicles in the case of *Flores v. Barlow*, 384 S.W.2d 173 (Tx. 1962). The *Flores* court held:

> Point one is that the Court erred in permitting the witness, [the police officer], to give his opinion of the speed of the vehicles at the time of their collision when such opinion was based entirely upon the damaged condition of the vehicles after the collision .

Id. at 174. The court went on to address the case of *Union Bus Lines v. Moulder*, 180 S.W.2d 509 and

held:

> In *Moulder*, Justice Norvell, in rejecting opinion testimony of speed based on impact damage alone, and in reversing the case because of the admission of such testimony, noted that there was an absence of evidence of technical or scientific support for such opinion. There is a similar absence of evidence here.
>
> We follow the above decisions and hold that such opinion evidence was inadmissible.

Id. at 176. The *Flores* decision was reversed and remanded.

Finally, in the recent case of *Hallmark v. Eldridge*, 189 P.3d 646 (2008), the Nevada Supreme Court made it exceptionally clear that before an expert can render an opinion regarding biomechanics, that expert, despite being qualified to do so, must have a sufficient foundation for offering such opinions. The Court found that the district court abused its discretion under NRS § 50.275 when it allowed the expert witness to testify because his biomechanical opinion was not based upon an adequate factual and scientific foundation. *Id.* The Court held that the district court abused its discretion because the expert's biomechanical testimony and report did not assist the jury in understanding the evidence or in determining a fact in issue. *Id.* That expert conducted no biomechanical analysis which would enable him to testify concerning biomechanics and offered insufficient foundation for the Court to take judicial notice of the scientific basis of the expert's conclusions regarding biomechanics. *Id.* If the Supreme Court in *Hallmark* found reason to exclude that expert, **who was a biomechanical engineer**, and precluded the expert from testifying that the collision was minor and not sufficient enough to cause Plaintiff's injuries, then certainly this court **must prevent defense counsel and his medical experts**, with no supporting scientific evidence, from simply proclaiming to the jury that this crash was minor and not sufficient to cause Plaintiff's injuries.

Defendant's pain management IME expert, Dr. David Fish, noted in his reports that there was moderate damage to the vehicles in the accident. When asked at his deposition the significance of the

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damage. Dr. Fish stated that he intended to testify at trial regarding a correlation between the damage to the vehicles noted in the accident photos and the severity of Plaintiff's injuries. *See* Dr. Fish's Deposition Transcript at **Exhibit "2,"** p.16:23-25 through p.19. Dr. Fish noted his "expertise" in biomechanics based on treating accident victims in the emergency room, as well as having been involved in motor vehicle accidents in the past. This is precisely the type of testimony the Nevada Supreme Court precluded in *Hallmark*.

What is apparent from all of the decisions set forth above is that an expert, absent detailed investigation providing a significant scientific basis, may not offer opinion testimony at trial. Here, the defense has failed to designate any expert to provide opinions regarding the biomechanics of the crash and whether or not the forces imparted upon William were severe enough to cause his injuries and which will require future treatment. As such, without any foundation in the form of scientific evidence, neither defense counsel nor Dr. Fish may not "testify" at trial and suggest that the subject crash was not significant enough to cause William's injuries.

There is no question that testimony relating to the nature of the impact and the effect on the occupants must be provided by a qualified expert in the field of biomechanics and be based upon hard data. Consequently, without any expert testimony from a biomechanical engineer, the defense must be precluded from arguing, suggesting or insinuating that the motor vehicle collision in this case was a minor impact collision and not significant enough to cause William's claimed injuries.

C. THE VEHICLE PROPERTY DAMAGE PHOTOS AND REPAIR INVOICE(S) SHOULD BE EXCLUDED

In like manner, because there is no qualified defense expert in this case who has formulated a biomechanical opinion regarding the nature of the forces imparted upon William and whether those forces were severe enough to cause his injury, Plaintiffs request that photographs of the property

damage of the vehicles involved in this case and the repair invoice(s) be excluded at trial because without qualified expert testimony, there is no way for a jury to know and understand what the photographs or repair invoice(s) depict, or how they relate to William's injuries. Introduction of the photographs, which to a lay person may only show minor damage, would be substantially more prejudicial than probative to William in that it is likely that a lay juror would speculate and interpret the photographs to signify that William could not have been injured as a result of the impact. As the Court may be aware, there is no correlation between the extent of the vehicles' property damage and the nature and extent of injuries to the occupants. People can be involved in automobile crashes in which the vehicles are completely mangled but the occupants walk away without a scratch. The converse is also true. People can be involved in automobile collisions in which the property damage is slight or non-existent but the occupants sustain severe traumatic injuries. Too many factors are at play to be able to draw a correlation between the extent of property damage and an occupant's injury. These include the shock absorption of the bumpers, the material of the bumpers, where the vehicles were impacted, the street surface, whether conditions, the safety rating of the automobile, seatbelt use (which is also not admissible in a civil action), etc. As such, vehicle photographs and repair estimates are not relevant. NRS 48.025. Moreover, in Nevada, only a qualified expert can state with a reasonable degree of scientific certainty whether or not an impact could cause injury to a plaintiff. NRS § 50.275, *Hallmark, supra*. Thus, in order to preclude the jury from speculating as to what the photographs and repair estimates depict and how they relate to Brandon's injuries, said photographs and repair estimates must be excluded from trial. NRS § 48.025, 48.035.

Although Nevada has not spoken directly on this issue, other Courts exclude photographs when no expert testimony is introduced linking the vehicles' property damage to with the extent of the

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injuries sustained by the Plaintiff. *See Twal v. Hinds*, 2008 N.J. Super. Unpub. LEXIS 2666 (2008) (excluding vehicle photographs as more prejudicial than probative since no foundation existed to support the Defendant's argument that a relationship existed between the vehicle damage and the Plaintiff's injuries); *Davis v. Maute*, 770 A.2d 36, 40 (Del. 2001)(stating "[a]s a general rule, a party in a personal injury case may not directly argue that the seriousness of personal injuries from a car accident correlates to the extent of the damage to the cars, unless the party can produce competent expert testimony on this issue").

The Supreme Court of Delaware explained that "[a]bsent such expert testimony, any inference by the jury that minimal damage to the plaintiff's car translates into minimal personal injuries to the plaintiff would necessarily amount to unguided speculation." *Davis*, 770 A.3d at 40. The *Davis* Court concluded that: "[A] party in a personal injury case may not directly argue that the seriousness of personal injuries from a car accident correlates to the extent of damage to the cars, unless the party can produce competent expert testimony on the issue." *Id.*, at 40; *see also, Eskin v. Carden*, 842 A.2d 1222, 1226 (Del. 2004); *DiCosola v. Bowman*, 342 Ill. App. 3d 530, 276 Ill. Dec. 625, 794 N.E.2d 875, *appeal denied*, 206 Ill. 2d 620, 806 N.E.2d 1065, 282 Ill. Dec. 477 (2003).

The *Davis* Court reasoned that "[c]ounsel may not argue by implication what counsel may not argue directly". *Id.* The *Davis* Court also stated that "defense counsel's characterization of the accident as a 'fender-bender' was improper". *Id.* In *DiCosola*, the trial court excluded photographs showing slight damage to plaintiff's vehicle and evidence of the dollar amount of the property damage, and further prohibited the defendant from arguing, without expert testimony, that a correlation existed between the amount of damage to the vehicle and the extent and origin of plaintiff's injuries. *Id.* The court in that case analogized the situation to a case requiring expert medical proof of causation when it

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is claimed that a pre-existing condition had been aggravated or exacerbated by injuries sustained in the subsequent accident at issue:

> This court has explained that the rationale for requiring a defendant to introduce this expert testimony is 'to avoid what amount[s] to the jury forming medical opinions.'
>
> The same principles apply to the relationship between damage to a plaintiff[']s vehicle and the nature and extent of a plaintiff[']s personal injuries.

DiCosola, supra, 276 Ill. Dec. 625, 797 N.E.2d at 880-81 (*quoting Hawkes v. Casino Queen, Inc.*, 336 Ill. App. 3d 994, 785 N.E.2d 507, 518, 271 Ill. Dec. 575 (2003)).

Photographs and the dollar amount of property damage cannot provide definitive evidence that the physics of a particular accident did or did not cause a particular injury to a particular individual. A party's use of photographs depicting minimal vehicular damage to suggest a lack of a causative correlation with an injury encourages supposition and conjecture, without a basis in the evidence that the plaintiff's injuries could not have been caused by a relatively minor impact.

As such, Plaintiffs respectfully request that the photographs depicting the damage to the vehicles and the repair invoice(s) showing the dollar amount of the property damage be excluded at trial under NRS 48.025 and 48.035.

V.

CONCLUSION

Based upon the foregoing, Plaintiffs respectfully requests that this Honorable Court **GRANT** their Motion in Limine to (1) Preclude Defendant from Raising a "Minor" or "Low Impact" Defense; (2) Limit the Trial Testimony of Defendant's Expert, David Fish, M.D., and; (3) Exclude Evidence of Property Damage.

DATED this 16 day of February, 2011.

MAINOR EGLET

DAVID T. WALL, ESQ.

003181

003181

003182

003182

EXHIBIT "1"

Event Number: 050415-0773
Code Revision: 011404

STATE OF NEVADA
TRAFFIC ACCIDENT REPORT
SCENE INFORMATION SHEET
Revised 1/14/04

Accident Number: NHP-L2005-003864
☐ Property ☒ Injury ☐ Fatal

☒ 1) Urban ☐ 2) Rural
☐ 1) Emergency Use ☐ 2) Office Report
☐ 1) Preliminary Report ☐ 3) Resubmission ☒ 2) Initial Report ☐ 4) Supplement Report
☐ 1) Hit and Run ☐ 2) Private Property
Agency Name: 1 - DPS NEVADA HIGHWAY PATROL

Collision Date	Time	Day	Beat / Sector	☐ County ☒ City
4/15/2005	15:08	FRIDAY	LG70	NORTH LAS VEGAS

Mile Marker	# Vehicles	# Non Motorists	# Occupants	# Fatalities	# Injured	# Restrained
45	2	0	7	0	1	4

Surface: ☐ 1) Asphalt ☒ 2) Concrete ☐ 3) Gravel ☐ 4) Dirt ☐ 5) Other
Intersection: ☐ 1) Four Way ☐ 2) > Four Way ☐ 3) T ☐ 4) Y ☐ 5) Roundabout ☐ 6) Other
Paddle Markers: ☒ 1) None ☐ 2) Left Side ☐ 3) Right Side ☐ 4) Both Side ☐ 5) Unknown

Occurred On: (Highway # or Street Name)
☐ 1) Parking Lot IR15

☐ 1) At Intersection With:
☒ 2) Or 750 ☒ 3) Feet ☐ 4) Miles ☒ 5) Approximate Of (Cross Street) NORTH IR15/CHEYENNE INTERCHANGE RAMP# c

Access Control: ☐ 1) None ☒ 2) Full ☐ 3) Partial

Roadway Character: ☐ 1) Curve & Grade ☐ 2) Curve & Hillcrest ☐ 3) Curve & Level ☐ 4) Straight & Grade ☐ 5) Straight & Hillcrest ☐ 6) Straight & Level ☐ 7) Unknown ☐ 8) Other

Roadway Conditions: ☒ 1) Dry ☐ 2) Icy ☐ 3) Wet ☐ 4) Snow ☐ 5) Sand / Mud / Oil / Dirt / Gravel ☐ 6) Other ☐ 7) Slush ☐ 8) Standing Water ☐ 9) Moving Water ☐ 10) Unknown

Total Thru Lanes: Main Road ☐ 1) One ☐ 2) Two ☒ 3) Three ☐ 4) Four ☐ 5) Five ☐ 6) > 5
Total All Lanes: 3

Average Roadway Widths: Travel Lane 12 Ft; Storage / Turn Lane 0 Ft; Median 0 Ft
Paved Shoulder: Inside 14; Outside 10

Roadway Grade: ☒ 1) Not Determined ☐ 2) Relatively Level Roadway ☐ 3) Up Slope (+) ☐ 4) Down Slope (-)
Relative To:
Grade: %

Pavement Markings and Type:
1) Centerline, Broken Yellow
2) Centerline, Solid Yellow
3) Centerline, Double Yellow
4) Lane Line, Broken White
5) Lane Line, Solid White
6) No Passing, Either Direction
7) Turn Arrow Symbols
8) Center Turn Lane Line
9) Edge Line, Left, Yellow
10) Edge Line, Right, White
11) Other
12) None
13) Unknown

Highway Description: ☐ 1) Two-Way, Not Divided ☐ 2) Two-Way, Div. Unpro.Median ☒ 3) Two-Way, Div. Median Barrier ☐ 4) One-Way, Not Div. ☐ 5) Unknown ☐ 6) Dirt Road

Weather Conditions: ☒ 1) Clear ☐ 2) Cloudy ☐ 3) Snow ☐ 4) Rain ☐ 5) Blowing Sand, Dirt, Soil, Snow ☐ 6) Other ☐ 7) Fog, Smog, Smoke, Ash ☐ 8) Severe Crosswinds ☐ 9) Sleet / Hail ☐ 10) Unknown

Light Conditions: ☐ 1) Dusk ☐ 2) Dawn ☒ 3) Daylight ☐ 4) Unknown ☐ 5) Other ☐ 6) Dark - No Roadway Lighting ☐ 7) Dark - Spot Roadway Lighting ☐ 8) Dark - Continuous Roadway Lighting ☐ 9) Dark - Unknown Roadway Lighting

Vehicle Collision Type: ☐ 1) Head On ☐ 2) Rear End ☐ 3) Backing ☐ 4) Angle ☐ 5) Rear to Rear ☐ 6) Sideswipe - Meeting ☐ 7) Sideswipe - Overtaking ☐ 8) Non - Collision ☐ 9) Unknown

Location of First Event: ☒ 1) Travel Lane ☐ 2) Turn Lane ☐ 3) Gore ☐ 4) Median ☐ 5) Inside Shoulder ☐ 6) Outside Shoulder ☐ 7) Intersection ☐ 8) Private Property ☐ 9) Roadside ☐ 10) Other ☐ 11) Ramp ☐ 12) Unknown

Highway / Environment Factors: ☒ 1) None ☐ 2) Weather ☐ 3) Debris ☐ 4) Glare ☐ 5) Other Highway ☐ 6) Other Environmental ☐ 7) Shoulders ☐ 8) Road Obstruction ☐ 9) Worn Traffic Surface ☐ 10) Wet, Icy, Snow, Slush ☐ 11) Ruts, Holes, Bumps ☐ 12) Active Work Zone ☐ 13) Inactive Work Zone ☐ 14) Animal in Roadway ☐ 15) Unknown

Property Damage To Other Than Vehicle
Describe Property Damage:
Owner's Name (Last First Middle): ☐ 1) Owner Notified
Owner's Address: (Street Address City, State Zip)

First Harmful Event
Code #: 217 Description: 217 SLOW / STOPPED VEHICLE

Description of Accident / Narrative

BOTH V-1 AND V-2 WERE TRAVELING SOUTHBOUND ON IR15, IN THE NUMBER ONE TRAVEL LANE. V-2 WAS IN FRONT OF V-1. V-2 SLOWED DOWN TO A COMPLETE STOP, DUE TO CONGESTED TRAFFIC. V-1 FAILED TO DECREASE HER SPEED AND STRUCK V-2'S REAR WITH V-1'S FRONT. BOTH VEHICLES WERE MOVED PRIOR TO NHP ARRIVAL.

Investigation Complete	Photos Taken	Scene Diagram	Statements	Date Notified	Time Notified	Arrival Date	Arrival Time
☒ 1) Yes ☐ 2) No	☐ 1) Yes ☒ 2) No	☐ 1) Yes ☒ 2) No	☒ 1) Yes ☐ 2) No # 2	4/15/2005	15:10	4/15/2005	15:24

Investigator(s)	ID Number	Date	Reviewed By	Date Reviewed	Page
582 SHAWN HAGGSTROM	582	4/15/2005	4/19	4-17-05	SIMA000001

Event Number:	STATE OF NEVADA TRAFFIC ACCIDENT REPORT SCENE INFORMATION SHEET Revised 6/21/03	Accident Number: NHP-L2005-003864
050415-0772		Agency Name: 1 - DPS NEVADA HIGHWAY PATROL

Description of Accident / Narrative Continuation

Indicate North

A.I.C.:

003184
003184
003184

Event Number: 050415-0773

STATE OF NEVADA
TRAFFIC ACCIDENT REPORT
VEHICLE INFORMATION SHEET

Accident Number: NHP-L2005-003864

Agency Name: 1 - DPS NEVADA HIGHWAY PATROL

Vehicle #: 1 | # Occupants: 4 | [X] 1) At Fault [ ] 2) Non Contact

Direction of Travel: [ ] 1) North [ ] 3) East [ ] 5) Unknown [X] 2) South [ ] 4) West

Highway / Street Name: IR15

Travel Lane #: 1

Vehicle Action: [X] 1) Straight [ ] 3) Left Turn [ ] 5) U-Turn [ ] 7) Wrong Way [ ] 9) Passing [ ] 11) Leaving Parked [ ] 13) Leaving Lane [ ] 15) Enter Parked [ ] 17) Lane Change [ ] 19) Unknown
[ ] 2) Backing [ ] 4) Right Turn [ ] 6) Parked [ ] 8) Stopped In [ ] 10) Starting [ ] 12) Entering [ ] 14) Other Turning [ ] 16) Driverless Vehicle [ ] 18)

Driver: (Last Name, First Name, Middle Name Suffix)
RISH JENNY

Transported By: [X] 1) Not Transported [ ] 2) EMS [ ] 3) Police [ ] 4) Unknown [ ] 5) Other

Street Address: 223 N. COTTONWOOD DR.

Transported To:

City: GILBERT | State / Country: [ ] 1) NV AZ | Zip Code: 85234

Person Type: 1 | Seating Position: 01 | Occupant Restraints: 7

[ ] 1) Male [ ] 3) Unknown [X] 2) Female | DOB: 5/7/1945 | Phone Number: 4805454874

Injury Severity: 0 | Injury Location: 0

OLN: 004155603 | State: [ ] 1) NV AZ | [ ] 1) CDL [X] 2) DL | License Status: 0

Airbags: 2 | Airbag Switch: 1 | Ejected: 0 | Trapped: 0

Compliance: [ ] 1) Restrict [ ] 2) Endorse

Endorsements | Restrictions

Alcohol/Drug Involvement
[ ] 1) Not Involved
[ ] 2) Suspected Involvement
[ ] 3) Alcohol [ ] 4) Drugs
[ ] 5) Unknown

Method of Determination (check up to 3)
[ ] 1) Field Sobriety Test [ ] 4) Urine Test
[ ] 2) Evidentiary Breath [ ] 5) Blood Test
[ ] 3) Driver Admission [ ] 6) Preliminary Breath

Test Results:

Driver Factors
[X] 1) Apparently Normal
[ ] 3) Had Been Drinking
[ ] 3) Drug Involvement
[ ] 4) Apparently Fatigued / Asleep
[ ] 5) Obstructed View
[ ] 6) Driver Ill / Injured
[ ] 7) Other Improper Driving
[ ] 8) Driver Inattention / Distracted
[ ] 9) Physical Impairment
[ ] 10) Unknown

Vehicle Year: 2001 | Vehicle Make: CHEVROLET | Vehicle Model: SUBURBAN | Vehicle Type: LL

Plate / Permit No.: 886 VDX | State: [ ] 1) NV UT | Expiration Date: 05/31/2005 | Vehicle Color: SILVER

Vehicle Identification Number: 3GNFK16T51G143851

Registered Owner Name: [ ] 1) Same As Driver RISH JAMES LINDA

Registered Owner Address: 3029 CONSTITUTION ST. APT. A HILL AFB,UT,84056

Vehicle Factors
[ ] 1) Failed To Yield Right Of Way
[ ] 2) Disregard Control Device
[ ] 3) Too Fast For Conditions
[ ] 4) Exceeding Speed Limit
[ ] 5) Wrong Way / Direction
[ ] 6) Mechanical Defects
[ ] 7) Drove Left Of Center
[ ] 8) Other: DUE CARE
[ ] 9) Failed To Maintain Lane
[ ] 10) Following Too Close
[ ] 11) Unsafe Lane Change
[ ] 12) Made Improper Turn
[ ] 13) Over Correct/Steering
[ ] 14) Other Improper Driving
[ ] 15) Aggressive / Reckless / Careless
[ ] 16) Driverless Vehicle
[ ] 17) Unsafe Backing
[ ] 18) Ran Off Road
[ ] 19) Hit and Run
[ ] 20) Road Defect (*)
[ ] 21) Object Avoidance
[ ] 22) Unknown (8)

Insurance Company Name: LIBERTY MUTUAL INS. CO
[X] 1) Insured

Policy Number: AB226106579410 | Effective: 5/13/2004 | To: 4/14/2005

Insurance Company Address or Phone Number: 74 E. S. STE 104 BOUNTIFUL, UT 84010 1-800-365-2004

[ ] 1) Vehicle Towed | Towed By:

Removed To: DRIVEN AWAY BY DRIVER

1st Contact
[ ] 2 [ ] 3 [ ] 5
[X] 1 [ ] 5
[ ] 8 [ ] 7 [ ] 6
[ ] 1) Override [ ] 3) Under Ride

Damaged Areas
[X] 1) Front
[ ] 2) Right Side
[ ] 3) Left Side
[ ] 4) Rear
[ ] 5) Right Front
[ ] 6) Right Rear
[ ] 7) Top
[ ] 8) Under Carriage
[ ] 9) Left Front
[ ] 10) Left Rear
[ ] 11) Unknown
[ ] 12) Other

Traffic Control
F 1) Speed Zone
2) Signal Light
3) Flashing Light
4) School Zone
5) Ped. Signal
6) No Passing
7) No Controls
8) Warning Sign
9) Turn Signal
10) Other
11) Stop Sign
12) Yield Sign
13) R. R. Sign
14) R. R. Gates
15) R. R. Signal (2)
F 16) Marked Lanes
17) Tire Chains/Snow Req.
18) Passing Zone
[ ] 19) Unknown

Distance Traveled After Impact: (7 - MOVED)

Speed Estimate: From 20 | To 20 | Limit 65

Extent Of Damage
[ ] 1) Minor [ ] 4) Total
[X] 2) Moderate [ ] 5) None
[ ] 3) Major [ ] 9) Unknown

Sequence Of Events

	Code #	Description	Collision With Fixed Object	Most Harmful Event
1st	217	217 SLOW / STOPPED VEHICLE	[ ]	[X]
2nd			[ ]	[ ]
3rd			[ ]	[ ]
4th			[ ]	[ ]
5th			[ ]	[ ]

[X] 1) NRS [ ] 2) CFR [ ] 3) CC / MC [ ] 4) Pending
(1) 484.353
Violation: NRS FAILURE TO USE DUE CARE IN. . | NOC: 01034 | Citation Number: 1514740E

[ ] 1) NRS [ ] 2) CFR [ ] 3) CC / MC [ ] 4) Pending
(2)
Violation: | NOC: | Citation Number:

Investigator(s)	ID Number	Date	Reviewed By	Date Reviewed	Page
582 SHAWN HAGGSTROM	582	4/15/2005	[signature] 4/19	4-19-05	SIMA000003

Event Number: 050415-0773	STATE OF NEVADA TRAFFIC ACCIDENT REPORT VEHICLE INFORMATION SHEET Revised 5/21/03	Accident Number: NHP-L2005-003864 Agency Name: 1 - DPS NEVADA HIGHWAY PATROL

Name: RISH LINDA L
Transported By: ☒ 1) Not Transported ☐ 2) EMS ☐ 3) Police ☐ 4) Unknown ☐ 5) Other
Street Address: 3029 A CONSTITUTION WAY
Transported To:
City: HILL AFB | **State / Country** ☐ 1) NV UT | **Zip Code:** 84056
Person Type: 2 | **Seating Position:** 03 | **Occupant Restraints:** 7
☐ 1) Male ☐ 3) Unknown ☒ 2) Female | **DOB:** 7/24/1965 | **Phone Number:** 8017749066
Injury Severity: 0 | **Injury Location:** 0
Airbags: 2 | **Airbag Switch:** 1 | **Ejected:** 0 | **Trapped:** 0

Name: RISH 3RD JAMES C.
Transported By: ☒ 1) Not Transported ☐ 2) EMS ☐ 3) Police ☐ 4) Unknown ☐ 5) Other
Street Address: 3029 CONSTITUTION WAY
Transported To:
City: HILL AFB | **State / Country** ☐ 1) NV UT | **Zip Code:** 84056
Person Type: 2 | **Seating Position:** 06 | **Occupant Restraints:** 7
☒ 1) Male ☐ 3) Unknown ☐ 2) Female | **DOB:** 4/6/1981 | **Phone Number:** 8017749066
Injury Severity: 0 | **Injury Location:** 0
Airbags: | **Airbag Switch:** | **Ejected:** 0 | **Trapped:** 0

Name: RISH CHRISTOPHER N.
Transported By: ☒ 1) Not Transported ☐ 2) EMS ☐ 3) Police ☐ 4) Unknown ☐ 5) Other
Street Address: 3029 CONSTITUTION WAY
Transported To:
City: HILL AFB | **State / Country** ☐ 1) NV UT | **Zip Code:** 84056
Person Type: 2 | **Seating Position:** 04 | **Occupant Restraints:** 7
☒ 1) Male ☐ 3) Unknown ☐ 2) Female | **DOB:** 10/15/1992 | **Phone Number:** 8017749066
Injury Severity: 0 | **Injury Location:** 0
Airbags: | **Airbag Switch:** | **Ejected:** 0 | **Trapped:** 0

☐ 1) Trailing Unit 1 VIN:	Plate:	State: ☐ 1) NV	Type:
☐ 1) Trailing Unit 2 VIN:	Plate:	State: ☐ 1) NV	Type:
☐ 1) Trailing Unit 3 VIN:	Plate:	State: ☐ 1) NV	Type:

Commercial Vehicle Configuration

☐ 1) Bus, 9 - 15 Occupants
☐ 2) Bus, > 15 Occupants
☐ 3) Single 2 Axle and 6 Tire
☐ 4) Single > 3 Axle
☐ 5) Any 6 Tire Vehicle
☐ 6) Tractor Only
☐ 7) Tractor / Trailer
☐ 8) Tractor / Doubles
☐ 9) Tractor / Triples
☐ 10) Truck with Trailer
☐ 11) Tractor / Semi Trailer
☐ 12) Passenger Vehicle, (Van, Limo)
☐ 13) Light Truck, (Van, Mini)
☐ 14) Other Heavy Vehicle

☐ 1) Commercial Vehicle ☐ 2) School Bus

Source
☐ 1) Driver
☐ 2) Log Book
☐ 3) Shipping Papers / Trip Manifest
☐ 4) State Reg.
☐ 5) Side Of Vehicle
☐ 6) Other

Carrier Name:
Power Unit GVWR ☐ 1) ≤ 10,000 Lbs ☐ 2) 10,000 - 26,000 Lbs ☐ 3) ≥ 26,000 Lbs
☐ 1) Haz-Mat ☐ 2) Released
Carrier Street Address: | **City:** | **State:** ☐ 1) NV | **Zip:**

Cargo Body Type

☐ 1) Pole
☐ 2) Tank
☐ 3) Flatbed
☐ 4) Dump
☐ 5) Van / Box
☐ 7) Concrete Mixer
☐ 8) Auto Carrier
☐ 9) Garbage/Refuse
☐ 10) Not Applicable
☐ 11) Grain, Gravel Chips
☐ 12) Bus, 8 - 15 Occupants
☐ 13) Bus, > 15 Occupants
☐ 14) Other

Haz-Mat ID #:
Hazard Classification #:
Type of Carrier
☐ 1) Single State
☐ 2) USDOT
☐ 3) Canada
☐ 4) Mexico
☐ 5) None
NAS Safety Report #:
Carrier Number #:

003186
003186
003186

Event Number: 050415-0772

STATE OF NEVADA
TRAFFIC ACCIDENT REPORT
VEHICLE INFORMATION SHEET
Revised 7/14/04

Accident Number: NHP-L2005-003864

Agency Name: 1 - DPS NEVADA HIGHWAY PATROL

Vehicle: 2 | # Occupants: 1 | ☐ 1) At Fault ☐ 2) Non Contact

Direction of Travel: ☐ 1) North ☐ 3) East ☐ 5) Unknown ☒ 2) South ☐ 4) West

Highway / Street Name: IR15

Travel Lane: 1

Vehicle Action: ☐ 1) Straight ☐ 2) Left Turn ☐ 3) U-Turn ☐ 4) Right Turn ☐ 5) Passing ☐ 6) Stopped ☐ 7) Wrong Way ☐ 8) Parked ☒ 9) Stopped (*) ☐ 10) Passing ☐ 11) Leaving Parked ☐ 12) Backing ☐ 13) Entering ☐ 14) Leaving Lane ☐ 15) Other Turning ☐ 16) Enter Parked ☐ 17) Other Lane Change ☐ 18) Other Driveway Vehicle ☐ 19) Other ☐ 20) Unknown

Driver
(Last Name, First Name, Middle Name Suffix)
SIMAO WILLIAM JAY

Street Address: 5105 JEWEL CANYON DR.

City: LAS VEGAS | State / Country: ☒ 1) NV | Zip Code: 89122

☒ 1) Male ☐ 2) Female ☐ 3) Unknown | DOB: 5/8/1963 | Phone Number: 7024369347

DLN: 1701633400 | State: ☒ 1) NV | ☐ 1) CDL ☒ 2) DL | License Status: 0

Compliance: ☐ 1) Restrict ☐ 2) Endors

Endorsements | Restrictions

Alcohol/Drug Involvement: ☐ 1) Not Involved ☐ 2) Suspected Involvement ☐ 3) Alcohol ☐ 4) Drugs ☐ 5) Unknown

Method of Determination (check up to 3): ☐ 1) Field Sobriety Test ☐ 4) Urine Test ☐ 2) Evidentiary Breath ☐ 5) Blood Test ☐ 3) Driver Admission ☐ 6) Preliminary Breath | Test Results:

Transported By
☒ 1) Not Transported ☐ 2) EMS ☐ 3) Police ☐ 4) Unknown ☐ 5) Other

Transported To:

Person Type: 1 | Seating Position: 01 | Occupant Restraints: 7

Injury Severity: C | Injury Location: 1 | 3 | 7

Airbags: 1 | Airbag Switch: | Ejected: 0 | Trapped: 0

Driver Factors
☒ 1) Apparently Normal ☐ 2) Had Been Drinking ☐ 3) Drug Involvement ☐ 4) Apparently Fatigued / Asleep ☐ 5) Obstructed View ☐ 6) Driver Ill / Injured ☐ 7) Other Improper Driving ☐ 8) Driver Inattention / Distracted ☐ 9) Physical Impairment ☐ 10) Unknown

Vehicle
Vehicle Year: 1994 | Vehicle Make: FORD | Vehicle Model: ECONOLINE | Vehicle Type: VN

Plate / Permit No.: 573 NHG | State: ☒ 1) NV | Expiration Date: 05/08/2005 | Vehicle Color: RED

Vehicle Identification Number: 1FTJE34H5RHA72334

Registered Owner Name: ☒ 1) Same As Driver

Registered Owner Address:

Vehicle Factors
☐ 1) Failed To Yield Right Of Way ☐ 2) Failed To Maintain Lane ☐ 10) Driverless Vehicle
☐ 3) Disregard Control Device ☐ 10) Following Too Close ☐ 17) Unsafe Backing
☐ 3) Too Fast For Conditions ☐ 11) Unsafe Lane Change ☐ 18) Ran Off Road
☐ 4) Exceeding Speed Limit ☐ 12) Made Improper Turn ☐ 19) Hit and Run
☐ 5) Wrong Way / Direction ☐ 13) Over Correct/Steering ☐ 20) Road Defect (*)
☐ 6) Mechanical Defects ☐ 14) Other Improper Driving ☐ 21) Object Avoidance
☐ 7) Drove Left Of Center ☐ 15) Aggressive / Reckless / Careless
☐ 8) Other ☐ 22) Unknown (E)

Insurance
Insurance Company Name: AMERICAN FAMILY INS. CO.
☒ 1) Insured

Policy Number: 162479040285 FBANV | Effective: 2/1/2005 | To: 8/1/2005

Insurance Company Address or Phone Number: 702-454-0643

1st Contact
☐ 2 ☐ 3 ☐ 4
☐ 1 ☒ 5
☐ 8 ☐ 7 ☐ 6
☐ 1) Override ☐ 7) Under Ride

Damaged Areas
☐ 1) Front
☐ 2) Right Side
☐ 3) Left Side
☒ 4) Rear
☐ 5) Right Front
☐ 6) Right Rear
☐ 7) Top
☐ 8) Under Carriage
☐ 9) Left Front
☐ 10) Left Rear
☐ 11) Unknown
☐ 12) Other

☐ 1) Vehicle Towed | Towed By:

Removed To: DRIVEN AWAY BY DRIVER

Traffic Control
F 1) Speed Zone
2) Signal Light
3) Flashing Light
4) School Zone
5) Ped. Signal
6) No Passing
7) No Controls
8) Warning Sign
9) Turn Signal
10) Other
11) Stop Sign
12) Yield Sign
13) R. R. Sign
14) R. R. Gates
15) R. R. Signal (2)
F 16) Marked Lanes
17) Tire Chains/Snow Req.
18) Permissive Green
☐ 19) Unknown

Distance Traveled After Impact: (7 - MOVED)

Speed Estimate: From: 0 | To: 0 | Limit: 65

Extent Of Damage
☐ 1) Minor ☐ 4) Total
☒ 2) Moderate ☐ 5) None
☐ 3) Major ☐ 6) Unknown

Sequence Of Events

	Code	Description	Collision With Fixed Object	Most Harmful Event
1st	214	214 MOTOR VEHICLE IN TRANSPORT	☐	☐
2nd			☐	☐
3rd			☐	☐
4th			☐	☐
5th			☐	☐

	Violation	NOC	Citation Number
☐ 1) NRS ☐ 2) FAR ☐ 3) CC > MC ☐ 4) Pending (1)			
☐ 1) NRS ☐ 2) FAR ☐ 3) CC > MC ☐ 4) Pending (2)			

Investigator(s)	ID Number	Date	Reviewed By	Date Reviewed	Page
582 SHAWN HAGGSTROM	582	4/15/2005	[illegible]	4.18.05	SIMA00000

Event Number: 050415-0773	STATE OF NEVADA TRAFFIC ACCIDENT REPORT VEHICLE INFORMATION SHEET Revised 6/21/03	Accident Number: NHP-L2005-003664
		Agency Name: 1 - DPS NEVADA HIGHWAY PATROL

Name: (Last Name, First Name, Middle Name Suffix)	Transported By: ☐ 1) Not Transported ☐ 2) EMS ☐ 3) Police ☐ 4) Unknown ☐ 5) Other
Street Address:	Transported To:
City: / State / Country ☐ 1) NV / Zip Code:	Person Type: / Seating Position: / Occupant Restraints:
☐ 1) Male ☐ 3) Unknown ☐ 2) Female / DOB: / Phone Number:	Injury Severity: / Injury Location:
	Airbags: / Airbag Switch: / Ejected: / Trapped:
Name: (Last Name, First Name, Middle Name Suffix)	Transported By: ☐ 1) Not Transported ☐ 2) EMS ☐ 3) Police ☐ 4) Unknown ☐ 5) Other
Street Address:	Transported To:
City: / State / Country ☐ 1) NV / Zip Code:	Person Type: / Seating Position: / Occupant Restraints:
☐ 1) Male ☐ 3) Unknown ☐ 2) Female / DOB: / Phone Number:	Injury Severity: / Injury Location:
	Airbags: / Airbag Switch: / Ejected: / Trapped:
Name: (Last Name, First Name, Middle Name Suffix)	Transported By: ☐ 1) Not Transported ☐ 2) EMS ☐ 3) Police ☐ 4) Unknown ☐ 5) Other
Street Address:	Transported To:
City: / State / Country ☐ 1) NV / Zip Code:	Person Type: / Seating Position: / Occupant Restraints:
☐ 1) Male ☐ 3) Unknown ☐ 2) Female / DOB: / Phone Number:	Injury Severity: / Injury Location:
	Airbags: / Airbag Switch: / Ejected: / Trapped:

☐ 1) Trailing Unit 1 VIN:	Plate:	State: ☐ 1) NV	Type:
☐ 1) Trailing Unit 2 VIN:	Plate:	State: ☐ 1) NV	Type:
☐ 1) Trailing Unit 3 VIN:	Plate:	State: ☐ 1) NV	Type:

Commercial Vehicle Configuration

☐ 1) Bus, 9 - 15 Occupants ☐ 2) Bus, > 15 Occupants ☐ 3) Single 2 Axle and 6 Tire ☐ 4) Single > 3 Axle ☐ 5) Any 4 Tire Vehicle ☐ 6) Tractor Only ☐ 7) Tractor / Trailer ☐ 8) Tractor / Doubles ☐ 9) Tractor / Triples ☐ 10) Truck with Trailer ☐ 11) Tractor / Semi Trailer ☐ 12) Passenger Vehicle, (Haz-Mat) ☐ 13) Light Truck, (Haz-Mat) ☐ 14) Other Heavy Vehicle

☐ 1) Commercial Vehicle ☐ 2) School Bus

Source: ☐ 1) Driver ☐ 2) Log Book ☐ 3) Shipping Papers / Trip Manifest ☐ 4) State Reg. ☐ 5) Side Of Vehicle ☐ 6) Other

Carrier Name:

Power Unit GVWR: ☐ 1) ≤ 10,000 Lbs ☐ 2) 10,000 - 26,000 Lbs ☐ 3) ≥ 26,000 Lbs ☐ 1) Haz-Mat ☐ 2) Released

Carrier Street Address: / City: / State: ☐ 1) NV / Zip:

Cargo Body Type: ☐ 1) Pole ☐ 2) Tank ☐ 3) Flatbed ☐ 4) Dump ☐ 5) Unknown ☐ 6) Van / Box ☐ 7) Concrete Mixer ☐ 8) Auto Carrier ☐ 9) Garbage/Refuse ☐ 10) Not Applicable ☐ 11) Grain, Gravel Chips ☐ 12) Bus, 9 - 15 Occupants ☐ 13) Bus, > 15 Occupants ☐ 14) Other

Haz-Mat ID #:

Hazard Classification #:

Type of Carrier: ☐ 1) Single State ☐ 2) USDOT ☐ 3) Canada ☐ 4) Mexico ☐ 5) None

NAS Safety Report #:

Carrier Number #:

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SIMA000006

003188

003188

Event Number:	STATE OF NEVADA	Accident Number:
050415-0773	TRAFFIC ACCIDENT REPORT Occupant / Witness Supplement Revised 1/14/04	NHP-L2005-003864
		Agency Name: 1 - DPS NEVADA HIGHWAY PATROL

V # 1

Name: (Last Name, First Name, Middle Name Suffix)	RISH KAYLEE L.
Transported By:	☒ 1) Not Transported ☐ 2) EMS ☐ 3) Police ☐ 4) Unknown ☐ 5) Other
Street Address:	3029 CONSTITUTION
Transported To:	
City:	HILL AFB
State / Country ☐ 1) NV	UT
Zip Code:	84056
Person Type:	2
Seating Position:	05
Occupant Restraints:	7
Sex:	☐ 1) Male ☐ 3) Unknown ☒ 2) Female
DOB:	10/28/1994
Phone Number:	8017749066
Injury Severity:	O
Injury Location:	0
Airbags:	
Airbag Switch:	
Ejected:	0
Trapped:	0

V # 1

Name: (Last Name, First Name, Middle Name Suffix)	RISH NATHANEL
Transported By:	☒ 1) Not Transported ☐ 2) EMS ☐ 3) Police ☐ 4) Unknown ☐ 5) Other
Street Address:	3029 CONSTITUTION
Transported To:	
City:	HILL AFB
State / Country ☐ 1) NV	UT
Zip Code:	84056
Person Type:	2
Seating Position:	03
Occupant Restraints:	2
Sex:	☒ 1) Male ☐ 3) Unknown ☐ 2) Female
DOB:	09/21/2003
Phone Number:	8017749066
Injury Severity:	O
Injury Location:	0
Airbags:	
Airbag Switch:	
Ejected:	0
Trapped:	0

V

Name: (Last Name, First Name, Middle Name Suffix)	
Transported By:	☐ 1) Not Transported ☐ 2) EMS ☐ 3) Police ☐ 4) Unknown ☐ 5) Other
Street Address:	
Transported To:	
City:	
State / Country ☐ 1) NV	
Zip Code:	
Person Type:	
Seating Position:	
Occupant Restraints:	
Sex:	☐ 1) Male ☐ 3) Unknown ☐ 2) Female
DOB:	
Phone Number:	
Injury Severity:	
Injury Location:	
Airbags:	
Airbag Switch:	
Ejected:	
Trapped:	

V

Name: (Last Name, First Name, Middle Name Suffix)	
Transported By:	☐ 1) Not Transported ☐ 2) EMS ☐ 3) Police ☐ 4) Unknown ☐ 5) Other
Street Address:	
Transported To:	
City:	
State / Country ☐ 1) NV	
Zip Code:	
Person Type:	
Seating Position:	
Occupant Restraints:	
Sex:	☐ 1) Male ☐ 3) Unknown ☐ 2) Female
DOB:	
Phone Number:	
Injury Severity:	
Injury Location:	
Airbags:	
Airbag Switch:	
Ejected:	
Trapped:	

V

Name: (Last Name, First Name, Middle Name Suffix)	
Transported By:	☐ 1) Not Transported ☐ 2) EMS ☐ 3) Police ☐ 4) Unknown ☐ 5) Other
Street Address:	
Transported To:	
City:	
State / Country ☐ 1) NV	
Zip Code:	
Person Type:	
Seating Position:	
Occupant Restraints:	
Sex:	☐ 1) Male ☐ 3) Unknown ☐ 2) Female
DOB:	
Phone Number:	
Injury Severity:	
Injury Location:	
Airbags:	
Airbag Switch:	
Ejected:	
Trapped:	

Investigator(s)	ID Number	Date	Reviewed By	Date Reviewed	Page
582 SHAWN HAGGSTROM	582	4/15/2005	BOD 4151	4.18.05	7 of 7

SIMA000007

003189

003189

INFORMAL STATEMENT BY:
☒ Driver ☐ Offices From Other Department
☐ Passenger ☐ Other
☐ Witness
V-1

NEVADA HIGHWAY PATROL

ACCIDENT NUMBER: L2005-003864
CITATION NUMBER: 15147408
OTHER NUMBER: 050415-0773

DATE:	TIME:	FULL NAME:
4-15-05	4: ☐ AM ☐ PM	Jenny Rish

RESIDENCE ADDRESS:	CITY:	STATE:	ZIP CODE:	TELEPHONE:
223 N Cottonwood Dr	Gilbert	Az	85234	480 545-4874

SOCIAL SECURITY NUMBER:	DRIVER'S LICENSE NUMBER:	STATE:
[redacted]	D04155603	Az

VEHICLE LICENSE NUMBER:	STATE:	YEAR AND MAKE OF VEHICLE:
886 VDX	UT.	2001 Chev SUV

MY OBSERVATION OR INVOLVEMENT IN THIS MATTER WAS AS FOLLOWS:

Traffic slowing down and came to a stop didn't have time to stop.

Everyone was wearing seat belts except Christopher and Nath, Nath was in mothers arms going to sleep. Christopher was behind driver.

Jenny Rish	59	223 N Cottonwood Gilbert AZ 85234	480	545-4874	Seat belt	D.
Linda L. Rish	39	5029 A Constitution Way Hill AFB UT 84056	801	774-9066	no	S.B.
James C. Rish III	14	4-2-91	801	774-9066	yes	S.B.
Christopher N. Rish	12	10-15-92	801	774-9066	No	S.B.
Kaylee L. Rish	10	10-28-94	801	774-9066	yes	S.B.
Nathaniel L. Rish	19 mos	9-21-03	801	774-9066	No	S.B.

SIGNATURE OF PERSON WRITING STATEMENT:
Jenny Rish

SIMA00000B

INFORMAL STATEMENT BY:
☑ Driver ☐ Officer From Other Department
☐ Passenger ☐ Other
☐ Witness
V-2

NEVADA HIGHWAY PATROL

ACCIDENT NUMBER: 2005-003864
CITATION NUMBER: 15147408
OTHER NUMBER: 050415-0773

DATE: 4/15/05 TIME: 3:20 ☐ AM ☑ PM FULL NAME: William Jay Simao

RESIDENCE ADDRESS: 5105 Jewel Canyon Drive CITY: LV STATE: NV ZIP CODE: 89122 TELEPHONE: 702-436-9347

SOCIAL SECURITY NUMBER: [redacted] DRIVER'S LICENSE NUMBER: 1701633400 STATE: NV

VEHICLE LICENSE NUMBER: 573 NHG STATE: NV YEAR AND MAKE OF VEHICLE: 1994 Ford E350 Van

MY OBSERVATION OR INVOLVEMENT IN THIS MATTER WAS AS FOLLOWS:

I was heading south on hwy 15 a little past Cheyenne. Traffic was stop-n-go. The cars in front of me stopped, I stopped, the car behind me ran into the rear of my vehicle.

SIGNATURE OF PERSON WRITING STATEMENT: William Simao 4/15/05

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003191

EXHIBIT "2"

DISTRICT COURT

CLARK COUNTY, NEVADA

WILLIAM JAY SIMAO, individually and CHERYL ANN SIMAO, individually, and as husband and wife, Plaintiffs, vs. JENNY RISH; JAMES RISH; LINDA RISH, DOES I through V; and ROE CORPORATIONS I through V, inclusive, Defendants.	)	Case No. A539455

DEPOSITION OF DAVID E. FISH, M.D.

Santa Monica, CALIFORNIA

Thursday, February 10, 2011

Reported by:
Gideon Choi
CSR No. 13258

003193

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DISTRICT COURT
CLARK COUNTY, NEVADA

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

Plaintiffs,

vs.) Case No. A539455

JENNY RISH; JAMES RISH; LINDA RISH, DOES 3 through V, and ROE CORPORATIONS I through V, inclusive,

Defendants.

Deposition of DAVID E. FISH, M.D., taken on behalf of Plaintiffs, at 1250 16th Street, Tower Building, Room 745, Santa Monica, California, beginning at 2:17 p.m. and ending at 4:18 p.m., on Thursday, February 10, 2011, before Gideon Choi, Certified Shorthand Reporter No. 13258

APPEARANCES

For the Plaintiffs
MAINOR EGLET, LLP
BY DAVID WALL, ESQ. (Appearing via video-conference)
400 South Fourth Street
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Las Vegas, Nevada 89101
Telephone (702) 450-5400
Facsimile (702) 450-5451
E-mail dwall@mainorlawyers.com

For the Defendant
ROGERS, MASTRANGELO, CARVALHO & MITCHELL
BY STEPHEN H. ROGERS, ESQ. (Appearing via video-conference)
300 South Fourth Street
Suite 710
Las Vegas, Nevada 89101

INDEX

Witness DAVID E. FISH, M.D.

EXHIBITS

(Continued)

INDEX (Continued)

INFORMATION REQUESTED

Page	Line
None	

QUESTIONS INSTRUCTED NOT TO ANSWER

Page	Line
None	

14:31:35 13
14:31:35 12

DAVID E. FISH, M.D.

called as a witness by and on behalf of the Plaintiff, and having been first duly sworn by the Certified Shorthand Reporter, was examined and testified as follows.

EXAMINATION

BY MR. WALL:

Q. All right. Could you state your name for the record, please?

A. David Eli Fish.

Q. Dr. Fish, just to kind of walk through some things, I have a -- do you have an updated CV?

A. Yeah, but before you start, what's your name?

Q. My name is David Wall. Thank you. W-a-l-l.

A. It's nice to meet you, sir.

Q. All right. Do you have a copy of your CV?

A. Yes, I do.

Q. Is that updated?

A. Yes, it is.

Q. All right. I'm not sure mine is, so we'll make that Exhibit 1 to the deposition.

A. Okay.

(Plaintiff's Exhibit 1 was marked for identification by the Certified Shorthand Reporter, a copy of which is attached hereto.)

Q. I have a list of cases, testimony history, but mine stops with 2008. Do you have a more recent one?

A. Yes.

Q. All right. Do you have that handy?

A. I can print it up for Gideon after we're done if you want.

Q. All right. We'll make that Exhibit 2. I have a fee schedule. I'm not sure whether it's updated. It shows -- actually, it says "2007 updated" in the lower left-hand corner. Is that still good?

A. Probably not.

Q. All right. Do you have an updated one available?

A. Yes.

Q. Will you be able to provide that to the court reporter as Exhibit 3?

A. Yes.

Q. On the list of cases since 2008, how many times do you think you've testified either in a deposition or in a trial or arbitration?

A. Since 2008, and maybe 25 times.

Q. And can you breakdown those 25 for me, roughly how many were on behalf of plaintiffs and how many were on behalf of the defense or as a treating doctor?

A. Yes, no problem. Hold on a second. I can do that. So for 2008 --

Q. I have 2008.

A. Okay. So for 2009, as a treating doctor, I did two, as an expert witness, I did seventeen, and for the plaintiff, I did nine, and for the defense -- actually, sorry -- that would be seven, and for the defense it looks like ten.

Q. Do you have the records from 2010 as well?

A. Yes -- oh, and of the court appearances, I have three, and they were all for plaintiff. The other ones were depositions. And for 2010, there were eleven total depositions, one as treating, and of the ten that were left over, two were plaintiff, and eight were defense.

Q. Can you estimate in 2009 and 2010, how many other cases besides this one involved Mr. Rogers or his firm?

A. Five.

Q. Is that who initially contacted you in this case?

A. I don't remember. Most likely, but I don't remember.

Q. Do you have correspondence that would reflect that?

A. I don't know.

Q. Do you know when you were first contacted on this case?

A. Sometime at the beginning of 2008, because my first report was in February of 2008.

Q. I show that your first report was February of 2009. Is that incorrect?

A. Yeah, I apologize. 2009 -- no. Actually, no, it was in 2008. I may not have done a report until 2009.

Q. When were you first contacted, do you know?

A. Again, I'd say at the beginning of 2008.

Q. Beginning of 2008?

A. Correct.

Q. What do you base that estimate on?

A. I have my -- I have a billing statement from February 14th, 2008, and it looks like there was an expedited review of records that were needed that was dated around 2008.

Q. Who did you bill?

A. Rogers, Mastrangelo, Carvalho & Mitchell.

Q. Your entire file, including the billing records, I'd like to have all of that provided to the court reporter and made an exhibit. I guess it would be Exhibit 4. Can you provide that after the conclusion of the deposition to the court reporter?

A. Do you want it on disc or do you want it printed out or what do you want to do?

Q. On disc.

A. On disc?

Q. On disc would be fine.

A. I don't think I can get it to you today. I'd have to send it to you.

Q. Okay. Do you know what your charges are to date in this case?

While you're looking for that, Doctor, you've had your

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deposition taken enough times that you'd waive all the normal admonitions, is that right?

A Yes, sir.

MR WALL All right. And while you're looking for that, Mr. Reporter, I'm going to provide to you a disc that we had prepared that has nine previous depositions of Dr. Fish, and that will be Exhibit 5.

THE COURT REPORTER Okay, sir.

THE WITNESS So I guess you did some light reading, is that true?

BY MR WALL

Q Do you have a total for me, Doctor?

A I'm working on it. Okay. I got a number for you. $19,200.

Q That's up to, but not including today?

A That is correct.

Q What did you do to prepare for your deposition?

A I reviewed the records that I had previously reviewed and read my reports, and I looked over the records that I thought were pertinent for the questions I hoped you would ask me.

Q Anything else?

A No.

Q Did you have any conversations with Mr. Rogers or anyone from his firm?

A Yes.

Q What was the nature of those -- how many?

A Well, when? Last week? Last year?

Q To prepare for your deposition.

A Oh, probably just one conversation just to make sure that I had all of the documents that I needed and to make sure that I had all the proper records that were needed.

Q When was that conversation?

A I think it was two days ago.

Q You are board certified, Doctor; is that right?

A Yes, sir.

Q What specialty?

A Physical medicine and rehabilitation and pain medicine.

Q You're not a board certified spine surgeon; is that correct?

A Well, I mean, define "spine surgery". I do some spine surgeries, so you have to be a little bit more --

Q Are you board certified in any orthopedic surgery or spine surgery?

A Well, yeah, I am.

Q Okay. In what?

A Well, I do spinal cord stimulators and morphine pumps, and so we do surgery to the spine in those cases as well as vertebroplasties and kyphoplasties which are also considered spine surgeries.

Q And have you ever done a fusion?

A No.

Q Ever assisted in a fusion?

A No.

Q Do you refer patients out to spine surgeons?

A Yes.

Q Have you referred any patients to any Las Vegas spine surgeons?

A Yes.

Q Who would you have referred to?

A Dr. Schifini. I've referred patients to Las Vegas surgeons quite a bit. It just depends. At UCLA our catchment area is very big so we get a lot of patients from Las Vegas, and so I try to keep them in Las Vegas as opposed to having surgery done here, if that needs be.

Q So Dr. Schifini is not a spine surgeon, is that right?

A No, no. That was the first person I thought about because I recently referred someone there. I can't tell you offhand who I did. There's a lot of surgeons in Las Vegas, so I can't tell you exactly who I referred to, but I know I've referred some patients over there.

Q Do you know Dr. McNulty?

A Not personally, no.

Q Have you referred any patients to Dr. McNulty?

A I don't know.

Q You don't know?

A I may have. I don't know. It depends on the group that the patients are coming from, and my office tends to try to help them find a surgeon or find somebody in Las Vegas, so it's possible that a referral has gone to him.

Q Are you a member of NASS, N-A-S-S?

A Yes.

Q Are you a member of ISIS?

A Yes.

Q I-S-I-S?

A Yes.

Q So are you familiar with the ISIS guidelines or criteria for pain management doctors?

A Yes.

Q Have you ever performed any discography?

A Yes.

Q I'm sorry?

A Yes.

Q Oh, the answer was yes. Cervical, lumbar, or both?

A Cervical, thoracolumbar, and lumbar.

Q Do you use those regularly?

A Yes.

Q When was the last time that you performed a cervical discography?

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14:31:30 1 A Two weeks ago
14:31:32 2 Q Do you consider yourself to have expertise in the area
14:31:39 3 of biomechanics as it relates to motor vehicle accidents?
14:31:43 4 A If you mean am I certified by any governing body, no,
14:31:50 5 but do I have expertise in understanding mechanics and injuries,
14:31:54 6 yes.
14:31:55 7 Q Would it be your intention to testify as an expert in
14:31:59 8 the area of biomechanics or whether a certain type of impact
14:32:05 9 between two vehicles would be sufficient to cause a certain type
14:32:10 10 of injury?
14:32:13 11 A If I'm asked a question, I would answer it I don't
14:32:16 12 know if I've been asked to specifically do that as an expert
14:32:20 13 Q All right Have you been asked to do that in this
14:32:23 14 case?
14:32:24 15 A Well, I mean, I think causation and the injury
14:32:30 16 component and whether or not a person was injured in a specific
14:32:33 17 car accident or if Mr. Simao had an injury occur from the car
14:32:40 18 accident, I've been asked I've made opinions as such, but I
14:32:43 19 did not measure velocities or G-force or measurements of tire
14:32:49 20 skid marks or anything like that, if that's what you're asking
14:32:52 21 Q So it wouldn't be your intention to offer testimony as
14:32:56 22 an expert that the actual collision in this case based on --
14:33:08 23 A Hello?
14:33:11 24 Q -- injury, would that be correct?
14:33:13 25 A You're going to have to say it again You cut out

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14:33:18 1 MR ROGERS Court Reporter, I'll lodge a compound
14:33:20 2 objection, and then go ahead, Doctor
14:33:24 3 THE WITNESS You have to say the question again It got
14:33:27 4 cut off
14:33:31 5 MR. WALL Oh, it got cut off.
14:33:33 6 MR. STEPHENS: Oh, okay
14:33:34 7 BY MR. WALL:
14:33:34 8 Q Is it your intention in this case to offer opinions at
14:33:39 9 trial regarding whether this accident was sufficient in the
14:33:47 10 magnitude of the collision to cause a particular injury?
14:33:53 11 A Yes. I mean, I'm going to make opinions based on the
14:33:58 12 MRI, based on the records on whether or not the accident
14:34:02 13 actually caused any injury to Mr. Simao
14:34:06 14 Q That's not my question My question is: Are you going
14:34:09 15 to do that from a biomechanical perspective, that is, looking at
14:34:13 16 the damage to the vehicles and the nature of the collision to
14:34:19 17 determine whether it was sufficiently severe to cause a
14:34:23 18 particular injury?
14:34:26 19 MR. STEPHENS: I object. Compound. Doctor, go ahead.
14:34:30 20 THE WITNESS: I think I've answered the question. I mean,
14:34:32 21 I'm not certified as a bioengineer. I'm not certified as
14:34:36 22 somebody who can measure G-forces, but I can tell what an
14:34:41 23 accident and what an MRI look like and whether or not a person
14:34:46 24 has been injured based on the medical records and the medical
14:34:49 25 complaints.

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14:34:49 1 BY MR WALL
14:34:49 2 Q Doctor, do you understand my question?
14:34:52 3 A Probably not because you've asked it for the third
14:34:54 4 time, so I would say no, I don't understand your question
14:34:57 5 Q There's a difference between looking at the MRI's or
14:35:00 6 the medical records to determine certain things surrounding
14:35:04 7 causation as compared to looking at the damage to the vehicles
14:35:08 8 and determining Delta V and whether or not that particular
14:35:13 9 collision with those two vehicles was sufficient to cause a
14:35:16 10 particular injury from a biomechanical perspective
14:35:20 11 Is it your intent to offer an opinion based on the
14:35:27 12 biomechanics of the accident?
14:35:29 13 A I don't think so.
14:35:30 14 Q Are you not sure?
14:35:35 15 A Well, I mean, I don't know if I understand your
14:35:38 16 question
14:35:40 17 Q Have you done any analysis of the vehicles or the
14:35:44 18 photographs of the vehicles or the damage estimates to the
14:35:46 19 vehicles in rendering your opinions?
14:35:49 20 A I've looked at them so I've done an analysis of the
14:35:54 21 pictures and the amount of damage as well as the cost to fix the
14:35:59 22 damage
14:36:00 23 Q Is it your opinion that the damage to the vehicles or
14:36:04 24 the amount to fix the vehicles is a significant consideration in
14:36:09 25 forming the basis of any of your opinions?

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14:36:12 1 A I don't know if I would say significant, but it is a
14:36:16 2 factor
14:36:18 3 Q And what training do you have to correlate the amount
14:36:25 4 of damage to the vehicle to a specific injury?
14:36:36 5 A Let me see if I got it right. Correlate the amount of
14:36:40 6 damage to a specific injury?
14:36:44 7 Q Correct, the amount of damage to the vehicle
14:36:45 8 A Well, it's experience. It's seeing many people who
14:36:49 9 have had significant car accidents. It's seeing people who were
14:36:54 10 injured and people who have had injuries as well as reviewing
14:36:57 11 previous cases and my patients that come through the door as
14:37:01 12 well as come through the emergency room who have had significant
14:37:05 13 accidents or non-significant accidents.
14:37:07 14 Q When you say "non-significant", is it your experience
14:37:10 15 that an accident has to have a significant amount of damage to
14:37:14 16 the vehicles in order to cause injury to one of the parties
14:37:19 17 inside?
14:37:19 18 A Well, again, I think that depends on the complaints of
14:37:23 19 the individual, where the individual may have -- either the body
14:37:27 20 struck or what kind of components of damage, where it is. I
14:37:31 21 mean, obviously, if the damage was done on a rear end bumper,
14:37:35 22 and a person is complaining of a wrist injury or an elbow injury
14:37:39 23 on the right side, and there's nothing that the person struck
14:37:42 24 and it's a very slight injury, then obviously you make the
14:37:46 25 correlation as to the medical components as well as the injury

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and the damage to the vehicle

Q So is it your intention in this case to say, essentially, I looked at the damage to these vehicles, and it wasn't significant to cause an injury to Mr. Simao, is that your intention?

A Well, I think that's part of the whole evaluation of Mr. Simao, and looking at the records, I think that's part of it. I'm not saying that it's purely based on the actual pictures or purely based on the actual amount of damage, but it's a factor.

Q Okay. And you believe that the impact was not severe enough to cause any type of injury beyond a whiplash injury to Mr. Simao, is that your opinion?

A No. If you see in my subsequent reports, I abandon the whiplash injury as a diagnosis and felt that he had a non-specific myofascial complaint, and that based on the pain complaints from his initial visit and the subsequent six months, I don't think Mr. Simao had a significant injury to his neck.

Q Is that because the impact wasn't severe enough to cause it?

A Well, I think that's part of it. I also think it's the complaints that he had. He really was not complaining of neck pain after the May 5th -- I'm sorry -- the April 15th, 2005 accident. You know, his first visit to a provider on the 4th -- on that day, you know, he may have complained of neck pain, but

after that he didn't really complain of neck pain, so there is a component of him not being injured to his neck.

Q But my question was, Is that based on your review of the photographs and the damage estimates of the vehicle?

A That is part of it, yes.

Q And what training do you have to measure or review photographs of an accident of the vehicles or the damage estimates and then to correlate that to whether or not someone could be injured either by whiplash or by some other mechanism; what training do you have in that?

A Well, I think I answered that before, but, you know, having been in two car accidents myself and experienced them as well as seeing patients through the emergency room at UCLA, at John Hopkins, and in the military, I've got a lot of experience with accidents and with injuries that were sustained as well as treating patients who have had accidents and what kind of injuries that were sustained. So it's part of my experience, part of my training, and part of my personal experience as well.

Q All right. I have what I think is your original report which shows a date of review of February 10th, 2009. Do you have a copy of that?

A Yes.

Q I'm going to have that -- if you have a copy of that -- and ask that that it be marked as Exhibit 6. I think that's the next in order.

A I have an electronic copy. I don't have the --

Q All right. Would you be able to print out a copy to make it Exhibit 6?

A Well, I was going to give him the whole disc. I really can't print everything out.

Q All right. Well, that. I want printed out and made a separate exhibit. Can you do that?

A Yes, I will try.

Q All right. And then I have what we'll call Exhibit 7, "Independent Record Review, Addendum No. 1" that shows a date of review of July 13th, 2010. Do you have that available?

A Electronically, yes.

Q All right. I would ask that that be printed out after the deposition and made Exhibit 7. And then I have "Independent Record Review Addendum No. 4"

A Yes.

Q Which appears to have a date of October 18th 2010. Do you have that available?

A Yes.

Q I would ask that that be made as Exhibit 8 to the deposition and printed out. Is there an Addendum 2 and 3?

A That's what I was trying to clarify. I think it was a clerical error, and that's why it came out to Addendum 4.

Q The answer is no, there is not?

A There is not.

Q All right. Do these three reports contain a complete statement of all of your opinions that you have in this case?

A No. There's an Addendum 5.

Q Where is Addendum 5?

A Right here. (Indicating.)

Q Has that been produced to anyone? The record should reflect that you're showing me a copy over Skype?

A Yes. I've given it to Mr. Rogers.

Q I have not received No. 5.

MR. WALL: Mr. Rogers, have you received No. 5?

MR. ROGERS: I have not. When did you send it, Dr. Fish?

THE WITNESS: Yesterday.

MR. STEPHENS: Okay.

BY MR. WALL:

Q All right. I'm going to ask that a copy be made of that and made Exhibit 9. I guess that would be the next in order.

(Plaintiff's Exhibit 9 was marked for identification by the Certified Shorthand Reporter, a copy of which is attached hereto.)

I won't be able to see that, obviously, so I'm going to reserve now the opportunity, once I review No. 5, to reconvene the deposition in order to do that.

Let me ask you this. In No. 5, does it list the records that you reviewed since No. 4?

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14:44:14 1 A Yes
14:44:17 2 Q What records are listed?
14:44:18 3 A The updated report of Kathleen Hartman dated 11/8/2010
14:44:24 4 Q Is that it?
14:44:25 5 A Yes
14:44:26 6 Q All right.
14:44:30 7 MR STEPHENS: Dated what?
14:44:33 8 THE WITNESS: 11/8/2010
14:44:35 9 BY MR WALL
14:44:39 10 Q All right. Do all of those four reports which we've
14:44:45 11 marked as 6, 7, 8, and 9 contain all the complete opinions you
14:44:53 12 intend to express in this case?
14:44:55 13 A Well, I tried to be as complete as possible. Since my
14:44:59 14 review of the records in preparation for this deposition, I may
14:45:03 15 make some other statements or opinions, so I'm hoping that it
14:45:07 16 contains a lot of them, but I may have more.
14:45:10 17 Q All right. Does it -- do the reports contain a
14:45:14 18 complete statement of the basis for your opinions?
14:45:18 19 A I don't know because I just got new records as well,
14:45:24 20 and so that may not contain some of the records that I've
14:45:28 21 received recently. Actually, in fact --
14:45:30 22 Q At least as of the date of the report, does it?
14:45:34 23 A As of the -- no, because I was not able to add the new
14:45:39 24 records in on a new report, so it's probably missing some
14:45:45 25 reports that I do not have. And I can list them for you, if you

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14:45:49 1 want.
14:45:50 2 Q What are you listing for me?
14:45:53 3 A Well, I know I have not made any opinions or referenced
14:45:56 4 some records that I received. And so you said does this
14:46:04 5 report, No. 5, include all the things that I had, and I actually
14:46:06 6 have some records, but I have not made any opinions on them.
14:46:10 7 Q What records are those, and when did you receive them?
14:46:18 8 A This week or last week. Oh, I have them on disc.
14:46:27 9 Q February 2011?
14:46:28 10 A Yeah. I forgot. I have a whole set of discs that I
14:46:33 11 have. They're in my office, so I can bring them in if you want.
14:46:37 12 I can show them to you on the Skype if you want.
14:46:40 13 Q What records did you receive within the last two weeks?
14:46:43 14 That's what I'm asking.
14:46:44 15 A No, I know. I just realized that I had these other
14:46:47 16 records. I apologize. The depositions of Brin Hill,
14:46:58 17 Dr. Seibel, Officer Hagstrom, Dr. Rossler, Dr. Ginyer,
14:47:05 18 Dr. McNulty, Jenny Rish -- R-i-s-h, a report from Dr. Winkler, a
14:47:12 19 report from Dr. Wang, W-a-n-g, cervical spine X-rays, 4/15/05,
14:47:30 20 10/18/05, 6/17/08, 1/11/10, a CT of the cervical spine,
14:47:34 21 8/8/08, 08/11/09, a CT of the brain, 5/14/2005; MRI of the
14:47:45 22 cervical spine, the actual images, 3/22/2010.
14:47:50 23 Q Let me stop you for a minute. These are things that
14:47:53 24 you just received in the last two weeks?
14:47:55 25 A Well, I didn't have the actual images and so they were

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14:47:59 1 sent to me, so I don't know if I've actually reviewed the images
14:48:03 2 in my previous reports and so -- I may have received them
14:48:07 3 beforehand, but I haven't had a chance to actually look at them
14:48:10 4 until the last two weeks.
14:48:11 5 Q And so all of these -- well, I'll let you finish the
14:48:17 6 list. Finish the list.
14:48:18 7 A Okay. MRI of the cervical spine, 9/24/2007; MRI of the
14:48:24 8 cervical spine, 4/30/2008, MRI of the cervical spine, 8/11/2009,
14:48:30 9 brain MRI of 5/23/2005, actual images. Oh, and vehicle photos.
14:48:37 10 Sorry. I didn't have those before.
14:48:39 11 Q And all of those things that you just listed you just
14:48:44 12 received within the last two weeks?
14:48:46 13 A I may have received them before, but I have not had a
14:48:49 14 chance to look at them until the last two weeks, so in my mind I
14:48:53 15 just received them in the last two weeks.
14:48:56 16 Q Including those depositions? Did you receive those
14:48:59 17 depositions within the last two weeks?
14:49:03 18 A I believe so, yes.
14:49:05 19 Q I didn't hear that Mr. Simao's deposition was listed in
14:49:13 20 that group, is that correct?
14:49:13 21 A I might not have seen that one. If I listed it on my
14:49:15 22 reports, I may have had them, but I might not have seen his
14:49:23 23 actual deposition.
14:49:24 24 Q Well, Exhibit 6 which is your original report lists no
14:49:30 25 depositions. Exhibit 7 which is your Addendum No. 1 lists the

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14:49:35 1 deposition of Dr. Adam Arita, A-r-i-t-a, and no others. And
14:49:43 2 Addendum No. 4 doesn't list any depositions.
14:49:45 3 So would you have listed all of the documents that you
14:49:49 4 reviewed in preparation of your reports in that particular
14:49:53 5 report or addendum?
14:49:57 6 A Which particular report or addendum?
14:50:00 7 Q All of them as you did each one.
14:50:04 8 A I'm not sure I understand your question.
14:50:06 9 Q All right. When you did your original report in
14:50:10 10 February of 2009, it listed records reviewed. Is that all of
14:50:14 11 the records that you reviewed in preparation for that report?
14:50:16 12 A Yes.
14:50:17 13 Q Same thing for Addendum No. 1 where it lists records
14:50:23 14 reviewed?
14:50:23 15 A Yes.
14:50:23 16 Q Same thing for Addendum No. 4?
14:50:26 17 A Yes.
14:50:27 18 Q And Addendum No. 5 apparently as well; is that right?
14:50:31 19 A Correct.
14:50:32 20 Q Same answer?
14:50:34 21 A Correct.
14:50:35 22 Q So you had -- the only deposition that you had that you
14:50:41 23 reviewed until the last two weeks was the deposition of
14:50:45 24 Dr. Arita; is that right?
14:50:47 25 A I believe so, yes.

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14:50:48 3 Q And have you – when did you review the depositions of
14:50:54 7 Dr Hill, Dr Seibel, Dr Rossler, Dr. Grover and Dr. McNulty?
14:50:59 3 A Over the last two weeks.
14:51:01 4 Q I'm sorry?
14:51:06 5 A Over the last two weeks
14:51:06 6 Q And is that because you've just received them?
14:51:15 7 A Like I said, I might have received them beforehand, but
14:51:18 8 I did not know that I had them until the last couple of weeks in
14:51:22 9 preparation for the deposition that was happening today.
14:51:2510 Q If you had them, why wouldn't you have known that you
14:51:2911 had them?
14:51:3012 A I'm a busy man I don't know what to tell you I have
14:51:3513 a lot of things going on on my plate. I've got research
14:51:3914 projects that need to be taken care of. I have grants that I'm
14:51:4215 submitting You know, I've got a lot of things going on besides
14:51:4516 this case, so it's possible that they were there, and I just
14:51:4817 didn't have a chance to get to them.
14:51:5118 Q How many –
14:51:5319 A I hope you can appreciate that.
14:51:5320 Q I'm sorry Go ahead
14:51:5421 A I hope you can appreciate that.
14:51:5727 Q How many depositions of Dr. McNulty did you have?
14:52:0323 A What do you mean? From this case?
14:52:0624 Q Yes
14:52:0725 A I think it's just one Is there another? Oh, he had

14:52:11 1 two, right?
14:52:14 2 Q Well, tell me how many transcripts you have?
14:52:17 3 A I believe I recall just one, but, actually, in thinking
14:52:20 4 about it, I think it wasn't completed, and he had to have a
14:52:24 5 second one
14:52:27 6 Q So all of these documents that you've listed here that
14:52:30 7 you say you either didn't receive or at least didn't review
14:52:41 8 until the last two weeks, are any of those mentioned in
14:52:50 9 Addendum No 5?
14:52:5010 A I don't believe so
14:52:5311 Q Did any of those depositions that you reviewed or the
14:52:5512 medical records that you've reviewed change any of your opinions
14:53:0413 in this case?
14:53:0614 A It reinforced them The deposition by Dr. Seibel in
14:53:1415 conjunction with the deposition of Mr. Hill and Dr. Arita really
14:53:1916 enforced the – a lot of my opinions and allowed me to actually
14:53:2517 get a better grasp and picture of the case in general.
14:53:3018 Q Your Addendum No 1 – I'm sorry – Addendum No. 4 from
14:53:4619 October of 2010, do you have access to that?
14:53:5520 A Yes, sir.
14:53:5621 Q On Page 4 in Paragraph No 3, it says, "I have reviewed
14:54:0622 the deposition testimony from Mr. Simao's treating physicians,"
14:54:1423 and then it goes on to reference portions of Dr. Anita's
14:54:2124 deposition
14:54:2225 When you said, "I have reviewed the deposition

14:54:25 1 testimony of Mr Simao's treating physicians," at that time was
14:54:31 2 Dr. Arita the only one that you had reviewed?
14:54:36 3 A I believe so, yes
14:54:37 4 Q If, in fact, all of those other depositions were not
14:54:44 5 sent to you until the last two weeks, did you ever request them
14:54:52 6 previously?
14:54:52 7 A Well, I mean, I requested all the records, but they may
14:54:56 8 have come in earlier, and I just didn't look at them or I didn't
14:54:59 9 see them There may have been a lot of different factors
14:55:0310 Q You would have wanted to see the deposition testimony
14:55:0611 of the treating physicians and the surgeon who performed the
14:55:1012 surgery, is that right?
14:55:1113 A Well, I would want to see all the records
14:55:1314 Q What period of time do you understand that Dr Arita
14:55:2815 actually treated Mr Simao?
14:55:3016 A Do you think we could take a quick break? I just want
14:55:4417 to get a drink. I'm starting to get dry here, okay?
14:55:4818 MR WALL. Sure
14:55:4819 (Recess taken from 2 55 p.m to 2 57 p m)
14:57:5820 MR WALL: All right Let's go back on the record
14:57:5821 BY MR WALL.
14:58:0022 Q Doctor, do you remember the question that was asked
14:58:0223 before we took a break?
14:58:0324 A Yes, I do.
14:58:0425 Q What was the period of time that you understand

14:58:07 1 Dr. Arita to have treated Mr Simao?
14:58:10 2 A I think it's between 8/24/2006 to 3/22/2007
14:58:18 3 Q Let me ask you That list of things that you read to
14:58:26 4 me that you had just reviewed within the last two weeks, where
14:58:31 5 does that list come from? What were you reading from?
14:58:33 6 A Oh, well, I realized that I didn't have some of the
14:58:38 7 records, and so I just quickly put it together in my – it's
14:58:42 8 just a summary, just a page
14:58:47 9 Q When did do you that?
14:58:4910 A In preparation for the deposition I realized that there
14:58:5211 was records that I didn't have listed there so I wanted to make
14:58:5612 sure that I had them
14:58:5813 Q And so did you contact Mr Rogers's office to obtain
14:59:0514 that information?
14:59:0615 A No. I think I might have had them already, but I just
14:59:0916 didn't – I don't know if they, you know, sent everything to me
14:59:1417 in the last couple of weeks or whether I had them already I
14:59:1818 mean, there's a lot of records for this case That's the
14:59:2119 thing.
14:59:2220 Q A lot of the X-rays and CT scans that you talked about
14:59:2721 seem to be referenced in your Addendum No 1 as films that you
14:59:3422 actually reviewed?
14:59:3623 A Correct, but he's had some more since that time so I
14:59:4524 wanted to make sure – well, I received some more since that
14:59:4925 time so I wanted to make sure that I was getting everything for

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14:59:52 1 you
14:59:55 2 Q Your Addendum No. 4 on Page 3 says that "the accident
15:00:20 3 report noted moderate damage to the vehicles and both were
15:00:24 4 driven away." Is that a significant basis for any of your
15:00:30 5 opinions in this case?
15:00:31 6 MR. STEPHENS: I'm going to object. Vague as to
15:00:35 7 "significant", but go ahead, Doctor.
15:00:36 8 THE WITNESS: I don't see where you're at. What page?
15:00:36 9 BY MR. WALL:
15:00:39 10 Q Page 3 of Addendum No. 4 in the first full paragraph
15:00:46 11 A The first full paragraph, so it's the top of Page 3?
15:00:54 12 Right. Okay. Well, at the time I don't think -- that was
15:00:58 13 basically from the reports, but I don't know if I can really say
15:01:02 14 that I had the actual images of the pictures or the estimates of
15:01:07 15 the damage at the time, so it may have just been taken from the
15:01:12 16 reports.
15:01:13 17 Q My question was: Did it play a part in forming your
15:01:17 18 opinions in this case?
15:01:25 19 A Maybe.
15:01:29 20 Q Could you elaborate on that a little bit?
15:01:33 21 A Well, I'm not really sure exactly how you want me to
15:01:37 22 determine this. I guess it's, you know, all the factors that go
15:01:42 23 into this case. It's seeing the initial records and seeing his
15:01:46 24 complaints at the time as well as looking at the photographs and
15:01:51 25 the actual damage of those photographs, and so it definitely

15:01:59 1 played a factor in the overall review of the case.
15:02:04 2 Q On the same page further down under Paragraph 1 it
15:02:12 3 says, "Mr. Simao had a significant history of headaches with
15:02:16 4 treatment prior to the motor vehicle accident of April 15th,
15:02:24 5 2005."
15:02:25 6 Did you review any records which predated -- medical
15:02:28 7 records which predated the accident?
15:02:30 8 A No.
15:02:37 9 Q Do you have any knowledge of the character or location
15:02:41 10 of those headings based on any medical records?
15:02:44 11 A Just from the recent records with his new neurologist
15:02:50 12 that he's been seeing in 2010 and him describing the history of
15:02:56 13 longstanding migraines as well as the other records that he
15:03:00 14 described to the Southwest Medical Associates when he presented
15:03:04 15 after the accident about his pre-existing migraines.
15:03:07 16 Q So what were Mr. Simao's presenting complaints on the
15:03:19 17 day of the motor vehicle accident?
15:03:21 18 A Neck pain, headache, left elbow pain.
15:03:45 19 Q Anything else?
15:03:47 20 A That's what the records say.
15:03:49 21 Q In Addendum No. 4 -- well, let me ask you this:
15:04:01 22 Addendum No. 4 -- you testified previously that since the time
15:04:05 23 of your original report until at least Addendum No. 4 or No. 5,
15:04:11 24 that you had abandoned certain conclusions; is that right?
15:04:16 25 A I modified them. I don't know if "abandoned" is the

15:04:20 1 right word, but I changed them.
15:04:22 2 Q I thought "abandoned" was the word you used earlier.
15:04:26 3 A Oh, was it? Okay. Abandon.
15:04:30 4 Q Should I disregard the first report and Addendum 4 or
15:04:37 5 Addendum 1?
15:04:38 6 A I wouldn't disregard any of the reports. I just was
15:04:42 7 looking at the diagnosis that I came up with, and I modified it
15:04:45 8 or abandoned it from the previous reports, but the opinions that
15:04:50 9 are in the earlier reports may not have been extended to the
15:04:55 10 next report.
15:05:00 11 Q In Addendum 4 you state that "Mr. Simao's care between
15:05:10 12 May and October of 2005 was sporadic and related to his
15:05:16 13 pre-existing headaches", do you see that?
15:05:19 14 A No, but I that's what I recall writing.
15:05:24 15 Q What basis do you have to determine that any treatment
15:05:30 16 between May and October of 2005 was related to the pre-existing
15:05:35 17 headaches as opposed to something different that occurred in the
15:05:38 18 accident?
15:05:39 19 A Well, his admission on 5/4/2005, that he had a history
15:06:07 20 of migraine headaches, no change in the mental status, if you
15:06:11 21 will, and no weakness into his legs based on the examination,
15:06:14 22 there's no neurological complaints; the MRI of the brain being
15:06:19 23 unremarkable showing no structural abnormalities from 5/23/2005,
15:06:29 24 the treatment for migraine type headaches with standard
15:06:36 25 medication such as Topamax and Carisoprodol.

15:06:43 1
15:06:48 2 Q So my question was --
15:06:50 3 A I'm listing -- hold on. I'm not done. The listing of
15:06:54 4 X-rays of the cervical spine in the left shoulder from
15:07:00 5 10/8/2005; and the inconsistencies of him following up where he
15:07:07 6 doesn't have consistent follow-up on a weekly or bi-weekly
15:07:13 7 basis, but actually had gaps in care. That, to me, is
15:07:16 8 consistent with a pre-existing migraine condition.
15:07:21 9 Q Did you understand that Mr. Simao described any
15:07:24 10 headaches he had post-accident during that period as being
15:07:28 11 different from the migraines he may have suffered prior to the
15:07:32 12 accident?
15:07:32 13 A Yes, I read that.
15:07:34 14 Q And have you disregarded that?
15:07:37 15 A No, I didn't disregard it. That's fine. I understand
15:07:41 16 where he's coming from. I'm going by the records, and this is
15:07:44 17 my opinion based on the simplicity of the records and his
15:07:48 18 pre-existing condition, as well as if you look at the records
15:07:51 19 from 2010, that really kind of starts talking about only
15:07:57 20 migraine headaches.
15:08:05 21 Q You write in Addendum No. 4, Exhibit 8, that it was not
15:08:09 22 until October 2005 that his neck pain began to be an issue, but
15:08:14 23 in fact he presented with neck pain at the hospital; is that
15:08:16 24 correct?
15:08:16 25 A Yeah, but you have to understand the neck pain that he

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presented with was not something that he continued to complain about. You know, if somebody has neck pain related to a significant trauma, in my experience at a Level I trauma center at UCLA, Johns Hopkins, and in the military, these individuals have continuous pain complaints every single day, and they will show up the following week.

I mean, he showed up on multiple visits between then and October and had no neck pain. And, actually, if you look at the physical exam, the range of motion of the neck was full without any pain. So just because he had it on the first day, obviously, doesn't mean that he had significant pain later on.

Q. Well, that's a significant basis for your opinions in this case, isn't it, that there wasn't neck pain from May to October of 2005 documented in the records?

A. It's not a significant basis. It's a portion of the basis of my opinions. I have other opinions. The MRI's actually being normal, reported as normal on subsequent MRI's after the first one. The fact that Mr. Simao had no improvement with his surgery for his neck condition, and the fact that he's been complaining of headaches, not neck pain, for consistently the last four years, five years.

Q. Are you saying that the records suggest that he hasn't been complaining of neck pain over the last four or five years?

A. No, but what I'm saying is that the consistency of his complaints appear to be related to a headache condition. The

other factor being -- and Dr. Arita has already established this -- that there may be no basis for his pain complaints. He doesn't understand where the pain is coming from. The MRI's are appearing normal. The discograms don't seem to make a concordance sense. And Dr. Seibel and Dr. Arita both seem to think that there may be no trauma that can explain the pain that he has -- or I'm sorry -- no pathology that can explain the pain that he has.

Q. So if he had, hypothetically, constant pain complaints in his neck from May to October of 2005, you're saying that wouldn't change your opinions in this case?

A. That's not what I'm saying. What I'm saying --

Q. Does it change your opinion?

A. No.

Q. The hypothetical?

A. No, it wouldn't change my opinions. You know, the MRI's are normal. It doesn't explain his symptoms. It may show a degenerative condition which is pre-existing, but his complaints based on the records show that it's a headache that he was complaining of, not neck pain, and the exam showed a normal neck examination so I don't see how hypothetical can fit in this case.

Q. Okay. In your practice, do you ever see patients who have multiple injuries or issues going on, issues of primary and secondary pain?

A. Yes.

Q. Have you ever seen it when the main focus of a pain generator is addressed and treated and all of a sudden the secondary pain generator becomes apparently where it hadn't been thought of as symptomatic previously?

A. I mean, we talk about that. I think as practitioners we like to focus on one problem and try to solve it to go to the next one, but I don't believe that. You know, if you're going to have significant trauma, and it happens to a significant portion of your body, you're going to complain of all of those things, not just focus and pick and choose. So if it's significant enough, you're going to complain of all the issues not just the one and forget the other.

Q. Do you remember testifying a little bit contrary to that previously in a deposition?

A. Well, it depends on the case, you know. I think that the issue may be that that case presented that the person was having significant issues in one area and may not have thought about the other areas, so it's a case-by-case basis. It's not that it's unheard of, but, you know, it's something that you got to consider when you're looking at all the facts in the case in general.

Q. In fact, you previously testified that -- and I quote -- "A lot of times in the patient population that I see, the main focus of the pain generator, once that's taken away, all of

a sudden you kind of see the forest from the trees, you know, and so things kind of open up and you start seeing the other areas that you haven't -- haven't been noticed before." And then you go on to say, "Yeah, there's a primary and a secondary pain." Do you recall testifying to that?

A. Which case?

Q. I believe it was the Gilbert case.

A. I don't remember. When was it?

Q. I believe 2007, and it was referenced again in a Schultz case in June of last year.

A. I think you have to look at the context of the question. There's definitely issues like that. I'm not saying that Mr. Simao couldn't have that as well. What I'm saying is it depends on the case by case and what the question was. I mean, you can pull out any quote you want, but unless you show the flow of that questioning, I don't really understand the relevance of your question.

Q. Well, ultimately, is it your opinion that he doesn't have neck pain or that he doesn't have neck pain that was caused by the motor vehicle accident in April of 2005?

A. My opinion is that he does not have neck pain that's significant from the accident itself, and that he may have presented on the first day with neck pains, but that had resolved within the first two weeks. The MRI's are completely normal in follow-ups, and you cannot relate any of the cervical spine

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15:14:27 1 pathology since there is none to any of the accident which is
15:14:30 2 why I decided to call this a non-specific muscle pain that had
15:14:36 3 resolved
15:14:38 4 Q You had in your earlier reports in this case discussed
15:14:43 5 a whiplash injury, and you had indicated that you're abandoning
15:14:48 6 that theory, is that correct?
15:14:50 7 A Yeah You have to look at all the records in general,
15:14:52 8 and based on that and based on Dr. Arita's testimony as well as
15:14:57 9 Dr. Seibel's testimony of possibly a secondary gain and possibly
15:15:01 10 not finding the source of the pain, that there has to be some
15:15:05 11 questions as to whether or not there was truly an injury to the
15:15:09 12 neck significant enough to warrant surgery
15:15:12 13 Q Well, I'm not asking if you relate any whiplash injury
15:15:15 14 to the surgery
15:15:20 15 I'm saying Did he suffer, in your expert opinion, a
15:15:24 16 whiplash injury at the time of the accident?
15:15:26 17 A No
15:15:26 18 Q You reference in your reports a prior motorcycle
15:15:37 19 accident suffered by Mr. Simao, do you recall that?
15:15:40 20 A Yes
15:15:40 21 Q Do you know when it was?
15:15:44 22 A 2005
15:15:45 23 Q The motorcycle was 2005?
15:15:49 24 A Oh, I'm sorry. I think it was the year before, 2004
15:15:54 25 Q Are you aware of any facts surrounding the accident?

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15:15:56 1 A Not other than what he had said to his providers
15:16:02 2 Q Have you reviewed any records of any medical treatment
15:16:05 3 as a result of that particular accident?
15:16:07 4 A No.
15:16:07 5 Q It's your opinion that any treatment after the end of
15:16:18 6 May of 2005 is not related to the motor vehicle accident, is
15:16:21 7 that right?
15:16:23 8 A Correct
15:16:22 9 Q You go on to criticize treatment that Mr. Simao
15:16:28 10 received for cervical issues in 2006 and beyond; is that right?
15:16:37 11 A Well, I'm asked to give an opinion on those treatments
15:16:40 12 and whether or not they are treatments that I would consider
15:16:44 13 performing and so – I was also asked whether or not they were
15:16:48 14 reasonable, necessary, and related to the accident, so I made
15:16:52 15 opinions on them.
15:16:53 16 Q Once you determined that nothing after May of 2005 is
15:16:57 17 related to the motor vehicle accident, you went on to state
15:17:02 18 whether you thought treatment in 2006 and beyond was reasonable
15:17:07 19 and necessary?
15:17:09 20 A As it relates to the accident.
15:17:12 21 Q But you've already determined that it wasn't related to
15:17:16 22 the accident.
15:17:17 23 My question is: Taking out any question of causal
15:17:21 24 relationship, if you already determined that nothing beyond
15:17:26 25 May 2005 is related to the accident, why is it necessary to

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15:17:30 1 render an opinion as to whether the subsequent treatment was
15:17:34 2 reasonable and necessary?
15:17:35 3 A Because I'm sure you're going to ask me about it
15:17:39 4 Q And so that's why you rendered the opinion?
15:17:43 5 A Well, I mean, I'm asked to give an opinion on the
15:17:45 6 records. I'm asked to give an opinion on the procedures so –
15:17:50 7 I'm asked to give an opinion, so I gave an opinion
15:17:53 8 Q The MRI from March of 2006, you have reviewed both the
15:17:58 9 report and the film, is that right?
15:18:02 10 A That is correct
15:18:03 11 Q And do you agree that it showed a mild narrow left
15:18:09 12 neural foramina at C3 and C4?
15:18:13 13 A No, I don't
15:18:14 14 Q Do you agree that it showed a small central disc
15:18:18 15 protrusion at C4 and 5?
15:18:21 16 A No I don't
15:18:22 17 Q If Dr. McNulty had – well, assume that he disagreed
15:18:28 18 with you would you agree that it was appropriate to send the
15:18:41 19 plaintiff for pain management treatment at that point?
15:18:47 20 A Well you know, it's always appropriate to send someone
15:18:50 21 to pain management because I don't think there was a surgical
15:18:52 22 issue So if the individual is – if you're trying to figure
15:18:57 23 out where the source of the pain is coming from, you're going to
15:19:00 24 want to try to determine that on a more concrete basis as
15:19:05 25 opposed to trying to solidify and fix a disc, and so I think it

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15:19:09 1 was definitely reasonable for Dr McNulty to pass him on to
15:19:14 2 someone else for a second opinion and maybe even an evaluation
15:19:19 3 to determine where the source of the pain is coming from
15:19:25 4 Q Do you agree that by the time Dr McNulty saw Mr. Simao
15:19:33 5 again in September of 2007, that there was evidence of a pain
15:19:37 6 generator at C3-4 and/or C4-5?
15:19:39 7 A No, I don't agree with that
15:19:45 8 Q Do you believe it was appropriate for Dr. McNulty to
15:19:49 9 order a new MRI in September of 2007?
15:19:53 10 A Appropriate, because he's trying to further determine
15:19:57 11 what's going on, sure I mean, I don't think that that's
15:20:03 12 unreasonable for him to make a decision because he was confused.
15:20:08 13 There was no real good source for the pain, and yet he was still
15:20:14 14 complaining of pain, and Dr. McNulty's a spine surgeon so he
15:20:18 15 wants to try and fix the spine. Whether it's relevant and
15:20:20 16 related to the motor vehicle accident, no, it's not.
15:20:26 17 Q The September 2007 MRI, you reviewed both the report
15:20:31 18 and the film?
15:20:36 19 A Yes I have it right here on my computer.
15:20:39 20 Q Do you see any differences between that and the
15:20:42 21 March 2006 MRI?
15:20:46 22 A You know, in general, it looks like it's improved which
15:20:47 23 is what happened in 2008 in August. It was reported as normal.
15:20:52 24 I mean, it looks like a very normal MRI for age
15:20:53 25 appropriateness.

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15:20:51 1 Q I'm just asking you about September 2007 as compared to
15:20:56 2 March 2006, you're saying there's an improvement between those
15:20:59 3 two?
15:21:00 4 A Well, in my mind, it looks like it's about the same. I
15:21:04 5 mean, I don't know if you can really quantify it as improved,
15:21:07 6 but it's still considered, to me, to be an age-appropriate,
15:21:11 7 normal MRI.
15:21:13 8 Q Dr. McNulty testified in his deposition that it showed
15:21:17 9 the same findings, the September of 2007 one as the March 2006
15:21:2510 one. You may disagree with the findings, but do you disagree
15:21:2911 that they are essentially the same?
15:21:3112 A My feeling is that they're essentially the same.
15:21:3513 Q All right. Following that MRI, Dr. McNulty either did
15:21:5114 or ordered a left C3-4 and C4-5 transforaminal epidural
15:21:5815 injections. Do you agree or disagree with that process to
15:22:0116 determine the pain generator?
15:22:0317 A I disagree. I don't think it's necessary to perform
15:22:0618 those injections. He wasn't having pain in that distribution
15:22:0919 pattern, and when it was done, he didn't have any improvement
15:22:1320 either, so it was --
15:22:1521 Q Actually -- I'm sorry.
15:22:1722 A Well, again, that's the problem with the reports of
15:22:2123 pain. You know, you're going by a subjective report. Mr. Simao
15:22:2624 said he felt better, but obviously he didn't because he was
15:22:3025 still having symptoms afterwards.

15:22:33 1 Q He reported 80 percent relief. You think that that's
15:22:39 2 placebo or what do you think?
15:22:40 3 A Well, I don't know. That's the problem. I mean, it
15:22:43 4 could be placebo. It also could be that we're just not clear
15:22:46 5 because the pain generator has not really been established, and
15:22:51 6 it appears to me that it was more related to a migraine headache
15:22:56 7 cause.
15:22:59 8 Q In your Addendum No. 4 you state that "I agree with
15:23:10 9 Dr. Arita that cervical spine surgery was not necessary based
15:23:1710 upon the images and Mr. Simao's pain complaints." Do you recall
15:23:2311 that?
15:23:2312 A Yes.
15:23:2213 Q You understand that Dr. Arita didn't have any records
15:23:2714 post-June of 2007 and never saw Mr. Simao after June of 2007, is
15:23:3615 that right?
15:23:3616 A I don't know. You'd have to ask Dr. Arita.
15:23:4417 Q Well, we did.
15:23:5118 A So --
15:23:5319 Q Is that -- the period of time we already established
15:23:5720 from you is that that was the period of time that you believe
15:24:0021 Dr. Arita saw Mr. Simao, is that right?
15:24:0522 A Do you want to go over it again because I'm not sure I
15:24:0923 understand the dates.
15:24:1124 Q All right. Dr. Arita treated Mr. Simao roughly from
15:24:1825 October of 2006 until June of 2007, is that consistent with your

15:24:23 1 understanding?
15:24:23 2 A That's about right.
15:24:24 3 Q When do you understand that the surgery actually was
15:24:28 4 performed? Do you understand that the surgery was in the spring
15:25:46 5 of 2009?
15:25:48 6 A I'm looking. March 25th, 2009.
15:26:29 7 Q All right. So that would have been almost two years
15:26:33 8 after Dr. Arita stopped seeing Mr. Simao, is that right?
15:26:36 9 A Yes.
15:26:3710 Q There was a discography performed in this case in
15:26:4611 August of 2008 by Dr. Rossler. Are you aware of that?
15:26:4912 A Yes.
15:26:4913 Q Do you know Dr. Rossler?
15:26:5214 A No.
15:26:5215 Q Did you review his records?
15:26:5516 A Yes.
15:26:5517 Q Did you review his deposition?
15:26:5818 A Did I list it?
15:27:0419 Q You read it to me today. You listed it when you read
15:27:0720 off a list of things that you received within the last two
15:27:1021 weeks.
15:27:1122 A Well, if I read it and I listed it off, then yes, I
15:27:1623 reviewed it.
15:27:1624 Q It's not listed in any of your reports. It's just what
15:27:1925 you told me today.

15:27:20 1 A That's what I'm saying. That's why I got the list so I
15:27:25 2 could expound with you.
15:27:26 3 Q During a discography procedure, it's generally blind to
15:27:32 4 the patient; is that right?
15:27:34 5 A The level that's being tested is blind, yes.
15:27:37 6 Q Any reason that you would conclude that Dr. Rossler
15:27:43 7 would tell Mr. Simao what levels he's injecting?
15:27:48 8 A No, I have no reason to believe that.
15:27:47 9 Q And the result, according to Dr. Rossler, was positive
15:27:5210 at C3-4 and C4 and 5; is that your understanding?
15:27:5611 A Based on the report, yes.
15:27:5812 Q Do you have any reason to believe that the procedure
15:28:0113 was not properly performed?
15:28:0214 A No.
15:28:0315 Q Any reason to believe that it was a false positive?
15:28:0816 A Yes, I do have reason to believe that.
15:28:1117 Q And what is that reason?
15:28:1318 A He has a normal MRI. Normal discs do not usually give
15:28:1919 pain that are considered pathological. A disc that has pain
15:28:2720 that's a normal appearance on an MRI is not a disc that you want
15:28:3121 to replace or do surgery for, so that would be considered a
15:28:3422 positive control, so if you think it's positive and you do
15:28:3923 surgery and it doesn't help him, which it didn't, then it's
15:28:4324 considered a false positive.
15:28:4625 Q So since -- let me just make sure I understand this.

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and please correct me if I'm wrong. Since you view the MRI to be normal, and the discogram was positive for C3 and C4 -- or C3-4 and C4-5, then you're rejecting the discogram and relying on the MRI and, therefore, the discogram must be a false positive?

A. Almost. You're almost there. It's a little more complex than that. I think, as you know -- I know you've probably read up on discograms in general and whether or not there's false positives, especially in cases of litigation and secondary gain, and cervical discograms are noted to be even more controversial and more considered to be false positives.

And you have to look at a lot of different factors. You have to look at the MRI. You have to look at the previous treatment. You have to look at the pain complaints. You have to look at where the patterns of pain travel. You have to look at the legitimacy of those complaints and what was previously treated as well as the discogram and the confines of that discogram and the MRI. So you're looking at a lot of different factors in conjunction with this. And based on what appears to be the pattern of pain for Mr. Simao as well as the disc appearance on the MRI, he was not a candidate for discograms to determine whether or not surgery was necessary or surgery would be done because he was never a surgical candidate for a cervical spine.

Q. Which -- what's a more valuable tool to see, for

instance, an annular tear in a disc, an MRI or something else?

A. Well, annular tears can happen with any kind of degenerative component. Annular tears can be present and we have no pain component of it. How do you determine what's a more significant way of evaluating that annular tear? It's a very difficult question, and we have not really found a positive way of determining that.

Now, you can put contrast in a disc with discogram and do a CT myelogram and see a tear or fissure, but that still may not mean anything clinically. You could look at an MRI and see that on the MRI, and it still may not make sense. So I don't know if we have really great imaging components to say what is the best way of looking at it.

Q. Well, an annular tear can exist and not show up on an MRI, is that correct or no?

A. No, I don't believe that. I think you have to show something on an MRI. If the MRI's our gold standard, you know, you're hoping that you see something. And this idea of a microtear or a microscopic tear that is only seen by you placing a needle and shoving a bunch of fluid in there doesn't make much sense to me.

Q. Well, if it's your conclusion that it was a false positive, but there's no reason to believe the procedure wasn't properly performed or that the equipment malfunctioned, then what would cause the false positive?

A. Well, many factors. You know, I don't know if you've undergone a procedure or have actually seen a procedure, but they're not the funnest things to have done to you, and they are quite traumatic. You're placing a very long needle into the anterior part of your neck, and you're partly awake because you have to give a response. It's not a pleasant procedure by any means. And so just the sheer fact of placing the needle is a component of pain, and people may misinterpret that.

The fact that you're pressurizing a disc, and if it's not in the center of the disc and it's on the annulus or if it's not in the nucleus, but somewhere off to the side, there's a possibility that you get a false read, especially if you have a higher pressure. The pressure component of that disc -- I wasn't there, so I can't tell you exactly, but if you look at it -- performing a disc, some of the times these discs are positive for individuals, and we don't exactly know why they're positive, but they can be, and the MRI is completely normal. That definitely confuses you. So if you're seeing a positive disc with an MRI that appears to be normal, you've got to conclude that it's potentially a false positive disc.

Not only that, but you also have the psychological components that need to be addressed, the secondary gain, the components of where the pain is located, and where does the pain travel? You know, are you saying that the disc is painful because it's painful or are you saying that it's concordant with

the pain of where you normally have pain on a day-to-day basis? That can also give you a false positive.

Q. So is it your testimony and your opinion to a reasonable degree of medical probability that the discography in August of 2008 rendered a false positive?

A. Yes.

Q. And you obviously disagree with Dr. Rossler on that, is that right?

A. Well, he called it positive, so I guess I disagree.

Q. And do you believe that under Propofol, that Mr. Simao gave a response to a blind discogram that rendered the false positive?

A. Well, I think that's also a component. I didn't even address that, but yes. I mean, if the person's out, and they're on Propofol, and they can't really think clearly, and they don't remember the treatment at all, absolutely anything can cause pain. You could just pinch their skin on the side and that could cause pain, so that's another component that I had not brought up, but thank you for bringing that up.

Q. Well, what do you use when you perform that? Do you use Propofol? Do you use Versed? What do you use?

A. Yeah, we use -- you know, we try to make the patient as comfortable as possible. I've done it without any sedation, and we've gotten through it. You know, patients have to be able to tolerate this procedure. We can give a little Fentanyl to make

sure they're somewhat comfortable, and then we give a little bit of Versed to again make them relax. The way I perform these tests is that I tell them up front that this is not going to be a fun test to perform, and there's going to be some pain aspect to it, but I need you fully awake so you can participate with me. When you knock somebody out with Propofol and then try to wake them up, it's a harder test

Q Dr Rossler testified in his deposition that the procedure he used followed the guidelines from ISIS Do you agree with that or disagree?

A I have no reason to disagree that he didn't follow a guideline, but like any guideline, it's a guide I mean, it's not the standard of care It's not the way that everyone does it Everyone has a little different component of performing a discogram

Q In your fourth addendum, Addendum No 4 which is Exhibit 8 – and I understand this was commenting on the life care plan, but you wrote on Page 4 "In a medical probability, injections were not necessary based on the motor vehicle accident The injections that were done did not resolve his pain and did not confirm cervical involvement"

Is it your position – setting aside the issue of whether it's related to the accident, is it your position that all of the injections that Mr. Simao has undergone were unnecessary?

A Well, it's hard for me to make a blanket statement like that. I guess what I was saying is that I didn't feel, based on his pattern of his pain, that he needed to have selective nerve root block and facet injections as well as facet rhizotomies His pain was obviously related to his migraine headaches in my opinion.

Now, I'm not faulting Dr Arita, but based on the -- and you told me not to base it on the accident, but I don't think I would have done those procedures. I don't think they would have really determined anything because the MRI was appearing normal, so you're not going to get these kind of need for an injection based on a normal appearing MRI and the pattern of pain that he described

Q So is that yes, you believed that the injections were unnecessary?

A Again, I didn't want to make a blanket statement so I tried to clarify that.

Q Well, you did make a blanket statement in your report That's why I'm asking.

A Well, I'm trying to hone it in on today's visit.

Q So is it yes, they were necessary; or no, they were unnecessary – strike that. Wait a minute. Let me – I think I just gave you a heads I win, tails you lose.

Is it you testimony that the injections were necessary or unnecessary setting aside the issue of causation?

A Hey, is Rogers there?

MR STEPHENS Are you soliciting an objection?

THE WITNESS Well, I mean, he corrected himself, so I thought you might have at least known what he was saying

THE WITNESS. Can you read the question back?

(The record was read by the reporter.)

THE WITNESS: Yeah, I don't think the injections were necessary based on his pain complaints and based on what I saw from the MRI, so no, it's not necessary

BY MR WALL

Q Is it your opinion that none of the injections confirmed cervical involvement?

A Yeah, I don't think any of the injections actually gave him the relief that we're looking for to determine the source of the pain, and I think that's why all the doctors were ordering so many MRI's trying to figure out what was going on I think Dr Arita was scratching his head trying to figure out why he wasn't getting any better and why he wasn't improving Dr Seibel is pretty much doing the same thing now And Dr McNulty did surgery, and he's still not better and still has pain So I don't think the actual generator has been found within the cervical spine. It's somewhere else

Q All right. Do you believe that the surgery performed was unnecessary?

A I don't want to say that it was unnecessary I think

it was unreasonable. It didn't make sense based on the MRI

Q If you used the word "unnecessary" in your report, are you changing that opinion?

A You know, you guys have your lawyer thing about it, so yes, I'll stick with what's in my report.

Q Do you believe the treatment by Dr. McNulty fell below the standard of care?

A I was never asked to look at standard care. I have no comments to make on standard of care so –

Q Would an unnecessary surgery be below the standard of care?

A I was not asked to look at standard of care. I'm not going to be able to comment on that question.

Q Well, do you have an opinion as to whether an unnecessary surgery would be below the standard of care?

A I have no opinion on that topic.

Q You write in your – I guess I'm looking at Addendum 1 now. Is Addendum 1 still valid or have we sort of moved on to something else? Are your conclusions – let me ask that a better way.

Are your conclusions and statements in Addendum No. 1 still some of your opinions?

A We can go through them if you want.

Q You write on Page 8: "The lack of response by the procedures done with Dr. Arita calls into question why the

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injections done by the spine surgeon Dr McNulty, were more successful"

Let me break that down Is it your belief that the selective nerve root blocks done by Dr Arita in October of 2006 evidenced a lack of response?

A Well, I think there's just inconsistencies with his response, and that's kind of the point of what I was saying is that how come you can have a good response with one provider and not with the other I mean, you should be consistent You know, you want to do a procedure by anybody and have the same result Since you didn't get good success with these things, and then all of a sudden you get to another provider and you have good success, it doesn't make much sense Plus, if you inject in different areas by one provider and you get results, and by another provider you don't, it just calls into question the inaccuracies and the inconsistencies of reporting by Mr Simao

Q So if Dr Arita testified that there was a 50 to 75 percent improvement according to Mr. Simao from the selective nerve root blocks in October of 2006, what conclusion might you reach from that particular fact?

A I don't know That's the problem I don't think I can make one

Q Well, would it be the lack of response by the procedure done by Dr. Arita? There was a response, and a positive

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response, wasn't there?

A Well, that's what's reported, but I think it's inconsistent, you know. I mean, from the pattern of pain that he described, the response that was the response, it confuses me It doesn't make sense. The MRI being normal and having no compression of any nerves. I mean, you're blocking a nerve that you assume is being compressed somewhere, and the MRI is not showing any compression anywhere, so it's -- why is it getting better? You just don't know.

Q Dr. Arita also did on at least two occasions a pulse radio frequency in the end of 2006, spring of 2007; do you recall that?

A Yes

Q And Mr. Simao reported a temporary reduction of pain for several months from each procedure; is that your understanding?

A From the records, yes.

Q Well, given those, why would you say that it was a lack of response by the procedures done by Dr. Arita?

A Maybe I just wasn't making myself clear. There was a lack of any long term response, any clinically significant response. And, you know, Mr. Simao is saying that he's better for a couple of months, but he's still not improved. He never made progressive improvement And an MRI that actually shows improvement to where you have an MRI in August of 2008 being

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normal -- that's not how it works I mean, that's not how you typically see these kind of patterns

Patients who get worse have MRI findings They have findings that are consistent with what you expect the pain to be, and this is not what you see in this case, and that's why it's confusing I mean, even Dr McNulty did a secondary set of discograms to see if he could further anesthetize the disc and make it better so in his mind he knew what was going on, but, you know, obviously, Mr Simao didn't even get relief from the surgery either Nothing was working, so then you have to call into question why is that, especially when you have a normal MRI

Q Is it your opinion that the pulse radio frequency should work for a long period of time, longer than a few months?

A Yeah The pulse radio frequency should work for anywhere between six months to twelve months If you look at the literature it can actually last up to twelve months so you're expecting a long term benefit from it

Q There's a difference between the pulse radio frequency that Dr Arita did and a rhizotomy, right?

A You know the rhizotomy is going to be a radio frequency ablation and so a rhizotomy can be a pulsed rhizotomy or a continuous heat rhizotomy I mean your question doesn't really make sense to me in terms of the difference between the two They're still rhizotomies

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Q Well if Mr Rossler testified that the pulse radio frequency procedure that he performed he expected to normally last for two to three months, would you disagree with that or have some question about what procedure he actually performed?

A No, I'm not disagreeing What I'm saying is if you look at the literature, and you look at the procedure itself, the expected results are going to be six to twelve months is what you're hoping for, especially when you're performing those procedures If Dr Rossler --

Q And --

A I'm sorry I apologize If Dr Rossler felt it only lasted for three months, maybe that's his experience I'm just going by what the literature shows

Q In your report that is Addendum No. 1, Exhibit 7, you say that "there is a possibility of a placebo effect with all injections and a bias by the performing injectionist who eventually performs surgical spine surgery." Do you recall writing that?

A Yes

Q Is that still your opinion today?

A Well, I mean I think Dr Arita put it very eloquently in his deposition, and he said that, you know, if you're going to be doing a surgery, you may want an independent person performing the injections so that they're not biased, because if you know that you're going to be doing the surgery at that site,

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15:48:04 1 and you're hoping to get some kind of positive response so you
15:48:05 2 can perform the surgery. there is a maybe unconscious bias that
15:48:14 3 can happen in that case
15:48:15 4 Q So do you believe that there is a bias by Dr McNulty
15:48:23 5 resulting in him either ignoring a placebo effect or creating
15:48:38 6 out of cold cloth the need for the surgery that he performed?
15:48:42 7 MR STEPHENS Objection Compound Go ahead, Doctor
15:48:45 8 THE WITNESS Yeah, you're going to have to rephrase it
15:48:49 9 BY MR WALL
15:48:49 10 Q Is it your opinion to a reasonable degree of medical
15:48:53 11 probability that Dr McNulty was biased and performed a surgery
15:49:00 12 that wasn't medically necessary?
15:49:04 13 MR STEPHENS Again, compound Go ahead
15:49:06 14 THE WITNESS You're going to have to be more specific
15:49:11 15 He's done many procedures Which procedure are you talking
15:49:14 16 about?
15:49:14 17 BY MR WALL
15:49:14 18 Q All right The one you wrote about when you said,
15:49:17 19 "There's a bias by the performing injectionist," tell me that
15:49:21 20 bias that Dr. McNulty had to a reasonable degree of medical
15:49:25 21 probability?
15:49:25 22 A Well, now I got to back up Which procedure was I
15:49:29 23 talking about because he had performed multiple procedures? Are
15:49:32 24 we talking about the discogram? Are we talking about the
15:49:35 25 surgery? What exactly are we talking about?

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15:49:38 1 Q You wrote "The lack of response by the procedures
15:49:40 2 done by Dr Arnis calls into question why the injections done by
15:49:45 3 the spine surgeon, Dr McNulty, were more successful There is
15:49:50 4 a possibility of a placebo effect with all injections and a bias
15:49:54 5 by the performing injectionist who eventually performed cervical
15:50:00 6 spine surgery." Does that give you the context?
15:50:05 7 A Maybe, but now ask your question again? I'm not sure
15:50:09 8 what we're talking about.
15:50:10 9 Q Explain to me the bias that you see, to a reasonable
15:50:14 10 degree of medical probability, from Dr. McNulty?
15:50:17 11 A I thought I just did I said that, you know, when
15:50:20 12 you're expecting a specific result, that you have an expectation
15:50:26 13 in your mind that this is where I'm going to be performing
15:50:30 14 surgery, so I hope this is where it works in terms of the pain,
15:50:33 15 so there's a possibility of a bias. That's what I'm saying
15:50:39 16 You know, I'm bringing that up.
15:50:42 17 Q Well, is it your opinion to a reasonable degree of
15:50:44 18 medical probability, based on everything you've reviewed in this
15:50:48 19 case, that there was a bias on the part of Dr. McNulty when he
15:50:55 20 performed that surgery?
15:50:56 21 A Well, I think based on my statement, that's what I
15:50:59 22 said, that there's a possibility of a bias.
15:51:02 23 Q And you described it previously as -- I don't remember
15:51:06 24 if you said "unconscious" or "subconscious", but do you believe
15:51:10 25 that it's a conscious bias on the part of Dr McNulty or not?

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15:51:15 1 A I don't know I'm just bringing it up
15:51:18 2 Q You wrote one sentence later that "Dr McNulty chose to
15:51:24 3 perform a surgery with very limited chance of success." Is that
15:51:29 4 also a result of the bias that you discuss?
15:51:34 5 A I don't know It's hard to know I mean, that's the
15:51:36 6 confusing part with the case I mean, Dr. McNulty had a normal
15:51:41 7 appearing MRI, and he obviously had the patient in his office,
15:51:44 8 and he was trying to do something proactive for him. I just
15:51:47 9 don't think you're going to have success with that kind of
15:51:51 10 surgery And low and behold, you didn't. He didn't get any
15:51:56 11 better, especially when he's complaining of these migraine
15:51:59 12 headaches. That's really where his complaint was He didn't
15:51:59 13 really have a pattern of neck pain complaints.
15:52:01 14 You know, again, we go back to the original thing that
15:52:04 15 you had said to me earlier which is that if everything after May
15:52:08 16 of 2005 is not related to the accident, then why am I even
15:52:13 17 giving an opinion anyway? And my response is exactly as before,
15:52:15 18 because I knew you were going to ask me about it
15:52:16 19 Q Do you believe that choosing to perform a surgery with
15:52:24 20 a limited chance of success is below the standard of care?
15:52:29 21 A I think I've already told you that I've not got an
15:52:32 22 opinion on that I was not asked to review the standard of
15:52:35 23 care
15:52:35 24 Q Do you believe that you're qualified to give an opinion
15:52:38 25 on the necessity of spine surgery?

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15:52:42 1 A Yes.
15:52:42 2 Q More so than a spine surgeon?
15:52:46 3 A I don't know if more so, but I'm qualified to give an
15:52:51 4 opinion because I see a lot of patients that come through my
15:52:55 5 door who either had surgery, will have surgery, need surgery,
15:52:59 6 want surgery, don't want surgery, or are not candidates for
15:53:01 7 surgery, and I make that decision every day
15:53:03 8 Q Now, your original report talked about myofascial pain?
15:53:09 9 A Right.
15:53:10 10 Q Define that for me?
15:53:13 11 A Well, I mean, that's just it. You're describing a
15:53:17 12 muscle in the connective tissue surrounding the muscle or where
15:53:23 13 the muscle connects as the source of the pain.
15:53:23 14 Q Do you --
15:53:26 15 A I hate to cut you off. So we only have fifteen more
15:53:30 16 minutes. I mean, I know we started a little bit late, but we're
15:53:33 17 sticking to two hours?
15:53:35 18 Q Myofascial pain doesn't appear in your No 1 and
15:53:42 19 No. 4 Addendum. Is that a change in your opinion?
15:53:46 20 A What do you mean "doesn't appear", appear where?
15:53:51 21 Q It doesn't appear in your two subsequent reports as
15:53:55 22 being one of your opinions as to what Mr. Simao suffered from.
15:54:03 23 Do you believe now that he suffered -- well, what is your
15:54:04 24 opinion today?
15:54:06 25 A Well, as I said before, I thought it was -- I believe

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15:54:11 1 in medical probability that it's a non-specific myofascial pain.
15:54:14 2 It's just -- we don't know where it's coming from and that --
15:54:19 3 Q Is that --
15:54:20 4 A Say that again?
15:54:21 5 Q Is that non-specific myofascial pain from his
15:54:25 6 migraines?
15:54:26 7 A Well, I don't know. It's not quite clear. You know,
15:54:28 8 that's the problem. It's possible, in my mind, that it's coming
15:54:33 9 from his migraines, his pre-existing migraines. It's not quite
15:54:37 10 clear where his pain's coming from, and I think that's the
15:54:41 11 issue. You know, you've got questions from his treating
15:54:45 12 providers, two of them, that call into question whether or not
15:54:46 13 these are legitimate complaints so, you know, I'm not really
15:54:49 14 sure where the pain is coming from. It doesn't make sense.
15:54:52 15 But looking at the records from the initial six months,
15:54:54 16 it's not a neck pain issue. Any treatment for his neck, any
15:54:59 17 surgery, any injections, it's not from the car accident.
15:55:03 18 Q What about his shoulder or trapezius?
15:55:05 19 A Again, I don't think it's coming from the car accident.
15:55:08 20 I mean, he was complaining -- he wasn't really complaining of
15:55:11 21 that component at the time of the accident, and I just don't
15:55:16 22 feel it's related to the accident, and I don't believe in
15:55:19 23 medical probability that it is.
15:55:21 24 Q And you believe that -- well, is it your opinion that
15:55:25 25 he suffers from left shoulder or trapezial pain?

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15:55:29 1 A Well, again, I think that's the problem. I'm not sure
15:55:32 2 what he suffers from. It's not quite clear. No one's been able
15:55:37 3 to clarify the actual pain generating source, so it's not clear.
15:55:43 4 Q You wrote in your report -- in fact, your initial
15:55:46 5 report, you refer to us reviewed surveillance video from, I
15:55:52 6 think, 2008, is that right?
15:55:54 7 A Yeah. You know, what I find interesting is that we
15:55:56 8 haven't brought that up, but he saw Dr. Kabins around that
15:56:00 9 timeframe, and Dr. Kabins was saying that he was at his wits end
15:56:04 10 in terms of his pain, and yet on these video surveillance you
15:56:06 11 see him moving his neck around with no pain behaviors
15:56:10 12 whatsoever. It's a very inconsistent appearance based on the
15:56:14 13 surveillance and based on what Dr. Kabins is noting.
15:56:18 14 Q Mine is just a yes or no question. By the way, I don't
15:56:21 15 think he ever saw Kabins, but if you want to produce a record
15:56:23 16 for me, I'd appreciate that.
15:56:25 17 A Oh, it wasn't Kabins? Maybe it was Grover. I
15:56:29 18 apologize.
15:56:30 19 Q The surveillance video, did you see any indication in
15:56:33 20 the surveillance video of any pain Mr. Simao suffered in his
15:56:37 21 neck or left shoulder?
15:56:50 22 A It was Dr. Grover, not Dr. Kabins, I apologize.
15:56:54 23 Q Did you hear my next question?
15:56:58 24 A No. I was trying to figure out which surgeon I had
15:57:00 25 talked about, and I misspoke, and I apologize. It was

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15:57:07 1 Dr. Grover, not Dr. Kabins.
15:57:09 2 Q Did you see in a surveillance video in 2008 any
15:57:08 3 indication of pain in Mr. Simao's neck on the left side or in
15:57:12 4 his left shoulder?
15:57:13 5 A No.
15:57:13 6 Q Never saw him wincing from pain from his left shoulder
15:57:21 7 area?
15:57:22 8 A No.
15:57:23 9 Q During the same period in time, that 2008, in your
15:57:29 10 original report you were claiming that Mr. Simao had a variety
15:57:34 11 of symptoms that weren't related to the motor vehicle accident,
15:57:38 12 like myofascial pain, degenerative cervical spine disease, left
15:57:43 13 shoulder subacromial bursitis, and migraines, is that right?
15:57:48 14 A That's what I authored at the time, yes.
15:57:51 15 Q So has your opinion changed on those?
15:57:55 16 A Well, now that I've got to see a better picture of the
15:57:59 17 records and have a more broader scope of what's been going on
15:58:04 18 since I've been preparing for this deposition, yeah, it's
15:58:08 19 obviously changed. I mean, he has multiple pain complaints.
15:58:08 20 It's not quite clear where it's coming from, and none of these
15:58:12 21 are related to the motor vehicle accident.
15:58:13 22 Q Is your opinion on the subacromial bursitis being the
15:58:18 23 cause of his left shoulder pain, have you abandoned that
15:58:22 24 conclusion?
15:58:23 25 A Well, I mean, I'm trying to come up with a reason for

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15:58:26 1 him to have the symptoms, but I don't think it's quite clear.
15:58:29 2 You know, I mean, what he displays on the videos, what he's
15:58:34 3 saying to his providers, it's just not clear, so I was trying to
15:58:34 4 come up with a diagnosis that makes sense.
15:58:38 5 But, you know, related to the motor vehicle accident
15:58:41 6 itself, I don't think he had any of these symptoms -- or any of
15:58:46 7 these diagnoses. Excuse me.
15:58:48 8 Q My question was have you abandoned or retreated from
15:58:55 9 your conclusion in your original report that he suffered from
15:59:00 10 subacromial bursitis in his left shoulder?
15:59:03 11 A Well, he may, so I don't know if I've abandoned it. He
15:59:06 12 may, but it's not related to the motor vehicle accident.
15:59:08 13 Q Do you believe or do you agree that there are
15:59:11 14 degenerative changes in Mr. Simao's cervical spine?
15:59:15 15 A Well, again, I think before I actually had a chance to
15:59:19 16 see the reports -- I mean, Dr. Arata didn't really get a chance
15:59:22 17 to see the films. He only went by reports. And now that I've
15:59:26 18 actually seen the films, I disagree with that. I don't think he
15:59:29 19 has degenerative changes. In fact, in 2008 of August, the MRI
15:59:34 20 was reported as normal, so there aren't any degenerative
15:59:37 21 changes.
15:59:39 22 Q So you've reviewed the films, the MRI's from March of
15:59:44 23 2006, September of 2007, and I want to say November of 2008, but
15:59:50 24 I'm not sure of the exact date, and it's your testimony to a
15:59:54 25 reasonable degree of medical probability that they do not show

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any degenerative changes in his cervical spine?
A Correct. There's an authored report on the very first film that there may be a change at the C2-3 level, but on the subsequent MRI's you can see that that actually improved, so it may be the technique of the MRI, a larger magnet. But the November -- or whatever the 2008 film -- I thought it was August, but if it's November of 2008, the film is normal. There is no degenerative change, so it may just be an incidental image variance on that first MRI.
Q So you disagree with any physician who has reviewed that and determined that there were degenerative changes in his cervical spine?
A I don't know if I disagree. My opinion is that there aren't any degenerative changes. If that's in disagreement, I guess, but I'm just telling you what I see personally.
Q All right. Are you aware of any record or any evidence that Mr. Simao suffered any cervical or neck pain prior to April 15th, 2005?
A Just from the reports of what he said to his providers. I don't think there's a record that I had been able to review.
Q Are you saying that he reported to a provider that he had left shoulder or neck pain prior to the accident?
A Well, he had that motorcycle accident, and he had a history of migraines, so he may have said to his providers that he may have had some symptoms in the shoulder, but I don't have

a specific record.
Q Are you aware of any complaint that Mr. Simao made to any medical provider indicating that he had left shoulder or neck pain prior to April 15th, 2005?
A Not offhand.
Q Do you feel that it's appropriate for a patient to follow a doctor's advice?
A Well, that's what it is, it's a doctor's advice. It's a recommendation, and I think it's important for a patient to understand what those recommendations are and make an informed decision.
Q Are you aware of any evidence of Mr. Simao during the course of his treatment being noncompliant?
A Noncompliant in what way?
Q With his doctor's advice?
A Well, you know, the doctors may recommend certain things, and he may not have followed them. I don't know how to answer that question.
Q Well, are you aware of any instances where he was noncompliant?
A I don't think there's evidence of him being noncompliant, but there may be recommendations that he did not follow. In your strict definition of noncompliant, it may be noncompliant.
MR. WALL: I don't have any other questions.

EXAMINATION
BY MR. STEPHENS:
Q Hello, Doc. I've got a few.
A Oh, great.
Q Dr. Seibel -- I may be --
MR. STEPHENS: Court Reporter, I may be mispronouncing it. Seibel. I believe it's S-i-e-b-e-l -- scratch that. S-e-i-b-e-l.
THE COURT REPORTER: Thank you.
BY MR. STEPHENS:
Q So let's start with the question. Dr. Seibel testified that in his opinion 50 percent relief from a diagnostic injection is not positive. Do you agree with that?
A That's a fair statement.
Q Okay. And you testified earlier in your deposition that you received films a week or two ago that in fact are cited in your July 13, 2010 report. If you look on Page 2 of that July 2010 report --
A Okay.
Q -- the first line reads, "Imaging and work up which I have personally reviewed the images."
A Okay.
Q Now, did you review those images when preparing this July 2010 report?
A Yes.

Q Okay. I want to walk through the bases for your opinions.
A Hey, you know what, you look older on video.
Q You want to see the other guy instead?
A Yeah.
Q All right. Do the diagnostic films show evidence of neck trauma?
A No.
Q Can the MRI findings be characterized as normal given the plaintiff's age?
A Yes.
Q You were asked just a few moments ago by Mr. Wall whether there were any degenerative findings in the MRI's. Would it be fair to say that those MRI's show age appropriate degeneration for the plaintiff?
A They may be age appropriate, but if you look at subsequent films, you're seeing a more normal picture. So the reason why I'm saying there's no degeneration is because by definition, each film should get worse and worse and worse or degenerated, and the fact that you're seeing a normal appearing MRI two years after the accident, in my mind, looking at the entire thing, well, it might make a change on the first film in terms of a degenerative appearance -- it's not what you're seeing. It should be consistent all through. That's why I was saying that there's really no evidence of degeneration on these

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films
Q Well, there is a comment by the radiologist relating to C3-4 facet hypertrophy. Is that a traumatically induced condition or a product of a degenerative process?
A Well, it's not in a traumatic condition, but you may have a large or hypertrophied facet because that may be genetically how that facet started to develop. It may not be a degenerative process. It could just be a larger facet.
Q Okay. Are there any findings in any of the MRI's or CT scans or X-rays that, to a medical probability, result only from a single traumatic event like a car accident?
A No.
Q In your medical opinion, would plaintiff's complaints to his provider be consistent with traumatic injury to the cervical spine?
A No.
Q Now, you commented a few times in today's deposition about your work at the emergency room at UCLA. Do they have a Level I trauma center there?
A Yes.
Q Do you work in that trauma center?
A I'm not in the trauma center, but I've been asked to evaluate patients who come through the trauma center, and I have on occasion been asked to evaluate a patient who's in the trauma room or the ER.

Q Okay. Where, other than UCLA, have you worked in a trauma center?
A Johns Hopkins and the U.S. military as an officer in the Army, U.S. Army.
Q Did you treat traumatically induced neck injuries in the trauma centers where you've worked?
A Yeah. I was stationed at the M.A.S.H during the Iraq -- I'm sorry -- not the Iraq. I'm glad I'm not there -- in the Bosnian conflict in '96. I was stationed in the forward M.A.S.H component, and we had a lot of injuries that had occurred from trauma ranging anywhere -- believe it or not -- from basketball injuries to shell injuries, so there was a wide range of traumatic events that happened in this M.A.S.H.
Q Okay. And in your experience treating traumatically induced cervical injuries, you've observed or reached the opinions that the plaintiff's clinical presentation doesn't match a trauma presentation?
A Correct.
Q Okay.
A Hey, we got to go.
Q Okay. Just give me one minute, Doctor. I'll go fast.
MR. STEPHENS: Court reporter, did he leave or go to the restroom?
THE WITNESS: There's another meeting here at 4:00, so we got to go.

BY MR. STEPHENS:
Q Okay. Let me just get through a couple of more points. What time is it right now?
A It's 4:10. We could probably sucker through another couple of minutes.
Q Okay. Then I'll move fast. Did the neck injections reveal traumatic injury?
A No, not at all.
Q Did the neck injections reveal a cause of the symptoms?
A No.
Q Is there a concern in the medical field about a surgeon doing neck injections and making surgical decisions on the injections?
A I don't know if it's in the medical -- well, I don't know how to answer that question. I just think that it's definitely a concern when you're performing injections to find a result when you're going to be doing surgery on that result.
Q Is it medically probable that the plaintiff's pre-existing migraines were aggravated by the accident?
A I don't think so. The evidence doesn't seem to show that. I think it's just his pre-existing migraines. There's a normal MRI. There's no evidence of a CT scan showing any trauma. There was maybe a little bruising -- or I'm sorry -- a little pain in the back of his occiput, but there does not appear to be a laceration or a contra coup injury, so I don't

see how the migraines would have been worsened by the accident.
Q Okay. Next, take the vehicle photos out of the equation altogether, does it change your opinion in any way about the plaintiff's condition?
A No, uh-uh.
Q All right. Now, next, you were asked questions about the discogram, and the plaintiff's average report of pain was seven of ten, yet at the discogram the reproduction was logged as one of ten. Is that concordant?
A Well, you know, obviously, you have to ask the patient, "Is this like your normal everyday pain?" I actually use the word "concordant" because I want to make sure that that's what we're relying on in saying that that's your concordant and equivocal pain. So I'm not so concerned about the numbers, but it's hard for me to say that the numbers one, three, seven, or five, whether or not it's concordant. It's really asking them, "Hey, is this like your normal pain in terms of the pattern of where it goes and where it generates?"
Q All right. You mentioned earlier that you prepared a supplemental report -- I haven't yet seen it -- on a Hartman report. I believe you said it was dated sometime in 2010. There's been a more recent report. Will you prepare a reply to her most recent supplemental report?
A Are you asking me?
Q I am now.

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A Yes. I'd be happy to
Q And if the plaintiffs produce records additional injections or any other treatment, will you prepare a reply to that treatment?
A Yes
Q Okay. Now, finally, the plaintiff testified he's been referred to a hand specialist who diagnosed carpal tunnel syndrome, and he's been referred to a shoulder specialist. Have you been supplied with any of those records?
A This is the first I've heard of it
Q All right. All of your opinions that you and I have discussed have been given to a reasonable degree of medical probability, correct?
A Yes.
Q Thank you, sir.

FURTHER EXAMINATION

BY MR. WALL

Q Doctor, just a follow-up. I need about 60 seconds of your time. Let me just kind of compartmentalize this. You believe that the only pain that Mr. Simao suffered post-accident -- let's even say after June or July of 2005 -- is the same migraines that he had before the accident?
A Based on the pattern of that pain, I would say yes
Q And so there is no pain generator at C3-4 or C4-5 in

your opinion?
A Correct.
Q And the auto accident didn't even exaggerate or exacerbate his migraine pain passed maybe two months, is that your testimony?
A I don't know if I would say two months, but, you know, from May 26th, 2005, was the last time he was seen until October. I mean, that's five months. It wouldn't be anything -- you know, he didn't have any other problems at that point related to any headaches, so yeah, I don't think it caused anything.
Q And he doesn't have any cervical condition that should be causing him pain?
A Well, again, I think we discussed that. I mean, it's a normal MRI. They're not sure where the pain's coming from. It's just not clear, you know.
Q So the answer is there is no objective reason for him to be having pain?
A I don't see any objective evidence. The injections don't seem to be helping him, and the surgery didn't help, and the MRI was normal, so I don't see an objective component of where the pain is coming from. There's no pain generator that's been determined at this point.
Q Okay. That's all I have.
MR. STEPHENS: All right, Doc. Thanks for giving us the

extra time
THE WITNESS No problem
MR. STEPHENS Mr. Court Reporter, do you have my information?
THE COURT REPORTER Yes. I got it off the caption from my office
MR. STEPHENS I want a copy with E-trans
(Discussion was held off the record.)
MR. WALL Okay. We'll stipulate to the doctor waiving signature
MR. STEPHENS That's fine
(Plaintiff's Exhibit 2, 3, 4, 5, 6, 7, and 8 were marked for identification by the Certified Shorthand Reporter, a copy of which is attached hereto.)
(Whereupon, the deposition of DAVID E. FISH, M.D. concluded at 4:18 p.m.)
(Declaration under penalty of perjury on the following page hereof.)

I do solemnly declare under penalty of perjury that the foregoing is my deposition under oath, that these are the questions asked of me and my answers thereto, that I have read same and have made the necessary corrections, additions, or changes to my answers that I deem necessary.
In witness thereof, I hereby subscribe my name this_____ day of _____, 20_____.

_____
DAVID E. FISH, M.D.

CERTIFICATION
OF
CERTIFIED SHORTHAND REPORTER

I, the undersigned, a Certified Shorthand Reporter of the State of California, do hereby certify:

That the foregoing proceedings were taken before me at the time and place herein set forth; that any witnesses in the foregoing proceedings, prior to testifying, were placed under oath; that a verbatim record of the proceedings was made by me using machine shorthand which was thereafter transcribed under my direction; further, that the foregoing is an accurate transcription thereof.

I further certify that I am neither financially interested in the action nor a relative or employee of any attorney of any of the parties.

IN WITNESS WHEREOF, I have this date subscribed my name.

Dated

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EXHIBIT "10"

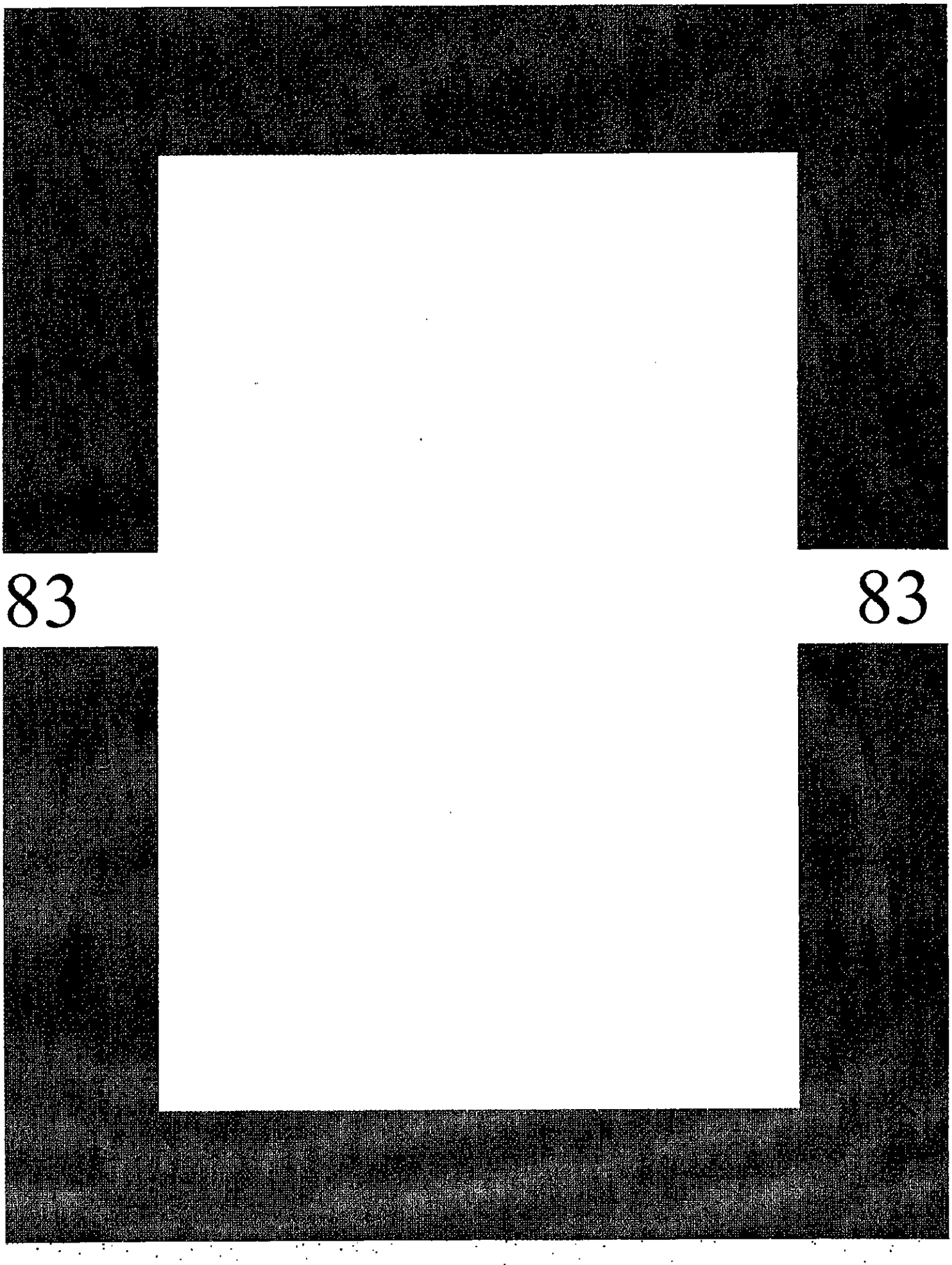
Table 105. Expectation of Life and Expected Deaths by Race, Sex, and Age: 2006

[Life expectancies were calculated using a revised methodology and may differ from those previously published. The methodology uses vital statistics death rates for ages under 85 and modeled probabilities of death for ages 85 to 100 based on blended vital statistics and Medicare probabilities of dying]

Age (years)	Expectation of life in years					Expected deaths per 1,000 alive at specified age [2]				
		White		Black			White		Black	
	Total [1]	Male	Female	Male	Female	Total [1]	Male	Female	Male	Female
At birth	77.7	75.7	80.0	69.7	76.5	6.71	6.12	5.01	14.48	12.23
1	77.2	76.1	80.0	69.7	76.5	0.44	0.40	0.36	0.76	0.60
2	76.3	74.2	79.0	68.7	75.5	0.30	0.29	0.23	0.46	0.48
3	75.3	73.2	78.0	67.8	74.6	0.21	0.22	0.17	0.37	0.24
4	74.8	72.2	77.1	66.8	73.6	0.16	0.18	0.15	0.27	0.24
5	73.3	71.2	76.1	65.8	72.8	0.17	0.17	0.13	0.27	0.21
6	72.3	70.2	75.1	64.8	71.8	0.15	0.16	0.12	0.26	0.18
7	71.3	69.2	74.1	63.9	70.8	0.14	0.15	0.11	0.24	0.16
8	70.4	68.2	73.1	62.9	69.8	0.12	0.13	0.10	0.20	0.14
9	69.4	67.3	72.1	61.9	68.8	0.10	0.10	0.09	0.15	0.13
10	68.4	66.2	71.1	60.9	67.7	0.09	0.09	0.08	0.10	0.14
11	67.4	65.3	70.1	59.9	66.7	0.09	0.08	0.08	0.10	0.15
12	66.4	64.3	69.1	58.9	65.7	0.12	0.13	0.10	0.17	0.17
13	65.4	63.3	68.1	57.9	64.7	0.20	0.24	0.15	0.34	0.26
14	64.4	62.3	67.1	56.9	63.7	0.31	0.39	0.21	0.58	0.23
15	63.4	61.3	66.1	56.0	62.7	0.43	0.54	0.27	0.84	0.27
16	62.4	60.4	65.2	55.0	61.7	0.55	0.69	0.33	1.09	0.32
17	61.5	59.4	64.2	54.1	60.8	0.65	0.84	0.38	1.31	0.36
18	60.5	58.4	63.2	53.1	59.8	0.74	0.98	0.41	1.50	0.42
19	59.5	57.5	62.2	52.2	58.8	0.82	1.10	0.43	1.67	0.47
20	58.6	56.6	61.3	51.3	57.8	0.89	1.23	0.44	1.84	0.54
21	57.7	55.6	60.3	50.4	56.9	0.97	1.35	0.45	2.01	0.60
22	56.7	54.7	59.3	49.5	55.9	1.02	1.43	0.46	2.15	0.67
23	55.8	53.8	58.3	48.6	54.9	1.03	1.44	0.47	2.23	0.71
24	54.8	52.9	57.4	47.7	54.0	1.02	1.40	0.48	2.26	0.75
25	53.9	51.9	56.4	46.9	53.0	1.00	1.35	0.49	2.28	0.79
26	53.0	51.0	55.4	46.0	52.1	0.99	1.31	0.50	2.30	0.83
27	52.0	50.1	54.5	45.1	51.1	0.98	1.27	0.51	2.31	0.87
28	51.1	49.1	53.5	44.2	50.1	0.98	1.26	0.53	2.34	0.92
29	50.1	48.2	52.6	43.3	49.2	1.00	1.27	0.55	2.38	0.98
30	49.2	47.3	51.5	42.4	48.2	1.02	1.29	0.57	2.43	1.04
31	48.2	46.3	50.6	41.5	47.3	1.05	1.31	0.60	2.47	1.12
32	47.3	45.4	49.6	40.6	46.3	1.09	1.34	0.64	2.53	1.21
33	46.3	44.5	48.6	39.7	45.4	1.13	1.37	0.69	2.59	1.30
34	45.4	43.6	47.7	38.8	44.5	1.18	1.42	0.74	2.69	1.40
35	44.4	42.6	46.7	37.9	43.5	1.24	1.48	0.80	2.75	1.51
36	43.5	41.6	45.7	37.0	42.6	1.32	1.55	0.86	2.88	1.63
37	42.5	40.7	44.8	36.1	41.7	1.41	1.66	0.94	2.99	1.78
38	41.6	39.8	43.8	35.3	40.7	1.53	1.80	1.04	3.16	1.96
39	40.7	38.9	42.9	34.4	39.8	1.68	1.97	1.15	3.36	2.17
40	39.7	37.9	41.9	33.5	38.9	1.84	2.15	1.27	3.58	2.37
41	38.8	37.0	41.0	32.6	38.0	2.00	2.34	1.39	3.83	2.58
42	37.9	36.1	40.0	31.8	37.1	2.18	2.55	1.52	4.12	2.82
43	37.0	35.2	39.1	30.9	36.2	2.38	2.77	1.66	4.48	3.08
44	36.1	34.3	38.2	30.1	35.3	2.59	3.01	1.81	4.89	3.36
45	35.2	33.4	37.3	29.2	34.5	2.81	3.28	1.98	5.31	3.66
46	34.3	32.5	36.3	28.4	33.6	3.03	3.52	2.14	5.76	3.95
47	33.4	31.6	35.4	27.5	32.7	3.27	3.80	2.31	6.26	4.28
48	32.5	30.8	34.5	26.8	31.9	3.53	4.11	2.48	6.82	4.57
49	31.6	29.9	33.6	26.0	31.0	3.82	4.45	2.65	7.65	4.90
50	30.7	29.0	32.6	25.2	30.2	4.13	4.83	2.85	8.47	5.25
51	29.9	28.2	31.7	24.4	29.4	4.46	5.22	3.06	9.32	5.63
52	29.0	27.4	30.8	23.7	28.5	4.80	5.62	3.30	10.10	6.01
53	28.2	26.5	29.9	23.0	27.7	5.13	6.01	3.57	10.76	6.39
54	27.3	25.7	29.1	22.3	26.9	5.46	6.37	3.84	11.29	6.78
55	26.5	24.9	28.2	21.6	26.1	5.79	6.73	4.13	11.80	7.14
56	25.6	24.1	27.3	20.9	25.3	6.14	7.11	4.44	12.34	7.54
57	24.8	23.2	26.4	20.2	24.5	6.52	7.54	4.78	12.88	7.96
58	24.0	22.4	25.6	19.5	23.8	6.95	8.05	5.20	13.46	8.43
59	23.2	21.6	24.7	18.8	23.0	7.52	8.67	5.69	14.16	8.96
60	22.4	20.9	23.8	18.2	22.2	8.17	9.40	6.28	14.97	9.56
61	21.6	20.2	23.0	17.5	21.5	8.90	10.22	6.96	15.89	10.30
62	20.8	19.4	22.2	16.9	20.7	9.65	11.07	7.64	16.79	11.08
63	20.0	18.7	21.4	16.3	20.0	10.35	11.86	8.23	17.55	11.76
64	19.2	18.0	20.6	15.7	19.3	10.99	12.59	8.80	18.12	12.41
65	18.5	17.1	19.8	15.1	18.6	11.65	13.36	9.40	18.57	13.01
70	14.9	13.8	15.9	12.3	15.1	15.01	16.25	13.65	22.05	16.72
75	11.6	10.5	12.3	9.8	12.0	23.15	25.77	21.02	25.72	22.66
80	8.7	7.8	9.3	7.7	9.3	30.69	32.57	30.17	28.22	28.04
85	6.4	5.7	6.7	5.9	7.1	34.73	34.06	37.56	22.77	30.41
90	4.6	4.0	4.7	4.5	5.3	30.44	26.27	34.01	15.78	26.97
95	3.2	2.8	3.3	3.5	3.9	17.64	12.62	23.12	7.97	17.71
100	2.3	2.0	2.2	2.8	2.8	17.37	8.04	23.73	6.12	28.48

[1] Includes other races not shown separately. [2] Based on the proportion of the cohort who are alive at the beginning of the indicated age who will die before reaching the age shown plus 1. For example, out of every 1,000 people alive and exactly 50 years old at the beginning of the period, between 4 and 5 (4.13) will die before reaching their 51st birthdays.

Source: U.S. National Center for Health Statistics, unpublished data.



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DISTRICT COURT
CLARK COUNTY, NEVADA

WILLIAM JAY SIMAO, individually and CHERYL ANN SIMAO, individually, and as husband and wife, Plaintiffs, v. JENNY RISH; JAMES RISH; LINDA RISH; DOES I through V; and ROE CORPORATIONS I through V, inclusive, Defendants.	CASE NO.: A539455 DEPT. NO.: X **PLAINTIFFS' FIRST SUPPLEMENT TO THEIR CONFIDENTIAL TRIAL BRIEF TO EXCLUDE UNQUALIFIED TESTIMONY OF DEFENDANT'S MEDICAL EXPERT, DR. FISH**

This Trial Brief is served pursuant to Eighth Judicial District Court Rule 7.27 which specifically states:

> Unless otherwise ordered by the court, an attorney may elect to submit to the court in any civil case, a trial memorandum of points and authorities prior to the commencement of trial by delivering one unfiled copy to the court, without serving opposing counsel or filing the same, provided that the original trial memorandum of points and authorities must be filed and a copy must be served upon opposing counsel at or before the close of trial.

I.

ARGUMENT

A. Introduction.

It is anticipated that the Defendant's counsel will attempt to elicit improper and unqualified trial testimony regarding Plaintiff's cervical surgery, from her medical expert, David Fish, M.D., (a Physiatrist). Dr. Fish is not qualified to offer opinions regarding Plaintiff's cervical spine fusion and/or his need for future surgical intervention, including whether or not these are or were reasonable and necessary.

There are three requirements a witness must satisfy to testify as an expert: (1) The expert "must be qualified in an area of scientific, technical or other specialized knowledge;" (2) the expert's "specialized knowledge must assist the trier of fact to understand the evidence or to determine a fact in issue;" ***and*** (3) the expert's "testimony must be limited to matters within the scope of [his specialized] knowledge." *Hallmark v. Eldridge*, 189 P.3d 646, 650, 124 Nev. Adv. Rep. 48 (2008) (citing to NRS 50.275) (emphasis added).

Dr. Fish does not have expertise with regard to spine surgery and any opinion attempted to be offered by him must be excluded as being beyond the scope of his area of expertise. Accordingly, Plaintiffs request that Dr. Fish be prohibited from testifying regarding William's need for surgical intervention, past and future.

B. David Fish, M.D.

During the course of litigation, Defendant retained as an expert David Fish, M.D.,

Director of Physiatry and Interventional Pain Management at the University of California, Los Angeles Medical Center. *See* Dr. Fish's Independent Medical Examination Report, at p. 1, attached hereto as **Exhibit "1."** **Dr. Fish is not a spine surgeon and has never performed a cervical spine fusion.** (*See* Deposition Transcript of Dr. Fish, attached hereto as **Exhibit "2,"** 12:2-10). Dr. Fish reviewed William's medical records; performed an Independent Medical Examination; and provided opinions based on the records as to medical damages caused by the accident, causation, future care needs, necessity for treatment, and overall recommendations. *See* Dr. Fish's Medical Record Review, at p. 1, attached hereto as **Exhibit "1."** Despite Dr. Fish's lack of knowledge regarding spine surgery, Dr. Fish is highly critical of the surgical recommendations that have been made in this case. (*See* **Exhibit "2,"** at 58:10-60:18; *see* also Report dated February 9, 2011, attached hereto as **Exhibit "3"**). Dr. Fish specifically opines that William has never been a surgical candidate and that the cervical fusion William underwent was unnecessary and unreasonable. (*See* **Exhibit "2,"** at 52:23-25; 53:1-5).

This Court has already limited Dr. Fish with regard to his lack of expertise in other areas. Specifically, the Court has prohibited Dr. Fish from offering an opinion regarding "minor impact," since he is not an expert in biomechanics. This, however, is not the only limitation that should be placed upon Dr. Fish's trial testimony. Dr. Fish should also be precluded from offering any opinions at trial related to William's need for spine surgery and his probable need for spine surgery in the future. Like his lack of knowledge in biomechanics, Dr. Fish lacks knowledge and expertise regarding a patient's surgical candidacy. As stated above, the Supreme Court of Nevada requires that expert testimony be limited to matters within the scope of the expert's area of expertise. *See, Hallmark, supra.* An expert's opinion will only assist the trier of fact when the expert's opinion is based on reliable methodology. *Id.* at 651. This is consistent with NRS 50.275 which states:

> If scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by special knowledge, skill, experience, training or education may testify to matters within the scope of such knowledge.

Due to Dr. Fish's lack of qualifications and education regarding spine surgery, any methodology he employs in reaching his conclusions regarding William's need for spine surgery is woefully unreliable. Moreover, he will not assist the jury. Rather, he will confuse and mislead them.

As this Court is well aware, physicians must state to a degree of reasonable medical probability that the condition in question, *i.e.* the need for spine surgery, was or was not caused by the subject incident. *Morsicato v. Sav-On Drug Stores, Inc.*, 121 Nev. 153, 157, 111 P.3d 1112 (2005) (*citing United Exposition Service Co. v. SIIS*, 851 P.2d 423, 425 (1993)). Here, because Dr. Fish, a physiatrist, is not a spine surgeon and has never performed a cervical spine fusion (and actually refers his patients out to spine surgeons to make that assessment; *See* **Exhibit "2,"** 12:2-10), he is unable to state to a reasonable degree of medical probability that William required cervical spine surgery. *See Hallmark, supra.* Simply put, Dr. Fish is not qualified to testify regarding William's need for spine surgery and whether or not spine surgery is reasonable. Accordingly, his testimony in this area must be excluded from trial.

C. There is no prejudice to the Defendant, by excluding Dr. Fish's Testimony

Defendants have also retained Dr. Jeffrey Wang, who is an Orthopaedic Spine Surgeon. Dr. Wang intends to testify at trial regarding William's need for spine surgery. As such, the Defendant will have an opportunity to elicit testimony and evidence from a qualified expert regarding William's need for spine surgery. Inasmuch as Dr. Wang will testify in this area, the Defendant will not suffer any prejudice by the limiting of Dr. Fish's testimony. Moreover, by eliminating Dr. Fish's testimony regarding spine surgery, the Court will be prohibiting

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cumulative testimony.[1]

II.

CONCLUSION

Plaintiffs ask this Court to consider the above law and argument and preclude Dr. Fish's trial testimony as indicated.

DATED this 22nd day of March, 2011.

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[1] Judicial economy is yet another reason to exclude Dr. Fish's testimony.

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EXHIBIT "1"

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Independent Medical Evaluation and Record Review

DATE OF REVIEW: 02/10/2009

RE: SIMAO, William

AGE: 45 currently; 42 at the time of the motor vehicle accident

DATE OF INJURY: 04/15/2005

To Whom this May Concern:

I was asked by the law offices of Rogers, Mastrangelo, Carvalho and Mitchell to review the medical records and physically examine William Simao. Below is my review of the medical records and physical examination. I was also asked to give my opinions, based on these records, as to assessment of medical damages caused by the accident, causation, future care needs, necessity for treatment, and overall recommendations. All of my opinions below are based on a reasonable degree of medical probability.

I am currently full time faculty member at UCLA Medical Center. My position is Director of Physiatry and Interventional Pain Management at the UCLA Spine Center. I am board certified in Physiatry and Pain Management. I have provided by CV.

RECORDS REVIEWED:

1. Traffic Accident Report
2. Southwest Medical Associates
3. Steinberg Diagnostic Medical Imaging
4. Desert Valley Therapy
5. Nevada orthopedic and Spine Center
6. Las Vegas Surgery Center
7. Medical District Surgery Center
8. University Medical Center
9. Navada Spine Clinic
10. Center for Spine and Spinal Surgery
11. Newport MRI

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12. Las Vegas Radiology
13. Nevada Anestheisa Cond.
14. Video Surveillance 1:13:29
15. Video Surveillance 0:35:26

CHIEF COMPLAINT: Left-sided head, neck and shoulder pain.

HISTORY OF PRESENT ILLNESS:
Mr. William Simao is a 45 year old who was involved in an MVA on April 15, 2005. According to the traffic accident report, he was slowing down to a stop for upcoming highway congestion when the car behind him collided with the rear-end of his van. No air bags were deployed. He informs me that he was in his work truck, which had a steel cage behind the driver's seat and at the time of impact he hit the back of his head on the cage. He had no loss of consciousness. Paramedics presented to the scene however, Mr. Simao refused any evaluation or treatment. Both vehicles were able to drive away from the accident. He reports that he did go to an Urgent Care later that afternoon, as he began to have neck and left elbow pain. X-rays were done not demonstrating any acute trauma and he was discharged home from the Urgent Care. He went to a follow up appointment 2 weeks later and there were no focal neurological deficits noted in the report. Also, he had no complaints of neck pain at this follow up appointment or his next appointment on May 12, 2005, but complaints of blurred vision, dizziness, and headaches.

He reports today that his neck pain persisted and he underwent intermittent conservative treatment since then including cervical epidural injections. He reports that the epidurals gave him less than four weeks of improvement after each injection. He informs me that his physician has advised him that surgery is a viable option to control his symptoms. He states that he is planning on having surgery soon.

Today, he reports having symptoms on the left side of his face and head. He also reports having left shoulder pain. The pain that he describes is rated 7/10. He reports it to be a stabbing, deep pressure, tightness-type pain for which he feels that movement or certain positions worsen the symptoms. He does report that it is somewhat better after the injections. Mr. Simao also reports that the pain does not limit him in that he is able to do all the activities that he was doing prior to the MVA of April 15, 2005.

Mr. Simao reports having a significant history of migraine headaches. He informs me that he had been treated by neurology and tried abortive therapies in the past before the MVA, but he has not tried these type of medications since the MVA. However, he did complain of headaches directly after the MVA for

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which imaging studies of the brain were performed and ruled out possible intracranial lesions. He continues to complain of migraines one to two times per week that can be severe with a pain level of 10/10 at times. He describes the migraine headaches as pain around the eye and into the head on the left side.

PAST SURGICAL HISTORY: None.

ALLERGIES: Penicillin.

PAST MEDICAL HISTORY: High blood pressure, high cholesterol, and neck pain.

CURRENT MEDICATIONS: Enalapril and Lovastatin.

FAMILY HISTORY: He denied arthritis, diabetes, bone disease, cancer and heart disease. Father, age 70, is healthy; mother is deceased at age 56.

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SOCIAL HISTORY:
He reports that he is the owner of a floor care company that polishes floors. He had been the manager of the same company before the motor vehicle accident and recently took over ownership of the company. He informs me that he did not take off much time from work since the motor vehicle accident. He has two employees. At work he is required to do some of the manual activities, which include polishing. The polisher weighs up to 40 pounds, which he loads in and out of a company truck. He tells me that he was never given any restrictions from his treating physicians. There are no changes in his work patterns that he describes, although he will give others jobs if he is not feeling well.

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He reports that he does not work out in a gym. He has two children at home, ages 20 and 24, and a wife. There are stairs to get into his house. He denies alcohol use. He does smoke one pack of cigarettes a day. He can walk without a cane. He can dress himself. He can drive his car independently, but he cannot sleep at night without pain.

REVIEW OF SYSTEMS:
Mr. Simao reports headaches, muscle pain and poor sleep. Otherwise, the patient denies problems with his eyes, skin, ears, genitourinary, respiratory, anemia, bleeding, bruising, depression, nervous breakdown, hallucinations, abnormal growth, goiter, heat/cold intolerance, palpitations, chest pain, leg swelling, fevers, chills, weight loss, nausea, vomiting, dermatitis, hay fever, appetite changes, jaundice, and hemorrhoids.

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