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

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

BY MR. EGLET:

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

A Yes, sir.

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

A Yes, sir.

Q And what is an MRI?

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

Q This cervical MRI.

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

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

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

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

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

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

A Right here.

Q Okay.

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

Q Okay.

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

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

A Yes, yes.

Q The bone back there.

A Yes.

Q That's what we saw?

A Yes.

Q Okay.

001546
001546
001546

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

Q Okay.

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

Q Asymmetry?

A Asymmetry.

Q Okay.

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

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

A Dr. Ruben [phonetic]?

Q Was it Dr. Momii?

A Oh, Mo- --

Q Or was it Doctor --

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

Q We're putting it up on the screen.

001547

001547

A I don't have it.
Q By Dr. George Momii. What was his impression?
A His impression was negative MR for -- of the cervical spine for age.
Q Now is Dr. Momii's interpretation incompatible with your documented findings?
A Well, my documented findings were that there is some changes in the facet joints. And obviously this was not reported.
Q Is that interpretation incompatible with yours?
A Well, I think that it's -- it -- I think what I saw on the MRI scan, what I read was not documented by the radiologist.
Q Okay. Do you see that in your practice?
A Yes.
Q Is that unusual?
A It's not unusual.
Q Does it necessarily mean anything?
A Not necessarily.
Q Okay. And what is a negative MR -- and that's short for MRI; right, MR -- of the cervical spine for age mean? He emphasizes or he states for age.
A Well, he apparently states that there's nothing to be seen on the MRI scan considering the patient's age.
Q Okay. And what does that mean? I mean what does

001548
001548
001548

that have to do with the age?

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

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

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

Q Okay.

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

Q Okay.

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

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

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

001549

001549

Q What is radiculopathy?

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

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

A Yes, sir.

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

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

And as you can see, those intervertebral discs, the

001550
001550
001550

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

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

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

Q What is axial pain, axial neck pain?

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

001551

001551

001551

So we have radicular pain and we have axial pain.

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

A Yes.

Q How does that happen?

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

Q So that can cause radicular symptoms as well?

A Yes, sir.

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

create this discogenic pain you're talking about?

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

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

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

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

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

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

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

A Yes, sir.

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

A Correct, sir.

Q Do MRIs always show the presence of annular tears?

A No, sir.

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

A No, sir.

Q And that is why?

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

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

001554
001554
001554

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

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

Q So one is history?

A Correct, sir.

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

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

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

A Correct, sir.

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

A Well, then you perform a physical examination.

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

A Yes, sir.

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

001555
001555

inconclusive?

A Correct, sir.

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

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

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

A Yes, sir.

Q What else?

A CT scans.

Q CTs. Anything else?

A These are the most common.

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

A Injection therapy.

Q Injection. What is injection therapy.

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

Q What other tools do you use then to reach a

001556

001556

001556

diagnosis or to determine or rule out discogenic pain?

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

Q Is that part of the injection therapy?

A Yes, sir.

Q Okay. All right, go ahead.

A We will do transforaminal or epidural steroid injection.

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

A Yes, sir.

Q Explain that.

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

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

A Well, then we have the discography study.

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

001557

001557

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

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

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

Q Okay. And so you try conservative treatment?

A Yes, sir.

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

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

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

A Yes.

001558
001558
001558

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

A It would not be helpful.

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

A Yes, sir.

Q And these tools can be used?

A Yes, sir.

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

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

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

A Yes, sir.

Q I just have trouble spelling that.

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

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

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

001559

001559

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

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

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

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

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

[Counsel Confer]

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

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

[Counsel Confer]

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

THE COURT: Okay.

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

THE CLERK: It's 64.

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

THE COURT: Any objection?

MR. ROGERS: Of what?

THE COURT: Admission of item 64.

MR. ROGERS: Oh, this is 64?

001560

001560

001560

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

001561
001561
001561

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

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

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

MR. ROGERS: But again, the objection --

MR. EGLET: May we approach, Your Honor?

THE COURT: Yes.

[Bench Conference Not Transcribed]

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

THE COURT: It was.

MR. EGLET: Thank you.

BY MR. EGLET:

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

A Yes, sir.

Q Okay. Can trauma cause internal disc disruption?

A Yes.

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

001562
001562
001562

disc?

A Yes, sir.

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

A Yes, sir.

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

MR. ROGERS: Your Honor, same objection.

THE COURT: Noted for the record.

BY MR. EGLET:

Q I'm sorry. Your answer?

A Yes, sir.

Q Okay.

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

BY MR. EGLET:

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

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

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

001563

001563

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

Q Okay. The spine surgeon?

A Yes, sir.

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

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

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

BY MR. EGLET:

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

A I performed those on May 10th of 2008.

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

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

001564

001564

Q Is this in a surgical suite?
A Yes, sir.
Q Okay. So it's in a surgical suite, and you -- there's people there in the room?
A Yes, sir.
Q Okay. Tell us about the equipment. What's going on?
A Well, there's equipment such as a fluoroscope, which is x-ray machine, a mobile x-ray machine.
Q Is it live x-ray?
A Live x-ray, yes, sir.
Q Okay.
A And then there's different equipment such as needles, syringes, and pointers like this. There are different types of medications, numbing medication, local anesthetic as well as cortical steroid.
Q Okay. So go ahead and demonstrate for us the procedure.
A Well, the patient comes into the procedure suite, and we prep the area to be injected, the surgical area, the neck, really carefully. And then you drape some sterile towels over the face and on both sides and down the chest. And then I have to use x-ray to make sure that I'm injecting the right level. And the only way for me to find the right level is knowing my anatomy and correlating this with the

001565

001565

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

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

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

Q Okay. What were --

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

001566
001566
001566

BY MR. EGLET:

Q What were the immediate results of this procedure?

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

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

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

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

A Yes, sir.

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

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

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

A Yes, sir.

Q Okay.

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

001567
001567
001567

BY MR. EGLET:

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

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

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

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

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

A Yes, sir.

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

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

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

001568
001568
001568

levels?

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

Q What does pathology mean?

A Like a disc disruption, for example.

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

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

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

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

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

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

001569
001569
001569

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

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

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

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

A Yes, sir.

Q What are the risks of cervical discography?

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

001570
001570
001570

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

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

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

BY MR. EGLET:

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

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

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

001571
001571
001571

done.

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

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

Q Is the patient awake when you do that?

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

001572
001572
001572

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

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

Q Why so little?

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

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

A Yes, sir, we do.

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

001573
001573
001573

A I did three discs.
Q Okay, three discs. So while the patient is sedated, do you put three needles into three different discs?
A Yes, one at a time.
Q Okay.
A Yes.
Q And so, there's three needles in -- okay. And then once the needles are placed -- how do you know whether the needles are placed at the right place in the disc?
A You know by looking at the fluoroscopy. And in AP and in lateral -- in the AP view, that means view from the -- straight from the view, and lateral view, from the side.
Q Okay. Does the patient have any idea what discs you're putting the needle into?
A No.
Q Okay. So is the -- the patient is blind to that?
A Correct.
Q Okay. And then you say -- after you place the needles and you let the patient wake up from this sedative completely.
A Yes.
Q Okay. I think -- you don't completely knock them out, right?
A You make them comfortable.
Q Okay. It's not like the type of anesthesia you

001574
001574
001574

would get for open heart surgery or something?

A No.

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

A Correct.

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

A One at a time.

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

A No, sir.

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

A Tell me if this is painful.

Q Okay.

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

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

A Yes, sir.

Q That's what concordant pain means?

A Yes.

001575
001575
001575

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

A Yes.

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

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

Q Okay. And you do this at each disc?

A You do this at each disc, yes.

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

A Yes.

Q Which ones were those?

A The C3/4 and C4/5.

Q C4/5.

A Uh-huh.

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

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

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

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

001576

001576

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

Q What does that mean, control disc?

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

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

A Yes, sir.

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

A Yes, sir.

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

A Yes.

Q You see this on the live x-ray?

A Yes.

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

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

001577

001577

001577

Q Now this is your operative report?
A That's the post-operative diagnose. That's a summary of the procedure. Yes, sir.
Q Okay. This -- I just read that. It says operative report. So --
A Yes, sir.
Q Okay. And this is the post-operative. What's highlighted here is the post-operative diagnosis. And you've got these three different levels, and it says positive provocation discography at C3/4, C4/5, and negative provocation disc at 5/6, is that right?
A Yes, sir.
Q So 5/6 was the control level --
A Yes.
Q -- we discussed. And there was no pain reported at that level.
A Correct.
Q And the patient had no idea which level you were pressurizing?
A Correct.
Q Okay. There was pain reported at the C3/4 and C4/5 level, is that correct?
A Correct.
Q And you documented this as concordant pain reported at those two levels?

001578

001578

001578

A Yes.

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

A Yes.

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

A Visual analog scale.

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

A Mel Gibson.

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

A Well --

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

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

001579
001579
001579

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

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

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

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

A Yes, sir.

Q And now the discography confirms that as well.

A Yes, sir.

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

A Yes.

Q And what does that mean?

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

001580
001580
001580

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

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

A Yes, sir.

Q Why?

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

Q Okay.

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

BY MR. EGLET:

Q Now what were the results of the CT discogram?

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

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

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

Q What is it, then?

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

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

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

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

001582
001582
001582

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

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

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

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

A Yes, sir.

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

A Yes.

001583

001583

001583

Q Was that done with Mr. Simao?
A Yes.
Q What is multiplanar fluoroscopy?
A Multiplanar fluoroscopy mills -- means different planes, different view angles. And the typical view angle, as I pointed out, is the AP, the anterior-posterior view that's from the front; and the lateral view from the side. Those are two planes, two angles; hence, multiplanar.
Q Is part of Mr. Simao's chart that you brought with you here today, do you have those fluorosca- -- images from his August 8, 2008, cervical discography?
A Yes.
Q Could you get those for us, please?
[Pause]
BY MR. EGLET:
Q So what I'm going to ask you to do, Doctor, is I'm going to ask you to place one of those, one at a time, on the Elmo. And if you could explain to us -- review these diagnostic images and explain for us what they show?
These were taken while you were performing your discography?
A Yes, sir.
Q Okay. Explain to us what these show.
A Well, this is obviously the mandible -- teeth --
Q What's a mandible?

001584
001584
001584

A Well, it's the jaw.

Q Okay. All right.

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

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

A Yes.

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

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

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

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

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

A Yes, sir.

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

001585

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

A Yes, sir.

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

A No, I would not.

Q Why not?

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

Q Okay.

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

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

A IV dye.

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

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

001586

001586

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

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

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

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

001587
001587
001587

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

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

A Correct.

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

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

A Yes, sir.

Q What is propofol?

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

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

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

001588
001588
001588

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

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

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

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

001589
001589
001589

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

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

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

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

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

001590
001590
001590

BY MR. EGLET:

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

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

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

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

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

A Yes,. sir.

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

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

001591

reasonable.

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

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

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

THE COURT: Ask for you to rephrase it.

MR. EGLET: May we approach, Your Honor?

THE COURT: Yes.

[Bench Conference Not Transcribed]

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

[Court Admonishes Jury]

[Recess]

THE COURT: Outside the presence of the jury.

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

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

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

001592

001592

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

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

MR. ROGERS: Yes, please.

Are the objections up here being recorded?

THE COURT: They are.

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

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

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

001593
001593
001593

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

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

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

THE COURT: Sure.

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

001594
001594
001594

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

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

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

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

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

Can we bring our jury in?

MR. EGLET: Yes, you can.

[Jury In]

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

001595

001595

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

Will counsel stipulate to the presence of the jury?

MR. EGLET: Yes, Your Honor.

MR. ROGERS: Yes, Your Honor.

THE COURT: Very well.

Mr. Eglet?

MR. EGLET: Thank you, Your Honor.

BY MR. EGLET:

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

A Yes, sir.

Q And what are your conclusions?

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

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

001596
001596
001596

conclusions regarding the diagnosis of his specific injuries?

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

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

A More likely right.

Q And beyond that are you certain?

A I'm certain.

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

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

001597
001597
001597

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

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

A Yes, sir.

Q Okay.

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

[Pause]

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

THE COURT: Yes.

BY MR. EGLET:

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

A Yes, sir.

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

A Yes.

001598

001598

001598

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

A Yes, sir.

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

A More likely true, sir.

Q And beyond that are you certain?

A Yes, sir.

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

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

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

A Yes.

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

A Yes.

MR. EGLET: Thank you, Doctor.

Thank you, Your Honor. I pass the witness.

THE COURT: Okay. Mr. Rogers?

001599

001599

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

THE COURT: Sure.

[Bench Conference Not Transcribed]

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

THE WITNESS: Sure.

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

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

THE COURT: Okay. Thank you.

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

001600
001600
001600

disc cause or make migraine headaches worse?"

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

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

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

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

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

001601

001601

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

MR. EGLET: No, Your Honor.

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

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

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

MR. ROGERS: Very good.

CROSS-EXAMINATION

BY MR. ROGERS:

Q Doctor, how are you?

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

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

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

A No, sir.

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

A No, sir.

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

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

001602

001602

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

A Yes, sir.

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

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

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

A Not to my knowledge, sir.

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

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

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

A Not to my knowledge, sir.

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

A I don't understand the question.

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

001603

001603

001603

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

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

MR. EGLET: Objection. Compound.

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

[Bench Conference Not Transcribed]

BY MR. ROGERS:

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

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

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

A Correct.

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

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

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

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

001604
001604
001604

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

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

MR. EGLET: Objection, asked and answered.

THE COURT: Sustained.

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

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

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

BY MR. ROGERS:

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

A That's correct, sir.

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

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

THE COURT: It is. Sustained.

BY MR. ROGERS:

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

A Correct, sir.

001605

001605

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

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

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

A No.

Q Oh, it was not?

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

MR. ROGERS: Just one moment here.

BY MR. ROGERS:

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

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

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

001606
001606
001606

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

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

A Yes, sir.

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

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

THE WITNESS: I was --

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

MR. ROGERS: Okay.

BY MR. ROGERS:

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

A I was aware of that.

Q Okay. When were you made aware of that?

A By looking through charts, preparing for this

001607

001607

001607

testimony.

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

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

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

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

THE COURT: Counsel, approach, please.

[Bench Conference Not Transcribed]

BY MR. ROGERS:

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

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

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

MR. ROGERS: I'll try again.

001608
001608
001608

BY MR. ROGERS:

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

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

THE COURT: I don't know --

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

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

BY MR. ROGERS:

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

A Yes, sir.

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

A That is correct.

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

A Correct.

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

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

001609
001609
001609

THE COURT: It does, sustained.

MR. EGLET: Lack of foundation.

THE COURT: Sustained.

BY MR. ROGERS:

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

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

THE COURT: Yes.

[Bench Conference Not Transcribed]

BY MR. ROGERS:

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

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

THE COURT: I'll allow it.

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

001610
001610
001610

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

BY MR. ROGERS:

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

A Yes, sir.

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

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

THE COURT: Sustained.

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

THE COURT: Sustained.

BY MR. ROGERS:

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

A That's correct, sir.

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

A Well, the patient was complaining of migraines. And

001611
001611
001611

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

Q Are you aware that he was taking Butalbital?

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

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

THE COURT: Overruled. I'll allow it.

BY MR. ROGERS:

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

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

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

A I'm sorry?

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

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

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

A He complained of occipital headaches.

001612

001612

001612

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

MR. EGLET: Objection, Your Honor.

BY MR. ROGERS:

Q It covers --

MR. EGLET: Counsel is testifying.

MR. ROGERS: I'm cross-examining.

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

BY MR. ROGERS:

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

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

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

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

001613

001613

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

A Of the occipital areas I was aware, yes.

Q What about the front?

A No.

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

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

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

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

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

A No.

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

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

001614
001614
001614

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

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

MR. EGLET: Objection, argumentative, Your Honor.

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

BY MR. ROGERS:

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

MR. EGLET: Same objection, Your Honor.

THE COURT: Same ruling. Sustained.

BY MR. ROGERS:

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

A Yes, sir.

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

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

Q But you share office space with him?

A That is correct, sir.

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

A That's correct, sir.

001615
001615
001615

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

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

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

A That is correct.

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

A Not to my knowledge, sir.

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

A Normal study for age, I believe, yes.

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

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

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

A Appeared to be, yes, sir.

001616

001616

001616

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

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

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

A Yes, sir.

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

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

Q I'm focusing on condition at this point.

MR. EGLET: Can the witness --

BY MR. ROGERS:

Q We'll get to symptoms soon.

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

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

MR. ROGERS: The question was as to condition.

001617

001617

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

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

BY MR. ROGERS:

Q Go ahead.

A Now I lost my train of thought.

THE COURT: If you remember.

BY MR. ROGERS:

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

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

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

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

001618

001618

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

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

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

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

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

Q There weren't.

A There weren't.

Q The one in 2007.

A Yes.

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

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

001619

001619

injection as a --

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

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

Q Dr. Grover is the surgeon, right?

A Yes, sir.

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

A That is correct, sir.

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

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

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

A Many and hundreds.

Q How long does a selective nerve root block procedure

001620
001620
001620

take?

A Anywhere between five to eight minutes I would say.

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

A Yes.

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

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

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

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

001621
001621
001621

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

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

BY MR. ROGERS:

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

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

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

A Well --

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

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

MR. ROGERS: Is -- okay.

001622

001622

BY MR. ROGERS:

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

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

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

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

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

MR. EGLET: Objection, argumentative.

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

001623

001623

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

BY MR. ROGERS:

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

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

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

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

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

A Facet joints don't innervate the area.

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

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

001624

001624

and the patient was asymptomatic.

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

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

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

A I did not see any.

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

A Yes, sir.

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

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

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

A It could conceivably be a risk factor. That is

001625
001625
001625

correct, sir.

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

A I don't understand your question.

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

A Yes, sir.

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

A Yes, sir.

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

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

001626

001626

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

A Correct.

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

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

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

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

UNIDENTIFIED SPEAKER: Exhibit number and a page number?

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

[Counsel Confer]

BY MR. ROGERS:

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

A Yes, sir.

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

A Yes, sir.

Q Fissures, you said, are synonymous with tears.

A Yes, sir.

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

A Absolutely. So can a tear.

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

A Yes, sir.

Q The third was not.

A Yes, sir.

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

A Yes, sir.

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

A Yes, sir.

001628

001628

001628

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

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

Q Yes.

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

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

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

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

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

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

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

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

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

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

A That's correct, sir.

Q That would be one such false positive.

A Correct.

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

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

THE COURT: Ask you to rephrase it.

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

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

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

MR. EGLET: Which one?

BY MR. ROGERS:

Q You're talking to the patient --

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

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

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

MR. EGLET: -- dozens of different procedures.

[Court Admonishes Jury]

[Bench Conference Not Transcribed]

[Recess]

THE MARSHAL: Please remain seated.

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

MR. ROGERS: Yes, Your Honor.

MR. EGLET: Yes.

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

MR. ROGERS: Okay.

BY MR. ROGERS:

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

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

MR. ROGERS: Yes.

001631

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

THE COURT: Sustained as to clarification.

BY MR. ROGERS:

Q You understand I'm asking discography?

A Okay.

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

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

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

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

THE COURT: Yes.

[Bench Conference Not Transcribed]

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

MR. EGLET: Thank you, Your Honor.

BY MR. ROGERS:

Q Did you ever take the Plaintiff off work?

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

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

001632

001632

001632

A To my knowledge, the patient continued to work.
Q And you don't know anything about his employment?
A As I pointed out earlier, to my knowledge, he was employed in the cleaning business.
Q Now, you found that the Plaintiff was debilitated due to pain. Correct?
A Yes.
Q That he had a six or seven of ten of pain?
A Yes, sir.
Q How long had he had a six or seven of ten of pain?
A Throughout my interaction with the patient.
Q Okay. Well, your interaction began three years after the incident.
A Yes, sir.
Q You don't know about his pain level before he presented to you?
A I did not see the patient before, sir.
Q What pain medications was the Plaintiff taking when he presented to your office?
A We -- off the top of my head, I don't know. I have to look this up, sir.
Q Okay. Well, take a look.
A It's in our computer system in our office.
Q It's not in the chart you brought with you?
A No.

001633
001633
001633

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

A Not necessarily, sir.

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

A That is correct.

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

A That appears to be correct, sir.

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

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

Q Could he do things like lift heavy objects?

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

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

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

001634

001634

001634

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

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

THE COURT: I believe it was answered. Overruled.

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

BY MR. ROGERS:

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

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

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

MR. ROGERS: Okay.

BY MR. ROGERS:

Q And same answer?

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

Q Okay. Could he go motorcycle riding?

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

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

001635

001635

level at the time you were seeing him?

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

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

A Yes, sir.

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

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

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

A Yes, sir.

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

A That is correct, sir.

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

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

001636
001636
001636

optimistic hopes. That is not unusual.

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

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

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

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

THE COURT: Sustain the objection.

BY MR. ROGERS:

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

A Yes, sir.

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

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

001637

001637

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

A Uh-huh.

Q And something unrelated to a car accident. Right?

A That is correct, sir.

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

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

THE WITNESS: It's beyond my scope.

THE COURT: I think it may be. Sustained.

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

THE COURT: Sure.

MR. ROGERS: Thank you.

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

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

REDIRECT EXAMINATION

BY MR. EGLET:

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

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

001638

001638

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

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

A No, sir.

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

A Yes, sir.

Q Is that your normal procedure?

A Yes, sir.

Q Is that what you are trained to do?

A Yes, sir.

Q Is that what the ICES guidelines provide?

MR. ROGERS: Your Honor, this is leading.

THE COURT: It is.

BY MR. EGLET:

Q Do you comply with the ICES guidelines?

A Yes, I do.

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

A Yes, sir.

001639
001639
001639

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

A No, sir.

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

A I had thought about this, yes, sir.

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

A Yes, sir.

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

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

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

001640

001640

001640

that?

A Yes, sir.

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

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

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

BY MR. EGLET:

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

A Yes, certainly.

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

A Yes.

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

MR. ROGERS: Your Honor --

THE COURT: Yes.

001641

001641

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

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

MR. ROGERS: Yes.

[Bench Conference Not Transcribed]

BY MR. EGLET:

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

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

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

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

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

A Yes, sir.

Q You did document?

A I do document if that happens.

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

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

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

A Absolutely.

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

A Absolutely.

Q Okay.

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

BY MR. EGLET:

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

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

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

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

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

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

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

BY MR. EGLET:

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

001644

001644

A Yes, sir.

Q Scrapes, bumps, bruises, things like that.

A Yes.

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

A Yes, sir.

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

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

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

A No.

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

A No, sir.

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

001645

001645

001645

A No, sir.

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

A No, sir.

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

A It would not surprise me, sir.

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

A That does not surprise me, sir.

Q Why not?

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

Q Okay.

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

BY MR. EGLET:

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

A Yes.

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

001646
001646
001646

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

A 0007?

Q Yes. Now, Doctor --

MR. EGLET: Do we have this?

BY MR. EGLET:

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

A Yes, sir.

Q And do you recognize this document?

A Yes.

Q What is the date of this document?

A 3/28/08, sir.

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

A Yes, sir.

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

A It's 10 out of 10, sir.

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

A No.

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

A Yes, sir.

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

001647

001647

001647

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

A Possible facet blocks, correct, sir.

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

A Yes, sir.

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

A Yes.

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

A No.

Q Why?

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

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

001648

001648

001648

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

A Yes, sir.

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

A For the discography study, correct, sir.

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

A He did not.

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

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

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

A Yes, sir.

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

A No, sir.

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

A Yes, sir.

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

001649
001649
001649

A No --

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

A It can be, sir, yes.

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

A Yes.

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

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

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

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

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

001650
001650
001650

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

A Yes, sir.

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

A Yes.

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

THE COURT: Yeah. Ask him to rephrase.

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

THE COURT: I know. I know.

BY MR. EGLET:

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

A Yes.

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

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

001651
001651
001651

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

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

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

001652

001652

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

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

A Yes, sir.

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

A Yes, sir.

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

A I do read the reports, sir.

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

A Yes, sir.

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

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

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

A No.

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

A No, sir.

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

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

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

001654
001654
001654

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

A That is correct, sir.

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

A Exactly, sir.

Q And they never meet any of these patients?

A No, sir.

Q Ever perform any physical examinations on these patients?

A No.

Q Do they ever get histories from these patients?

A No.

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

A Not unusual, sir.

Q Thank you.

THE COURT: Any follow-up?

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

THE COURT: All right.

RECROSS-EXAMINATION

BY MR. ROGERS:

Q All right. Anything on the screen here?

001655
001655
001655

A Not right now, sir.

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

BY MR. ROGERS:

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

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

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

A No, sir.

Q It's to reproduce the most extreme pain?

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

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

001656

001656

It was a 7.

A His worst pain was a 10.

Q His average pain was a what?

A A 7.

Q Okay.

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

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

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

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

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

Q Do you have any understanding of his current condition?

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

001657

001657

patient.

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

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

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

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

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

A No, sir.

Q Which can also cause arm symptoms.

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

Q Wrist symptoms.

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

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

001658
001658
001658

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

Q Thank you.

MR. ROGERS: Thank you.

THE COURT: Any follow-up?

MR. EGLET: Just briefly, Your Honor.

FURTHER REDIRECT EXAMINATION

BY MR. EGLET:

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

A Yes, sir.

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

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

MR. EGLET: Thank you.

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

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

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

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

001659

001659

001659

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

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

MR. EGLET: No, Your Honor.

RECROSS-EXAMINATION

BY MR. ROGERS:

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

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

Q Explain to the jury --

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

THE COURT: Yes.

MR. ROGERS: Just explain it --

MR. EGLET: Let him finish his answer --

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

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

the occipital area.

THE COURT: Any follow-up?

MR. EGLET: No.

MR. ROGERS: No, Your Honor.

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

[Court Admonishes Jury]

[Bench Conference Not Transcribed]

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

001661

001661

001661

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

Laura Hinton

LAURA HINTON, Transcriber

Erin Goold

ERIN GOOLD, Transcriber

Antoinette M. Franks

ANTOINETTE M. FRANKS, Transcriber

BONNIE FURLONG, Transcriber

Rebecca M. Breitenbach

REBECCA BREITENBACH, Transcriber

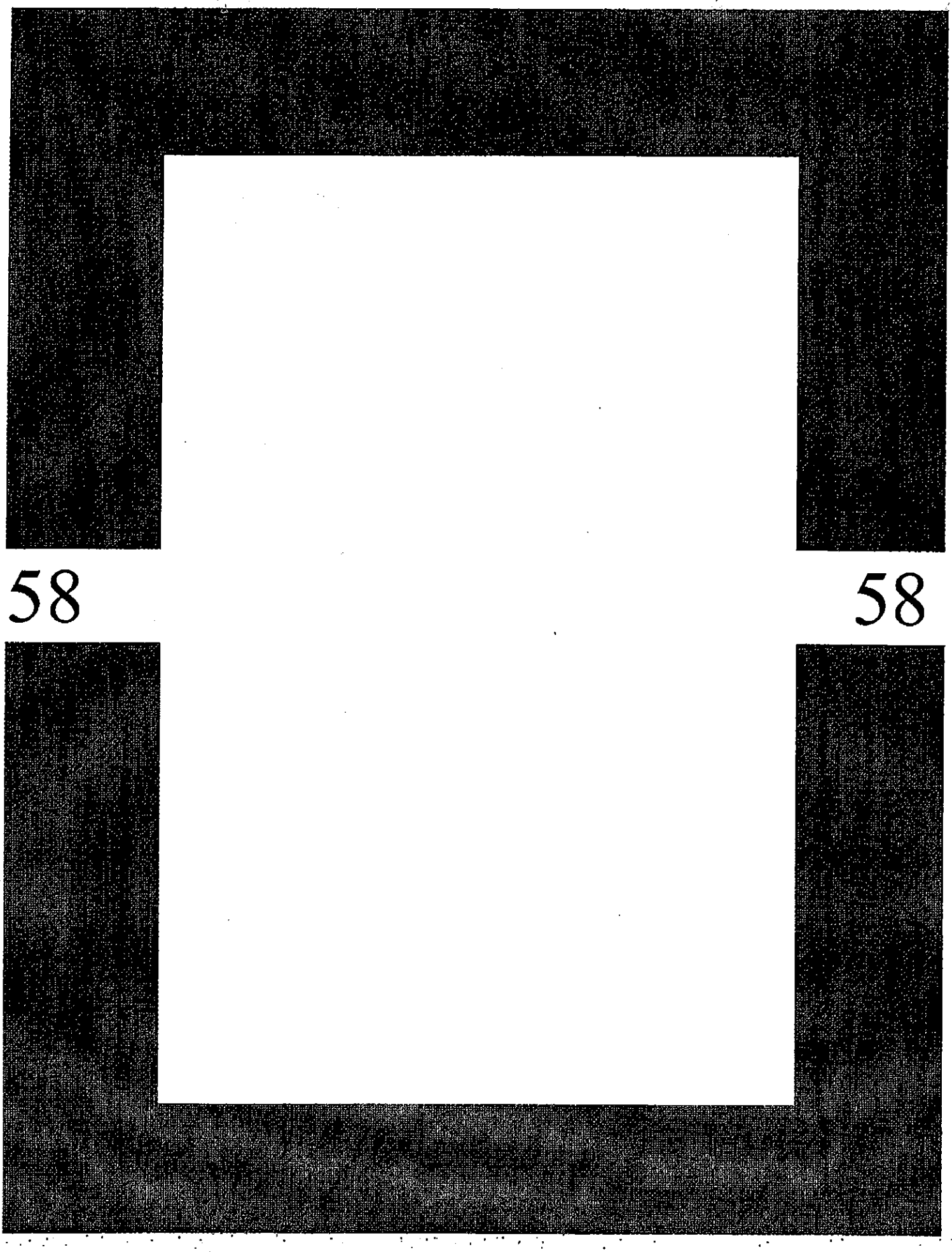
Kelley Grijalva

KELLEY A. GRIJALVA, Transcriber

001662

001662

001662



58

58

001663

001663

Electronically Filed
03/22/2011 03:10:16 PM

CLERK OF THE COURT

OPP
ROBERT T. EGLET, ESQ.
Nevada Bar No. 3402
DAVID T. WALL, ESQ.
Nevada Bar No. 2805
ROBERT M. ADAMS, ESQ.
Nevada Bar No. 6551
MAINOR EGLET
400 South Fourth Street, Suite 600
Las Vegas, Nevada 89101
Ph: (702) 450-5400
Fx: (702) 450-5451
dwall@mainorlawyers.com

MATTHEW E. AARON, ESQ.
Nevada Bar No. 4900
AARON & PATERNOSTER, LTD.
2300 West Sahara Avenue, Ste.650
Las Vegas, Nevada 89102
Ph.: (702) 384-4111
Fx.: (702) 384-8222
Attorneys for Plaintiffs

DISTRICT COURT
CLARK COUNTY, NEVADA

WILLIAM JAY SIMAO, individually and CHERYL ANN SIMAO, individually, and as husband and wife, Plaintiffs, v. JENNY RISH; JAMES RISH; LINDA RISH; DOES I through V; and ROE CORPORATIONS I through V, inclusive, Defendants.	CASE NO.: A539455 DEPT. NO.: X **PLAINTIFFS' OPPOSITION TO DEFENDANT'S TRIAL BRIEF IN SUPPORT OF ORAL MOTION FOR MISTRIAL**

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

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

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

DATED this 18th day of March, 2011.

MAINOR EGLET

ROBERT T. EGLET, ESQ.
Nevada Bar No. 3402
DAVID T. WALL, ESQ.
Nevada Bar No. 2805
ROBERT M. ADAMS, ESQ.
Nevada Bar No. 6551
400 South Fourth Street, Suite 600
Las Vegas, Nevada 89101
Attorneys for Plaintiffs

///

///

///

001665

001665

MEMORANDUM OF POINTS AND AUTHORITIES

I.

ARGUMENT

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

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

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

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

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

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

The *Sanders* Court further instructed:

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

Id. at 668. [Emphasis Added].

Witherspoon, supra,[1] relied upon by the Florida Supreme Court, is one of the seminal cases concerning voir dire during a death penalty case and sets forth the importance of selecting an impartial jury who is willing to follow the law when the life of a human being is at stake. The *Witherspoon* Court held:

[1] *Witherspoon* was overruled on other grounds unrelated to the subject matter of the instant Opposition. *See Brown v. Lambert*, 2004 U.S. Dist. LEXIS 30496 (W.D. Wash. Sept. 15, 2004); *see also Valle v. State*,, 474 So. 2d 796, 1985 Fla. LEXIS 1460, 10 Fla. L. Weekly 381 (Fla. 1985)

> It is, of course, settled that a State may not entrust the determination of whether a man is innocent or guilty to a tribunal "organized to convict." *Fay* v. *New York*, 332 U.S. 261, 294. See *Tumey* v. *Ohio*, 273 U.S. 510. It requires but a short step from that principle to hold, as we do today, that a State may not entrust the determination of whether a man should live or die to a tribunal organized to return a verdict of death. Specifically, we hold that a sentence of death cannot be carried out if the jury that imposed or recommended it was chosen by excluding veniremen for cause simply because they voiced general objections to the death penalty or expressed conscientious or religious scruples against its infliction. No defendant can constitutionally be put to death at the hands of a tribunal so selected.

Id. at 521-522.

Recognizing the importance of selecting an impartial jury in a death penalty case, and applying its own statute, the Supreme Court of Florida held that it was reversible error to not permit the defendant's counsel to question the excused juror.

Similarly, in *O'Connell v. State,* 480 So.2d 1284 (Fla. 1986), the Supreme Court of Florida reversed a conviction of death after the trial court refused to allow a defendant to voir dire two (2) prospective jurors who stated that they were opposed to the death penalty. *Id.* at 1287. The Court also cited to Florida Rule of **Criminal** Procedure 3.300 which spells out a defendant's right to conduct voir dire of each prospective juror. *Id.* at 1286-1287. The Court therefore reversed on this premise, holding that the trial court should have allowed defendant the right to question the excused prospective jurors due to the right expressed in the criminal code. *Id.* at 1287.

In *State v. Anderson,* 4 P.3d 369 (Ariz.2000), also a death penalty case, the high court reversed a sentence of death because the trial judge committed error when it did not permit defense counsel to question three (3) prospective jurors who were excused for cause after voicing general objections to the death penalty in jury questionnaires *Id.* at 317. The refusal to permit

the questioning was a direct violation of Arizona Rule of Criminal Procedure 18.5, permitting voir dire by a defendant.

Further, the Court also expressed that under *Witherspoon, supra*, as modified by *Wainwright v. Witt*, 469 U.S. 412, 105 S. Ct. 844, 83 L. Ed. 2d 841 (1985):

> The United States Supreme Court has held that the Sixth Amendment is violated if the trial jury in a capital case is chosen by excluding for cause persons who have general objections to the death penalty. *Witherspoon v. Illinois*, 391 U.S. 510, 88 S. Ct. 1770, 20 L. Ed. 2d 776 (1968). A general objection to the death penalty is not sufficient to create a presumption that a prospective juror is unfit because of bias to sit on the panel. The Court's language was quite clear:
>
> It is, of course, settled that a State may not entrust the determination of whether a man is innocent or guilty to a tribunal 'organized to convict.' It requires but a short step from that principle to hold, as we do today, that a State may not entrust the determination of whether a man should live or die to a tribunal organized to return a verdict of death. Specifically, we hold that a sentence of death cannot be carried out if the jury that imposed or recommended it was chosen by excluding veniremen for cause simply because they voiced general objections to the death penalty or expressed conscientious or religious scruples against its infliction. No defendant can constitutionally be put to death at the hands of a tribunal so selected. *Id.* at 521-23, 88 S. Ct. at 1776-77 (citations and footnotes omitted).
>
> **However, this rule is not applicable to prospective jurors who state unequivocally that they could never impose the death penalty regardless of the facts of the particular case.** *Id.* at 514, 88 S. Ct. at 1772; *see also Morgan v. Illinois*, 504 U.S. 719, 734 n.7, 112 S. Ct. 2222, 2232 n.7, 119 L. Ed. 2d 492 (1992)("The process of voir dire is designed to cull from the venire persons who demonstrate that they cannot be fair to either side of the case. Clearly, the extremes must be eliminated -- i.e., those who, in spite of the evidence, would automatically vote to convict or impose the death penalty or automatically vote to acquit or impose a life sentence.").
>
> . . .
>
> ...a person's opposition to the death penalty need not be proved with "unmistakable clarity," **but a prospective juror may be excused if his views "would prevent or substantially impair the performance of his duties as a juror...."** *Id.* at 424, 105 S. Ct. at 852 (quoting *Adams v. Texas*, 448 U.S. 38, 45, 100 S. Ct. 2521, 2528, 65 L. Ed. 2d 581 (1980)). Arizona adopted an identical standard in *State v. Martinez-Villareal*, 145 Ariz. 441,

> 449, 702 P.2d 670, 678 (1985). In Arizona, "disqualification when a juror states his inability to be impartial is not only permissible but imperative." *State v. Wiley*, 144 Ariz. 525, 534, 698 P.2d 1244, 1253 (1985)(overruled on other grounds by *State v. Superior Court*, 157 Ariz. 541, 760 P.2d 541 (1988)); *see also State v. Willoughby*, 181 Ariz. 530, 892 P.2d 1319 (1995)(excusing venire person who could not convict due to religious opposition to the death penalty does not violate state constitutional provision against disqualification based on religious beliefs).
>
> In the present case, the trial judge's denial of questioning beyond the prospective jurors' written answers forces us to determine from the questionnaire answers alone whether their attitudes toward the death penalty were so entrenched as to disqualify them from service. On this record, we must conclude that it is possible that the three could have been rehabilitated by oral voir dire that established their ability to set aside their beliefs and follow the law.

Id. at 318-320. [Emphasis Added].

Notably, the Court recognized that voir dire by the parties is not required if a juror's views "would prevent or substantially impair the performance of his duties as a juror." *Id.* at 319-320. There, however, the Court determined that relying upon the record presented, it was possible that the three (3) excused jurors could have been rehabilitated.

Lastly, in *People v. Lefebre*, 981 P.2d 650 (Colo. App. 1998), the trial court excused three jurors who indicated on jury questionnaires they could not be fair and impartial. The Court of Appeals of Colorado reversed the criminal conviction noting that under Colorado Rules of Criminal Procedure 24(a)(2), an express right is granted for a defendant to voir dire a prospective jury panel. *Id.* at 651-652. The Court held:

> The mandatory language of the rule and the statute providing that counsel be allowed to examine potential jurors expresses a strong policy from the General Assembly and the Supreme Court that counsel for the parties not be denied input in the jury selection process as to any potential juror. See Crim. P. 24(b)(1)(X); 16-10-103(1)(j), C.R.S. 1998;

Id. at 652.

These cases relied upon by the defense involve specific criminal procedure statutes and also describe the importance of empanelling a fair and impartial jury who will follow the law when freedom and/or life is at stake. Thus, a defendant whose freedom and/or life is at stake is sometimes permitted to conduct voir dire of a prospective juror even though that prospective juror has demonstrated that he or she may not be able to follow the law. *See Witherspoon, supra.* Because the instant case involves a civil matter, the cases relied upon by the defense should be disregarded.

Rather than rely on the inapposite case law cited to by the defense, there is ample case law, including cases from Nevada, which justifies the removal of the jurors who have demonstrated that they cannot be fair and impartial.

The purpose of voir dire is to facilitate the identification and removal of potential jurors "who, because of bias or prejudice, cannot serve as fair and impartial jurors." *Silver State v. Shelley*, 105 Nev. 309, 774 P.2d 1044 (1989). The scope of voir dire "rests within the sound discretion of the district court, whose decision will be given considerable deference by the Nevada Supreme Court. *Johnson v. State*, 122 Nev. 1344, 1354-55, 148 P.3d 767, 774 (2006); *Thomas v. Hardwick*, 231 P.3d 1111, 1115 (Nev. 2010).

As has been expressed by the Nevada Supreme Court, "[t]he test for evaluating whether a juror should [be] removed for cause is 'whether a prospective juror's views would prevent or substantially impair the performance of his duties as a juror in accordance with his instruction and his oath.'" *Weber v. State*, 121 Nev. Adv. Rep. 57, 119 P.3d 107, 125 (2005), citing *Leonard v. State*, 117 Nev. 53, 65, 17 P.3d 397, 405 (2001); See also *Wainwright v. Witt*, 496 U.S. 412 (1985).

The United States Supreme Court in *Wainwright* held that prospective jurors must be excused if their views could substantially impair their ability to perform their function as jurors, and the impairment need not be shown with unmistakable clarity. The Supreme Court of Nevada has provided guidance for the District Court and trial counsel in determining whether a juror should be removed for cause. The Court explained, "[i]t is not enough to be able to point to detached language which, alone considered, would seem to meet the statute requirement, if, on construing the whole declaration together, it is apparent that the juror is not able to express an absolute belief that his opinion will not influence his verdict." *Thompson vs. State of Nevada*, 111 Nev. 439, 443, 894 P.2d 375, 377 (1995), citing *Bryant v. State*, 72 Nev. 330, 305 P.2d 360 (1956). This rule was recently affirmed by our Supreme Court, wherein the court stated: "[d]etached language considered alone is not sufficient to establish that a juror can be fair when the juror's declaration as a whole indicates that she could not state unequivocally that a preconception would not influence her verdict." *Weber v. State*, 119 P.3d 107, 126, 121 Nev. Adv. Rep. 57 (2005), citing *Thompson, supra.*

Any doubt should be weighed in favor of being excused in order to remove even the possibility of bias or prejudice infecting the deliberations. See *Walls v. Kim*, 549 S.E.2d 797, 250 Ga.App. 259 (Ga. 2001).

The Nevada Supreme Court emphasized this point in *Thompson*, and found that, "...[s]imply because the district court was able to point to detached language that prospective juror eighty-nine could be impartial does not eradicate the fact that he previously demonstrated partial beliefs, capped by an unequivocal statement that [the Defendant] was guilty." *Thompson, supra* at 443. The Court further explained: "It may be true that on examination [the prospective juror's] answers tended to contradict his previous statements, but we believe that his very self-

contradictions do not increase his fitness as a juryman." *Id.* citing *Bryant*, 72 Nev. at 334. The *Thompson* court ultimately concluded that ". . . it was prejudicial error that [the] prospective juror was not excused for cause.

Again, decisions concerning the scope of voir dire and the manner in which it is conducted are reviewable only for abuse of discretion," *Hogan v. State*, 103 Nev. 21, 23, 732 P.2d 422, 423 (1987), and draw "considerable deference" on appeal. *Johnson v. State*, 122 Nev. 1344, 1355, 148 P.3d 767, 774 (2006). *See e.g. Lamb v. State*, 127 Nev. Adv. Op. 3 (March 3, 2011). Here, the record will reflect that all nine (9) jurors unequivocally demonstrated that they could not be fair and impartial and were justifiably removed from the panel for cause. This Court was well within its discretion to strike the subject panel members and a mistrial is not warranted.

B. This Court has not erred by allowing Plaintiff to conduct meaningful voir dire of the prospective jury panel.

Defendant's second basis for a mistrial, that this Court failed to properly restrict Plaintiff's voir dire, is also misplaced and certainly does not warrant a mistrial.

The Nevada Supreme Court has specifically held that an attorney has a substantive right to participate in voir dire. *See Whitlock v. Salmon*, 104 Nev. 24, 26, 752 P.2d 210 (1988). In *Whitlock*, (also cited to by the defense) Appellants, Phyllis and J.T. Whitlock, brought an action against Donald Salmon, M.D. for injuries received by Mrs. Whitlock during surgery for removal of a brain tumor. *Id.* at 25. The Whitlocks' counsel specifically requested permission of the trial judge to voir dire the jury. *Id.* However, voir dire was conducted exclusively by the judge. *Id.* The Supreme Court found the trial judge's failure to permit counsel to voir dire the jury to be reversible error. *Id.*

NRS 16.030(6) provides:

> The judge shall conduct the initial examination of the prospective jurors and **the parties or their attorneys are entitled to conduct supplemental examinations which must not be unreasonably restricted.**

[Emphasis Added]. The Court in *Whitlock* held that "the statute confers a substantive right to reasonable participation in voir dire by counsel; and this court will not attempt to abridge or modify a substantive right." *Id.* at 26. In so holding, the Court explained:

> Usually, trial counsel are more familiar with the facts and nuances of a case and the personalities involved than the trial judge. Therefore, they are often more able to probe delicate areas in which prejudice may exist or pursue answers that reveal a possibility of prejudice. Moreover, while we do not doubt the ability of trial judges to conduct voir dire, there is concern that on occasion jurors may be less candid when responding with personal disclosures to a presiding judicial officer. Finally, many trial attorneys develop a sense of discernment from participation in voir dire that often reveals favor or antagonism among prospective jurors. The likelihood of perceiving such attitudes is greatly attenuated by a lack of dialogue between counsel and the individuals who may ultimately judge the merits of the case. In that regard, we expressly disapprove of any language or inferences in *Frame* that tend to minify the importance of counsel's voir dire as a source of enlightenment in the intelligent exercise of peremptory challenges.

Id. at 28.

The Supreme Court further explained the importance of trial counsel's substantive right to participate in voir dire by emphasizing that this right was specifically safeguarded by the legislature *via* a statutory enactment:

> NRCP 47(a) contemplated a healthy respect on the part of trial judges for appropriate supplemental participation by trial counsel in voir dire. Historically, in most of Nevada's courts of general jurisdiction, counsel have been accorded meaningful opportunities for involvement in the voir dire of prospective jurors. The Legislature thus saw fit to enthrone the historical practice selectively enjoyed by counsel in most trial procedures, in a substantive enactment that vouch-safes the right to all counsel in every department of our district courts. We accordingly view the statutory right thus bestowed as an acceptable solidification of the basic intendment of N.R.C.P. 47(a).

Whitlock, supra, at 26.

In the instant matter, William Simao has suffered severe life-altering injuries as a result of Defendant's carelessness and, as such, William will be requesting from the jury millions of dollars to compensate him for his injuries. Moreover, William's wife, Cheryl Ann Simao, will be requesting monetary damages for the losses she has sustained as a result of William's injuries. Therefore, Plaintiffs' counsel is entitled to conduct voir dire of the jury panel which should not be unreasonably restricted. "The voir dire examination of jurors . . . [is] to enable counsel to exercise intelligently the peremptory challenges allowed by the law." *State v. Brown*, 53 N.C. App. 82, 280 S.E. 2d 31, Cert Denied, 304 N.C. 197, 285 S.E. 2d 102 (1981). Therefore, the purpose of voir dire is for counsel to gather information for peremptory as well as for cause challenges. However, "[p]eremptory challenges are worthless if trial counsel is not afforded an opportunity to gain the necessary information upon which to base such strikes." *Id.* at 27, citing *United States v. Ible*, 630 F.2d 389, 395 (5th Cir. 1980).

Further, Defendant's reliance on *Lamb v. State*, 127 Nev. Adv. Op. 3 (March 3, 2011) is not helpful to the defense's argument as the Court in *Lamb* simply points out that a trial judge who limits voir dire questions "aimed more at indoctrination than acquisition of information" does not abuse her discretion. The *Lamb* court speaks nothing of mistrial or any example of what constitutes "indoctrination" versus "inquisition." Apparently, it is the Defendant's hope that this Court simply accepts his argument on its face that "indoctrinating" questions are being asked without demonstrating when or how the panel members have allegedly been indoctrinated. The defense has completely failed to set forth how this case applies to the facts of the instant matter and, therefore, it must be disregarded.[2]

[2] Judges are not to be treated like pigs hunting for truffles buried in briefs. *Bishop v. Potter*, 2010 U.S. Dist. LEXIS 105845 (D. Nev. Oct. 1, 2010)

Lastly, Defendant claims that Plaintiff has "tainted" the jury pool by improperly advising the pool on the burden of proof because Plaintiff has advised the jury that the parties are "equal." As has been argued at length, Plaintiff is not advising the jury on the burden of proof when asking questions designed around the parties starting positions in the minds of the prospective jurors. Plaintiff is very familiar with the burden of proof and in no way, shape, or form, is trying to shift that burden. Rather, as both parties are entitled to a fair and impartial jury who will follow the law, it is imperative to know whether or not a potential juror has preconceived notions which would place one party over the other prior to hearing any evidence. The notion that this is improper is truly inconceivable given the fact that empaneling a fair and impartial jury is so elementary to today's jurisprudence.

Defendant relies upon *Joynt v. California Hotel & Casino,* 108 Nev. 539 (1992) in support if her "burden of proof" argument. *Joynt,* however, does not involve voir dire, or any matter involving the selection of a fair and impartial jury. Instead, the case simply and correctly explains that a plaintiff carries the burden of proof in a negligence action. *Id.* at 542. Aside from this, *Joynt* offers nothing with regard to determining the propriety of advising the jury panel that it should not give an advantage, or feel any affinity toward one party or the other prior to hearing evidence. The illustration that the parties are to be placed evenly on the scales before the introduction of evidence and that the empaneled jury is to then weigh the evidence and decide whether or not the scales have been tipped by the Plaintiff is designed to convey the importance of impartiality and expose potential jurors who might be unable to be impartial. Defendants argument, that this sort of an example misconstrues the burden of proof, is unfathomable because if Defendant were correct and she does in fact start ahead of the Plaintiff, it would mean that Plaintiff would first be required to overcome the burden of rising to the same level on the scale

as the Defendant and then overcome the burden of tipping the scale in Plaintiff's favor. This would change the standard of proof from a preponderance of the evidence (more likely than not) to something greater. Such a scenario would be patently unfair and contrary to well-settled Nevada law.

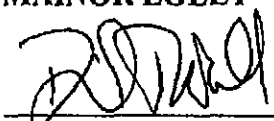
II.

CONCLUSION

Based upon the foregoing, Defendant's Motion for a Mistrial must be summarily **DENIED.**

DATED this 18th day of March, 2011.

MAINOR EGLET



ROBERT T. EGLET, ESQ.
Nevada Bar No. 3402
DAVID T. WALL, ESQ.
Nevada Bar No. 2805
ROBERT M. ADAMS, ESQ.
Nevada Bar No. 6551
400 South Fourth Street, Suite 600
Las Vegas, Nevada 89101
Attorneys for Plaintiffs

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

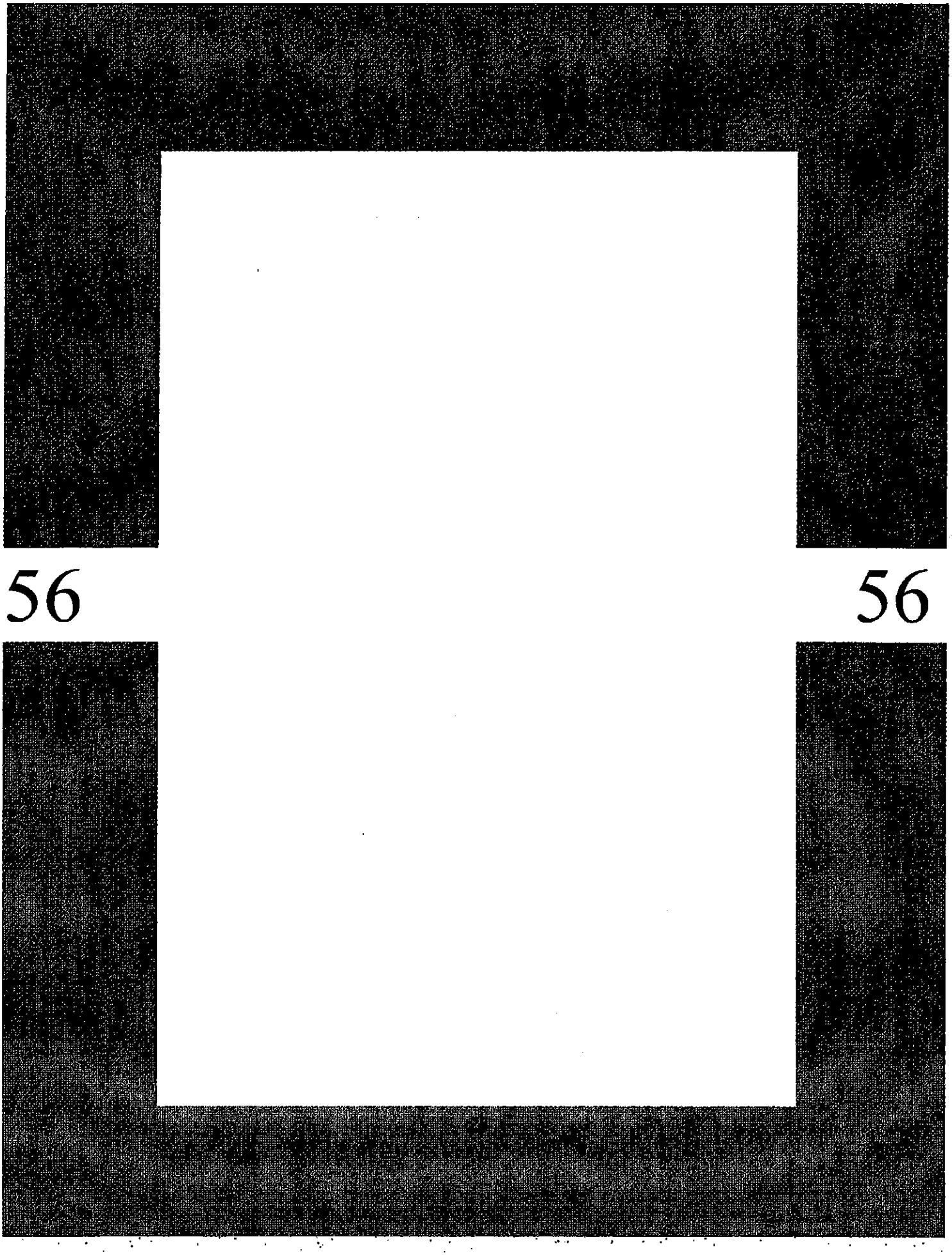
APPELLANT'S APPENDIX
VOLUME 7
PAGES 1428-1677

DANIEL F. POLSENBERG
State Bar of Nevada No. 2376
JOEL D. HENRIOD
State Bar of Nevada No. 8492
LEWIS AND ROCA LLP
3993 Howard Hughes Pkwy., Suite 600
Las Vegas, Nevada 89169
(702) 474-2616
DPolsenberg@LRLaw.com

STEPHEN H. ROGERS
State Bar of Nevada No. 5755
ROGERS MASTRANGELO CARVALHO & MITCHELL
300 South Fourth Street, Suite 170
Las Vegas, Nevada 89101
(702) 383-3400
SRogers@RMCMLaw.com

Attorneys for Appellant

TABLE OF CONTENTS TO APPENDIX



56

56

001428

001428

Electronically Filed
04/16/2011 06:45:47 AM

ORIGINAL

CLERK OF THE COURT

TRAN

DISTRICT COURT

CLARK COUNTY, NEVADA

WILLIAM SIMAO,

Plaintiff,

v.

JENNY RISH,

Defendant.

A539455

CASE NO. ~~A-539445~~

DEPT. X

BEFORE THE HONORABLE JESSIE WALSH, DISTRICT COURT JUDGE

MONDAY, MARCH 21, 2011

REPORTER'S TRANSCRIPT
TRIAL BY JURY
DAY 1 - VOLUME I

APPEARANCES:

For the Plaintiff: DAVID T. WALL, ESQ.
ROBERT M. ADAMS, ESQ.
ROBERT T. EGLET, ESQ.
Mainor Eglet, LLP

For the Defendant: STEVEN M. ROGERS, ESQ.
Hutchison & Steffen, LLC

RECORDED BY: VICTORIA BOYD, COURT RECORDER

001429
001429
001429

MONDAY, MARCH 21, 2011 AT 1:05 P.M.

[Within the Presence of the Jury]

THE CLERK: Please remain in order. Department X is now in session. The Honorable Jessie Walsh, Judge, presiding.

THE COURT: Please be seated. Good afternoon, members of the jury. Verbal response. That's a great start. Thank you. Thank for returning each and every one. Will Counsel stipulate to the presence of the jury?

MR. WALL: Yes, Your Honor.

MR. ROGERS: Yes, Your Honor.

THE COURT: Ladies and gentlemen of the jury, I would like to briefly explain to you the proceedings you are about to witness. You will, at the conclusion of the evidence, determine the facts in this case, apply to those facts the law which will be stated to you by the Court and on that basis, reach a verdict consistent with the facts and the law. Observe carefully each witness as he or she testifies and consider carefully all of the evidence as it is presented to you. For it is you who must determine the credibility of the witnesses and wherein the truth lies.

If the Court sustains an objection to any evidence, do not infer any bias of the Court based upon such rulings or speculate about any feeling on the part of the Court for or against either side in this case. If any objection to the testimony of a witness is sustained, you must not guess as to

001430

001430

what the answer might have been or draw any inferences from the question objected to itself. Remember that questions and arguments of Counsel are not evidence. Questions are important on insofar as they give meaning to the answer of the witness. Arguments of Counsel are only their opinion as to matters and have no evidentiary weight.

During the course of the trial, matters may arise which must be determined by the Court outside the presence of the jury as a matter of law. Again, you are not to speculate or be concerned in any way as to the reasons for such occurrences. I assure you they will be as limited in frequency and in duration as the law permits.

Your verdict in this case is to be based upon the testimony of the witnesses and other evidence that is produced in this courtroom and not on anything that occurs outside this room. Accordingly, you are not to visit any site or location that may be described by witnesses or to conduct experiments or perform any research on any subject connected with this case.

If during the examination of a witness some questions occur to you which you would like to see answered, please be patient. Your questions will probably be answered before the examination has been concluded. If not, write your questions on a slip of paper and give it to the bailiff. And if it is a proper one under the law, I will see that it is

001431

001431

answered.

You may individually take notes. And for that purpose, you have been provided pencils and notepads. However, in the event of a conflict between the notes of the individual jurors during your deliberations, you are not to rely upon the notes. You are to rely upon your own recollection of the testimony and the evidence.

Ladies and gentlemen of the jury, you are admonished that no juror may declare to his or her fellow jurors any fact relating to the case as of his or her knowledge and if any juror discovers during the trial or after the jury has retired that he or she has personal knowledge of any fact in controversy in the case, that juror shall disclose such a situation to the Court outside the presence of the other jurors.

One more reminder that Marshal Diamond is your only point of contact during these proceedings. None of the rest of us may have any direct contact with you.

Will Counsel stipulation that the reading of the pleadings may be omitted?

MR. WALL: We'll waive, Your Honor.

THE COURT: Okay.

MR. ROGERS: Defense will too.

THE COURT: Then, ladies and gentlemen, this is the time when the attorneys give you their opening statements. The law

001432

001432

001432

requires that the attorney for the Plaintiff goes first. Mr. Wall are you prepared to proceed?

MR. WALL: I am. Thank you very much, Your Honor.

Good afternoon, ladies and gentlemen. No one is allowed to needlessly endanger the public. If you needlessly endanger the public and you hurt someone, you are responsible for all of the harms and losses that follow. If you rear-end another vehicle and you hurt someone, you are responsible for all of the harms and losses that follow.

Now this case is about accountability and responsibility. When we talk about responsibility, what we're really talking about is who is to blame.

Let me tell you the story of this case. On the morning of April 15th, 2005, the Defendant, Jenny Rish, left Ogden, Utah, in a Chevy Suburban being driven by her daughter-in-law, Linda Rish. For most of the day -- before I get to this, let me tell you something. Thursday afternoon when Mr. Rogers was questioning you, during the jury selection process, I noticed something, realized something. When I spoke to you a week ago today, I told you this occurred, I believe, I guess, on the 215. Because a couple of you told that to Mr. Rogers. That was my mistake.

For most of the day on April 15th, 2005, Defendant Rish was a passenger in the Suburban that was headed toward Las Vegas on I-15. Just outside of Las Vegas, the Suburban

was stopped to get gas and Defendant Jenny Rish took over the driving responsibility. And after taking over those duties, she came upon heavy traffic before the Cheyenne exit southbound on I-15. And in this heavy traffic at about 3:00 p.m., she was following behind the white van driven by Mr. Simao. And after driving in this traffic for about -- approximately three minutes, the Defendant crashed that Suburban into the rear of Mr. Simao's van. The crash caused his head to hit a metal cage located behind the driver's seat. This was a work van. And behind the front seats, there's a cage and then equipment in the back. So the crash from behind caused his head to hit the metal cage immediately behind the driver's seat. After the impact, the Defendant, Jenny Rish, immediately called 911.

Now, to get here, Mr. Simao sued Defendant Rish by filing what we call a complaint. And in that complaint, he alleged that she was negligent and careless in the operation her vehicle that afternoon. And the complaint specifically says,

> "At the time of the collision herein complained of and immediately prior thereto, Defendant Jenny Rish was negligent and careless in the following particulars. A, in failing to maintain a proper lookout for other vehicles on the roadway, and more particularly, the Plaintiff's vehicle. B, in

001434

001434

operating the Defendant's vehicle without due caution and with disregard for the rights of Plaintiff. C, in failing to maintain a safe distance behind William's vehicle. D, in failing to keep her vehicle under proper control. And E, in operating her vehicle without paying full time and attention to its operation."

On behalf of the Defendant, her attorney answered the complaint, which is how lawsuits begin, and denied the allegations that were in the complaint. The answer says, and it was Paragraph 12 of the complaint that I just showed you, answering Paragraphs 12, 13, 14, 15 and beyond, the Defendant denies the allegations contained therein. And through her counsel, the Defendant blamed the crash on William. She posited what's called an affirmative defense in her answers, reasons why she shouldn't be held responsible. His damages, if any, were caused in whole or in part by the Plaintiff's own negligence, which was greater than the negligence if any of this Defendant. And through her counsel, she also blamed third parties for the crash. Plaintiff's damages, if any, were caused by the acts or omissions of a third party over whom this Defendant had no control. So who is blame?

In October of 2008, the Defendant answered interrogatories under oath. It's a part of what happens in a civil lawsuit. They are written questions sent from one side

001435

001435

001435

to the other that have to be answered in writing. And then they're sworn to. So the answers are sworn. And unlike what was in that answer, the one that I just showed you from her counsel, Defendant Rish did not blame William for causing the crash. She did not blame an unknown phantom third party for causing the crash. The interrogatory said, "State how the accident occurred, giving the speed, direction and location." And her response was, "The parties were driving in bumper to bumper traffic. Traffic slowed. Defendant Rish did not slow. The accident followed." And as you're required to do for interrogatories, she swore and verified that the contents of those answers were true of her own knowledge.

In April of 2009, the Defendant gave deposition testimony under oath. You'll learn that a deposition is questioning of a witness. It's done under oath. And the answers are preserved in writing. And you'll be instructed by the Court that the oath and the testimony in a deposition is to be taken as if basically it occurred here in court. It's the same oath that you take before a deposition. And under oath in that deposition, the Defendant testified that the crash was her fault. She was asked, "Yes, it was your fault. Correct?" Answer, "Yeah. I hit him." She was asked, "What happened after the impact?" She said, "I called 911." "Did somebody arrive at the scene?" "A fire truck, an ambulance, and a policeman or highway patrol."

So who is to blame? Even though she has testified in her deposition that the crash was her fault, the defense continues to blame others.

MR. ROGERS: Objection, Your Honor. This seems to have no relevance to this case at all. The defense admitted liability. And they seem to intend to demonize the attorneys.

THE COURT: Counsel, approach, please.

[Bench Conference Not Transcribed]

MR. WALL: Objection's overruled, Your Honor?

THE COURT: Yes.

MR. WALL: Thank you. Ladies and gentlemen, this is Bill Simao. You've seen him in court so far. He was born in San Francisco in 1963. He's lived in Las Vegas for about nine years, since 2002, when he and his wife moved here from Modesto, California. He has three children, Justin, William, and Amanda. He's the owner of a cleaning service. A small family business called Ameri-Clean. Do a lot of floor cleaning work and carpet cleaning work. In fact, his son and his daughter actually work in the small family business with him. He enjoyed riding motorcycles. At least until April 15, 2005. And his wife, Cheryl Simao, who's been here in court. Born also in San Francisco. They got married in 1984. So they've been married for 26 years. Almost 27. She works as a biller for a surgery -- a medical provider. And she has a claim in this case as well. She has a claim for the loss of

the companionship and support of her husband, now, in the past, and in the future.

So as a result of this crash, Mr. Simao has had 139 medical visits so far. He's had 14 separate surgical interventions so far. He'll be subject to lifelong medical dependency. He losses [sic] in the millions of dollars, including his medical bills to date, in the future, and loss of enjoyment of life.

The constellation of injuries he suffered as a result of this accident, for one, he had an exacerbation of his migraine headaches. You will hear that he had migraines even before this accident on occasion. After the accident, as a result of the injuries in the accident, those became worse and more frequent. He had muscle tension headaches, which will be described to you, as a result of some of the muscle and cervical issues, the neck issues, that he suffered in the crash. He had a left elbow strain. He actually whacked his left elbow in the crash, also against the cage. He had left upper extremity radiculopathy. Now, you're going to learn a lot of things in this case. That's going to be one of them. What that means, your left upper extremity is your left arm. Radiculopathy is pain that radiates from an injury here down into your arm. It radiates, so it's called radiculopathy.

Most notably what he suffered is a neck injury. He had disk disruption. Disruption of the disks in his neck, at

two separate levels, which required an anterior cervical discectomy. Now, you'll learn that basically what that is, anterior means front. Cervical means neck. Discectomy means the removal of two disks. Ectomy is removal. An appendectomy, the removal of your appendix. Discectomy, the removal of two disks.

All right. The spine. You're going to be learning a lot about the spine. It's the information highway of the body. It protects our spinal cord so the brain can direct messages to the rest of the body. It allows us to turn, to walk, to pick up things. It is unique. It is complex. It is not solid or rigid. Because of the placement of all the bones and the softer disks and the joints that are involved, it gives us the ability to bend back and forth and twist.

Now, the spine is divided into separate areas. The top area, the neck, is called the cervical spine. The central portion is called the thoracic vertebrae. And the bottom, the low back, is called the lumbar vertebrae. Below that is the sacrum and then your tailbone, the coccyx, which actually makes up the tailbone. So when you hear the doctor talk, he'll either talk about a cervical region, a thoracic region or a lumbar region. Especially when they talk about the cervical, they're talking the neck.

And in addition to that, they actually number each level. And they number the separate bones in the neck. So at

the top would be C-1, C-2, C-3, C-4, C-5, C-6, C-7. There's seven at the top. There's 12 thoracic and then there's five lumbar. So when they talk about C-1 or C-2 or C-3, on medical provider can reference that in a report and the rest of the medical providers who see that will know exactly that he's talking about. Now, the discs themselves, which are between each layer of bone -- so if this is C-3 and this bone is C-4, the disc in the middle they call C-3-4 because it sits between the vertebras C-3 and C-4.

Now, this is a disc. If you took one of the discs and slid it out, this is sort of what it would look like. It is soft. It is softer than bone. It gives us the ability to move and bend and turn. It's made up of an outer substance called an annulus fibrosis, which is sort of a tough membrane. And the inner part is called the nucleus pulposus. It's a softer, more like a jelly type material. You'll hear sometimes the medical providers talk about it, the whole thing, like it's a jelly donut. The outside is a little bit tougher and the inside is a little mushier. Not a medical term. My term. Mushier. All right? And that's what's in each disc between each level of the bones. And so the spine, with a disc in between each bone, that disc allows us to move and bend. It acts as sort of a shock absorber for the bones and allows us to move and do the things we need to do every day.

001440

001440

All right. When there's an injury to the spine -- see these things that come out at every level. They are nerve roots emanating from the spinal cord, which is in the middle. And those nerve roots that come out between each level send nerves to distinct parts of the body. And when the spine is injured in one spot, pain sometimes shoots down or radiates to another part of the body. For instance, in the low back, you see all of these go down this way. When someone has a low back injury, you'll often see them with pain that radiates down their legs to one leg or the other or to both. Sometimes it's numbness that goes down. From the neck, you can see it goes into this area. You'll get radiating pain into upper extremities. Sometimes here. Sometimes back down the shoulder into the arms down to the hands. Now, sometimes it's pain that radiates. Sometimes it's numbness. Sometimes it's nothing. Some days there's nothing. Some days there's more pain. Some days there's more numbness. Some days there aren't any.

This, if we took one of these and took a cut right here and pulled the whole thing out, vertebrae, disc, bone, and held it up, this is what it would look like. A picture in the upper left hand corner, you see the disc sitting on top of a vertebrae. You see the nerve roots that come out. You see the spinal cord in the middle. It's actually floating in fluid. It's not really attached to the bone. Those nerve

001441

001441

roots come out and go to different parts of the body. Now, on the bottom left, if you took this and cut it this way and pulled it open and looked at it, you'd see what's on the bottom left of that picture. You'd see each of the vertebras right here, the discs in between, and the spinal cord in the center.

Now, one type of injury that can occur to the spine is what's called a disc herniation or a disc protrusion. And what's happens is that the disc actually bulges out slightly. It may bulge out all the way around. A disc bulging, a disc herniation, a disc protrusion, they're often used interchangeably, those words. And what happens is that the disc moves out in a way. And it can move in different directions. Sometimes, it can even move toward the spinal cord. Now, understand that when this happens because there's nerves all the way through that area, that often you have pain. You have radiating pain. You have pain actually in the location as well as that pain which radiates.

Now, another thing that can actually happen is where there's a tear in the disc. The disc, itself, actually tears. And because there's nerves actually in the disc, itself, the disc can tear and cause pain. And cause that same radiating pain I talked about a moment ago.

All right. These are some of the treating provider who have treated Mr. Simao. They will come in and testify as

001442

001442

001442

well as some of the other providers. The first one is Dr. Patrick McNulty. Dr. McNulty is a fellowship trained, board certified spine surgeon. Dr. Jas Grover is a fellowship trained, board certified spine surgeon. Dr. Jorg Rosler is a fellowship trained, board certified pain management specialist. Someone who also treated Mr. Simao. And finally, Dr. Sible, who is a fellowship trained, board certified pain management specialist.

So April 15th, 2005 is the date the crash. And on the date of the crash, once William got home, he waited for his wife to come home and then went on to Southwest Medical and went to urgent care. And this is what they noted. Post motor vehicle accident. Complains of neck, back and shoulder pain. The patient is a 41-year-old who was involved in a motor vehicle collision at 3:30 p.m. His chief complaint is left elbow, pain and tenderness in the back of his head. He was the driver of a large van which was rear-ended at an unknown speed, nearly stopped on the freeway. He had a hyperflexion and extension movement of his neck which caused him to strike the back of his head on a cage in the inside of his work van. He denies loss of consciousness. On the examination, they noticed his scalp is tender in the occipital area. The occipital area sits right above the spine. Right here on the back of your head, just at the top of the spine is the occipital area. So he had pain to the touch there.

001443

001443

They did x-rays of the his spine, his left elbow and his left forearm, as well as his neck. Well, the C-spine. That's his neck. And they were looking basically for fractures. And when they do an x-ray, they're looking to see if anything is fractured. The x-ray came back negative. They told him to return to the clinic or seek primary care follow up if you're not improving in the next week or ten days.

He returned on May 4th to Southwest Medical. And is says, now having recurrent occipital pain. Occipital is the area at the top of your neck. On May 4th, he presented for follow up. He'd been in a motor vehicle accident where he was rear ended on the highway. That caused his head to bang up against the back of the wall of his cargo van that he was driving. He does have a history of migraine headaches. However, according to him, this feels different. He denies that he experienced any loss of consciousness at the time of the accident. They refer him for a CT scan which is similar to an MRI. Gives them a better look. That's the occipital region. At the top of the cervical spine. At the base of the head. So they did that CT scan. Basically, they're looking for some type of injury inside the skull. Some sort of hemorrhage inside the skull. Maybe some aneurism. And they found nothing.

He goes back on May 12th. Again, this is time he has numbness to his upper lip and parts of the side of his

face. He has a persistent pressure sensation in his occipital head, at the top of his neck, after being involved in the motor vehicle crash. He's had that for two weeks. A two-week history of that pressure. He also now has blurred vision and some facial numbness. He's referred for an MRI at that time. And understand that to this point, every time he's gone to see someone at a medical provider at Southwest Medical, he has not seen a physician. He has seen a PA, a physician's assistant. The do an MRI of his brain, which comes back negative. No injury inside his skull.

He comes back on May 26th, 2005. He does have a history of migraine headaches. He did experience a change in his headache intensity and character after a motor vehicle accident. He had cervical x-rays and a CT of his head, which were all normal. He's had an MRI of the head and brain which came back normal. All those were explained to Mr. Simao that day, May 26th, 2005. And they tell him to come back in six months for a checkup if he hasn't had any problems.

Understand what's happening at this point. He was hurting since the motor vehicle accident. You saw how he tried to find out what was wrong. Had some history of migraines, but this was much, much different. The pressure. The pain in the occipital region of his head. He took every test they would give him because he knows something is wrong. So by May 26th, 2005, five or six weeks after the accident,

001445

001445

001445

they tell him every test is negative. You're okay. He's been told they can't find anything yet. And you'll hear that none of the tests that they had run to this point would have diagnosed the condition that he actually had. They tell him essentially it'll go away. He trusts them. He believes them. He goes home. They tell him, come back in six months. So he does what they tell him to. He assumes that it will go away. And instead, it gets progressively worse. The head pain. The pressure at the back of his head. The neck pain. That's what worried him the most. He has this neck pain. It's the pressure inside his head that made it difficult for him. But he had pain in his neck just as he did on the date of the accident.

And even though they told him to come back in six months, he couldn't wait that long. The pain was too great. And by the way, he wasn't just sitting around this whole time. He continued to work. He had a business to run, a family to feed. And so he continued to work. But he couldn't make it six months. He only made it four and a half. And on October 6th, 2005, he comes back to Southwest Medical. Again, sees a PA. Check up. Neck and shoulder pain with headaches. He has tension type headaches and he has migraine headaches. This is a 42-year-old male with history of migraine headaches. Those have become worse in the last few months. He's having it more frequently. Nausea and vomiting. Occasionally, they start as

001446

001446

001446

tightness and pain in his left shoulder and then radiates up into his neck. And later on, he will develop a migraine headache. He's tried multiple various migraine headache medications. Hasn't worked. They put him on some new medications, including a muscle relaxant. And tell him to follow up in six or eight weeks.

Six days later on October 12th, he returns. They do x-rays of his neck and left shoulder -- or order them because of his history of tension headaches associated with shoulder discomfort. The x-rays actually take on October 18th, 2005, x-ray of his neck and his left shoulder. Again, those would not detect what he ended up with.

They tell him it's going to get better. But he comes back on December 21st, 2005. He sees a Dr. Sy [phonetic]. This is the first time he actually sees a doctor instead of a physician's assistant. And the doctor notes, neck and left shoulder pain. But he's been complaining of neck and shoulder pain off and on for the past several months. We are seven months now -- eight months post accident. And it's gotten worse. He doesn't do any activities which may worsen or exacerbate it.

And at that this point, Dr. Sy says, I think we should recommend some supportive measures for his neck and trapezial pain. Your trapezius is this muscle you can grab sort right on top, on the top of your shoulders. Emanates

from your neck.

So they recommend physical therapy for him. And on his initial visit to physical therapy, January 16th, 2006, it's reported that he initially sustained injury to his neck and upper trap region when he was involved in a motor vehicle accident on April 15th, 2005. His left hand goes numb. He has pain at the back of his neck and his left upper trapezius. Always the left. And increased frequency of his migraines. They note that his left scapula, that's your shoulder blade, is slightly depressed. And he has a tendency to lean his head to the right. They note muscle guarding. And muscle tightness is noted in that left upper trapezius. That's the beginning of physical therapy. He goes just as he's directed to physical therapy. Twice a week. Every week. Desert Valley Therapy. He goes. One of the reports, from February 13th, 2005, from physical therapy shows pain more localized to his left side. And a decrease in his headache frequency and intensity. But continued numbness of his left hand. Unable to play the guitar. So this is affecting his everyday life.

They give him what's called a tens unit, which is sort of electric -- electronic nerve stimulator that you can take home and use there. So he's still in the course of his physical therapy. He continues to go twice a week, every week.

We're up to March 6th, 2006. Twenty-five medical

001448

001448

visits. On March 9th, 2006, he presents for follow up. Again this is with a physician's assistant. He has been fairly chronic neck pain with pain, burning, and numbness radiating to his left shoulder and left upper extremities. You'll hear that in the medical parlance, the word chronic. When they say chronic pain, it means that it has lasted at least six months if not more. He does complain of discomfort radiating to his left shoulder with numbness with range of motion of his neck and shoulder. He has tension headaches, migraine headaches, cervicaljo [phonetic], which is a fancy word for neck pain, with left upper extremity radiculopathy.

At this point, they decide, you know what, he hasn't gotten any better. And due to the chronic nature, the chronicity [sic] of his neck pain, with radiating symptoms, maybe it's time to refer him to an orthopedic specialist. They order an MRI, which is -- better than an x-ray, more like a CT scan. It allows, with the technology now -- it's a magnetic resonance imaging test -- to get much better pictures of what's going on inside someone. And they do this in March of 2006, March 22nd. And the result is two-fold. First, there's a mild central broad based disc bulge. Remember we talked about how a disc can bulge out from the area where it's supposed to be. And that's at C-4/5. So between the C-4 bone and the C-5 bone, the disc in the middle is the C-4/5. That disc shows a slight bulge. There's also facet hypertrophy,

which is actually sort of an enlarging of one of the bones on the back -- or the joints in the back. These are facet joints back here that help us move. This is a problem at the C-3/4 level. So now, we're one disc up and we're noting that there's problems there too based on the MRI. And there may be left C-4 nerve root contact. This nerve root that comes out, if something is in contact with it, pinches it, you get extreme pain and you get the radiating symptoms that William suffered from. So the MRI shows there's at least a problem, something to be aware of at C-3/4 and C-4/5. And he goes back to Southwest Medical, sees a PA who has the results of the MRI. And they say time to refer to an orthopedic specialist. So they officially refer him to an orthopedic specialist.

So on April 18th, 2006, he has his first visit with an orthopedic spine surgeon, Dr. Patrick McNulty. One year and three days after the accident on medical visit number 30, he has his first visit with the spine surgeon.

In that evaluation, the report of Dr. McNulty says, the patient has a one-year history -- one year and three days -- of posterior, that's the back, cervical, that's the neck, pain with occipital radiation, that means radiation up to the occipital area, and trapezial radiation, down to this muscle. More so to the left with left upper extremity parathesis. Okay. You know this is the left upper extremity. Parathesis is the numbness that radiates down. It's described as

001450

001450

aching, pins and needles, numbness, stabbing, pressure. He's had medications. He's had physical therapy. The symptoms started after the motor vehicle accident. His primary issue is cervical pain. Pain in his neck. And then what Dr. McNulty writes is interesting. Options were discussed with Mr. Simao. In a simple sense, the patient does not feel that the problem would mandate surgery. But at the same time -- and I think it's supposed to be vocalizes -- he vocalizes how his pain is getting worse and he needs to find out what is wrong and fix it. The patient was given general comments on the role of injections to help to define pain generators as well as potentially help to decrease his overall pain. But the chance of long term pain relief with injections only is relatively low. And that the patient would most likely require some type of surgical intervention to get definitive long term pain relief. Understand that to this point, Mr. Simao had seen some PAs. He'd gotten some medication. He'd done some physical therapy. The idea of surgery was first broached with him by Dr. McNulty at this point.

Dr. McNulty says, the patient will be referred to pain management for bilateral C-3/4, C-4/5 for set blocks and they're going to document if he gets any relief from it. This is a procedure that an orthopedic surgeon would use in a cervical neck injury to determine what happens next. And he says, I will see the patient back after that's done.

Now, by this point, as I mentioned, William has had a course of physical therapy, now they're really taking notice of the problem -- actually, McNulty needs to identify what actually is generating the pain in William's neck. It's been there for over a year and so he sends him to a pain management doctor -- a specialist in this, but first he sees Douglas Yong [phonetic], another PA, who says he has a history of insidiously worsening neck and hand pain over the past year. He's interested in any type of interventional treatments that may be helpful in controlling his pain. His focus for over a year was to find out why it hurt and how to fix it. He was tender again over the left trapezius, they gave him little trigger point injections -- little injections of pain relief or steroid into his actual trapezius to try to break up the tension of that muscle.

And he's referred then and he sees Dr. Ross Sible. Dr. Ross Sible is a board-certified fellowship trained pain management doctor. His specialty is pain management and anesthesiology and he sees Mr. Simao on June 7th, 2006 and does a surgical procedure called a cervical transforaminal steroid injection. All right, what he does is he performs an injection into my client's neck. It has two main purposes. One is diagnostic. We're going to try to diagnose what the problem is. The second purpose is therapeutic. We're going to try to provide some therapy for this and try to help with

001452

001452

the pain.

The MRI has shown them that there's potential problems at C-3/4 and C-4/5, so they take this healthy size needle into his neck. This is not like getting a flu shot or having blood drawn at the doctor. This is a surgical procedure, a very sophisticated. And so what they do, cervical means neck; transforaminal -- this area back here, see where the gap is, the hole? That's the foramen, so they go across the foramen, transforaminal. It's a steroid injection. It's got steroid in it, as well as pain relief, and they inject an area near the nerve root where they think the pain is coming from. Here it's C-3/4 and C-4/5 and they inject it.

And it's got two main components. It's got some pain medication, sometimes marcaine, sometimes lidocaine, it's supposed to work quickly and wears off after awhile, like Novocain. It works quickly, it numbs the area, but it wears off after six or eight hours. And then the second part of that injection is a steroid, not a Barry Bonds-type steroid. This is a steroid which is sort of an anti-inflammatory. It's supposed to help try to calm the inflamed nerve. And they inject it in there and they see what the result is.

So they did -- on June 7th, 2006 Dr. Sible did a cervical transforaminal steroid injection. And they do this with what's called fluoroscopy. That's why -- one of the

reasons why it's such a sophisticated procedure. They have the patient lay on his stomach, they have fluoroscopy, which is sort of like an X-ray, and they have it available so that it can see the top and the side, they can see from multiple angles, except it's hooked to basically a monitor, so as he begins the injection into my client's neck he can see on this screen where the needle is going. So it's like an X-ray that is in motion and he can watch it on the monitor.

So the first thing that happens in this type of procedure is that there's an anesthetic needle that goes in to dull the pain, this is the nerve root -- this is from the back of the spine, here's those bones that stick out, the nerve roots that I talked about, that's the nerve that they're trying to test. And so the needle goes very close to the nerve and then comes the injection of a contrast solution, it's dye. It makes it easier on the fluoroscopy scene to see exactly where the nerve is and exactly where you're going.

Then the needle -- the syringe is changed and they put in this medicated solution. Pain medicine and a steroid. The pain medicine, because it acts quickly, tells them, if after this procedure there's no pain in that area, they know they probably have the right area. That pain medication in that area has helped calm the nerve, if it does that's the diagnostic part of it. It's helped them diagnose whether this is the right nerve root that's causing pain. And then the

001454

001454

001454

steroid and the medication helps to try to at least calm the pain for a longer period of time.

Now that steroid has an anti-inflammatory, like Advil, ibuprofen is an anti-inflammatory, sometimes it works, sometimes it doesn't, sometimes it works for awhile. It's not really intended to work very long, especially in an injury that's been there for over a year.

So according to Dr. Sible, when he did this is on June 7th, 2006 it was meant to be both therapeutic and diagnostic. It worked for awhile. Mr. Simao came back and saw the PA, the physician's assistant Douglas Yong, on June 20th, 2006. He returns for a follow-up, he is status post-left C-3, C-4 transforaminal epidural steroid injection, states he's had a good overall response. He's noticed a decrease in the severity and frequency of the headaches, however he still has some pain in the left trapezial area. They had done those little trigger point injections previously, they tried those again, and the PA says I'll see you back soon.

July 27th, 2006, so since that injection that you saw was on June 20th -- or I'm sorry, June 7th, we're now about a month-and-a-half, a little more than a month-and-a-half after that injection. He comes back for follow-up. His headache frequency has significantly reduced, as is his neck pain. That steroid worked a little bit in that

001455

001455

area. He's satisfied with the outcome. We'll see him back in about three months or so on an as-needed basis as long as he continues to do well.

He didn't make it three months. August 24th, 2006, about two-and-a-half months after the initial injection, he returns, sees the PA again. He returns to the clinic today with a complaint of exacerbation or worsening of his left trapezial pain. We had discussed in the past the result of his epidural steroid injections were not stellar. He did have a reduction in the frequency of his tension type headaches, however the pain over the C-4 distribution on the left continues to worsen and have more frequent exacerbations. C-4 distribution, remember we talked about from C-4 it will distribute nerves to a certain area. That's what they're talking about. It continues to worsen.

The PA says I've talked to Mr. Simao about trying a left C-4 selective nerve root block to see if we can get this to stop during the anesthetic period of the procedure. He's in favor of moving forward with this. Depending on the results, we can look at pulse radio frequency versus second surgery consultation. So along with the PA, Mr. Simao is doing whatever he can to try to find out why he has pain since the motor vehicle accident.

All right. He goes back on October 3rd, 2006 and has another injection. This one's called a cervical -- neck

001456

001456

001456

-- selective nerve root block. It's very, very similar to the injection that we just saw in the animation, except it's a little more selective. They use a little less of the medication so it doesn't spread as far. It stays in a smaller place, right around the particular nerve that they're trying to isolate to see if that's the one that's causing the pain. It's done here by a Dr. Adam Arita. And according to him, he just thinks that Dr. Sible wasn't available on October 3rd, and so he did the injection instead.

Now, there was some success with it. Because you're using less medication, that initial pain medicine that you put in -- like the -- like Novocain. It worked, but it only worked for about eight hours or so. The fact that the pain returned after eight hours means that that steroid that you're putting in there really isn't having much effect, which is not surprising since we are now over a year-and-a-half after the original injury.

So he goes back, Mr. Simao does, after that selective nerve root block, and talks to Dr. Arita again and they try something else. They try another injection procedure, a cervical selective nerve root block, same thing he had up here, smaller amount, trying to be more selective, with pulse radio frequency on the left side at C-4.

All right. Another injection you're going to learn about. It's very similar to the one I just talked about.

001457

001457

It's across, in the same area that we were before. They go in there with the pain medication and the steroid, but now they add a third quantity. It's basically, along the needle there's sort of a wire that goes into the area and around the nerve they use radio frequency and they pulse it. It actually sort of warms the area around that nerve root. You know, if normally we're, what, 98.6 degrees? This is about 106, 107 somewhere around there. They warm the area around the nerve root.

I'm going to let the doctors explain to you why that helps, but it essentially creates a nice, warm environment around the nerve. Who doesn't like a nice, warm environment? It makes for almost a happier nerve root, okay? And it lasts for a period of time and it changes the way the nerve root sends pain signals. So now they're trying something new and expect -- and it's expected to hopefully help, but it's not a cure. It's just a treatment for a finite period of time.

They do this and he comes back on January 10th, 2007. It was November 2006, so about two months. His pain is still there, he says seven or eight out of ten. And what you'll find is that doctors will ask you, on a scale of one to ten, how is your pain today? Zero being no pain, ten being the worst pain you've ever had in your life. So his pain is seven to eight out of ten on average, but it's intermittent. It's not constant.

001458

001458

001458

Patient believes that the pulsed radio frequency did help and continues to be a benefit. Great, come back in three months. Comes back in two months. When he comes back in two months he tells them that it has worn off, as it is supposed to do. I mean, it's not unusual that it wears off. It's going to wear off. It's not a cure, it's just a temporary treatment.

And so on March 22nd, 2007 they set up another one. Patient wants to try repeating the procedure, that pulse radio frequency, and will consider surgery if it doesn't work. So five days later, on March 27th, 2007, he has that same procedure, the one where we're warming the nerve as well as putting in the pain medication. It works for a while. Patient underwent a repeat left C-4 selective nerve root block with the radio frequency. Pain has improved over his left shoulder and trapezial area, his pain is three out of ten overall, so it did work. He now has discrete pain around the left medial scapular and paravertebral area, and they try to treat that.

So what has happened here, and what you will hear from some of the medical providers, is what they call the Gate theory of pain. That is, this radio frequency, warming the nerve, worked to help stop that, but he also has pain in other areas, left medial scapular, C-2, which is even higher, that he feels now because that injection with the -- that warmed

the nerve didn't address those areas. He may not have even been aware of those areas. The Gate theory of pain is essentially that you will respond to whatever the greater pain is.

Here's the example: if I have low back pain and it bothers me every single day and then someone takes a hammer and smacks my thumb, I'm not thinking about my back pain. My back pain is not my primary focus anymore, it's my thumb. So even though they took care for a while with warming the nerve through that pulse radio frequency, a problem at C-4, there's still pain in other areas that may have been masked by the fact that his neck hurt so badly at the area that they did the pulse radio frequency.

So they've assessed him and said well, it improved, but he does have pain in other areas that we'll try to treat. This time it lasts for about two-and-a-half months and he comes back in June of 2007. We are over two years after the accident. Dr. Arita does a third one, because it does work for a little while. And the third one, on June 12th, 2007 also works, but about this time, after it's done, Mr. Simao and Dr. Arita have a discussion. Essentially, "Look, do you want to keep going through this surgical injection procedure every two months or every month or every three months or is there another option where you need to go back to the spine surgeon, Dr. McNulty?"

001460

001460

001460

And on June 18th, in a follow-up with another one of -- a PA who he actually had worked with before the accident ever took place, Brit Hill [phonetic]. Patient was seen, he still has neck pain, radiculopathy. Patient was seen by Dr. McNulty already and sent for epidural steroid injections and pain management medications. Patient has failed conservative treatment and wants to see Dr. McNulty about surgery.

So on September 6th, 2007, he goes back and sees Dr. McNulty. Dr. McNulty report says the patient was seen by me approximately a year-and-a-half ago, on April 18th, 2006, where he had cervical thoracic pain with occipital radiation, trapezial radiation, bilateral scapular radiation, some upper extremity parathesias, numbness, and he was referred to pain management. And it appears that pain management took him on a course of various injections in order to avoid surgery.

I have no definitive diagnostic information as far as clearly defining what's causing his pain. The patient has failed measures of injections, as well as pulse radio frequency. His pain has persisted. He decides to order a new MRI of the cervical spine, at those levels -- and this is a mistake, it should be C-4/5, because we're not talking about the low back. He wants to do new epidural steroid injections to further define what's causing the pain.

Now, Dr. McNulty at this point has gotten to review

001461

001461

001461

everything that's taken place so far and the results that have and have not been achieved. He's still not sure of the exact source of what's causing Bill's pain. I told you initially how complex this area is, even for spine surgeons who deal with it every day, and how many different things can overlap, and before you go in and do surgery on someone's cervical spine, a spine surgeon wants to be fairly clear about what they're doing and why it should help.

So Dr. McNulty decides, "I'm going to try these injections again, since it's been a while since they've been done, and I'm going to do it myself." And so on November 16th, 2007 that very first one that we saw the animation of, the injection near the spine with fluoroscopy, you send in the dye first so you can isolate the nerve, see where the needle is going, you add in some pain medication and some steroid. And Dr. McNulty does that himself, both at C-3/4 and at C-4/5, in the areas around those vertebrae and the disc.

And afterwards, on December 6th, 2007, he meets with Mr. Simao and he says he had significant pain relief from the left transforaminal epidural injection and this confirms those levels of his cervical spine as being the pain generators. Understand the relief was very short. It's that pain medication that you put in there, like Novocain, but it worked right away, which tells the spine surgeon that's an area that's causing pain. It confirms those levels as pain

001462

001462

001462

generators.

So his plan -- Dr. McNulty's plan is an anterior cervical reconstruction of two-level arthrodesis C-3 to C-5. That is a fusion. That is a discectomy, where he's going to go in and remove two discs, put something back in the space where the discs used to be, and fuse it all together and screw it together. That's his recommendation as of December 6th, 2007.

Now he hasn't taken that lightly, obviously, because of the measures he's had William undergo up to that date, but time didn't heal it, medications didn't heal it, physical therapy didn't heal it, those injections worked for a little while, but they didn't cure the problem, they didn't heal Mr. Simao. The pulse radio frequency worked for awhile, but hasn't solved the problem.

Now as you may or may not expect, someone to whom this is communicated has some doubts about whether they want someone to open up and fuse their cervical spine together. And Mr. Simao had some reservations. So what he did is he went out and got a second opinion from Dr. Jas Grover, who is also like Dr. McNulty, a board-certified fellowship trained spine surgeon. And he first saw Dr. Grover on March 28th of 2008.

And from Dr. Grover's report, the patient is a 44-year-old right-hand dominant gentleman who was the restrained

driver of an automobile that was involved in a rear-end type collision two to three years ago, we are just short of three years after the accident. He's been treated since that time through a variety of modalities, including care -- physical modalities of care, medical management, injection therapy, he's been under the care of Dr. McNulty, who recommended surgical treatment for him. He has tenderness back here, he has discomfort with left cervical rotation, that hurts, and he has this persistent left upper extremity symptomology. He has these symptoms that have persisted for almost three years.

So Dr. Grover does what Dr. McNulty does. He says look, on my own, I'm going to send him out for some pain management and see what our results are and see if they're the same as those that Dr. McNulty's -- Dr. McNulty and those to whom he referred Mr. Simao found. So he recommends some of those injections.

In April of 2008, exactly three years after the accident, William meets with Dr. Jorg Rosler, who like Dr. Sible, Dr. Arita is a board-certified fellowship trained pain management doctor, the type that gives those injections to try to isolate pain generators. And he notes that there's neck pain radiating into his left upper extremity. This gentleman relates his symptomology -- his symptoms, to a motor vehicle accident about two to three years ago. There's pain to the touch, there's some loss of that normal curve.

001464

001464

001464

Remember that diagram -- even with this, you can see that it's not straight, there's a curve, what's called the lordosis of the spine. He's lost some of that, which is noted by Dr. Rosler.

And Dr. Rosler says, as recommended by Dr. Grover, we're going to set him up for some left side C-4 and C-5 selective nerve root blocks for both diagnostic and therapeutic purposes, similar to what he's gone through before. They do a new MRI in April 3rd -- in April of 2008. He goes back to Dr. Grover, who finds out that he actually hasn't had the injection yet, because that takes place on May 10th, 2008. It's done by Dr. Rosler, it's on the left side, it's those selective nerve root blocks, just as Dr. Arita did. It's a little more selective; we're going to try to isolate those two levels as the place where the pain is coming from.

And on May 10th, 2008 Dr. Rosler performs them with fluoroscopy, the same way that the other doctors performed theirs. And Bill had some relief. It was very short lived, remember that pain medication wears off in a very short time, but he did have some relief, which tells them this might be the location. There was very little help from the anti-inflammatory, that steroid. Before the injection he had pain at a six out of ten. Immediately after his pain score was one out of ten. So that temporary pain medicine worked for a short period of time. He goes back to see Dr. Grover in

June of 2008, still has pain, obviously the steroid didn't have any effect, ongoing neck pain, sub-occipital headache, potentially related to disc disruption. The patient is at his wits end with his symptoms. I would recommend he proceed to discography, to better understand his condition.

In August of 2008 he undergoes a procedure called discography. This is the most invasive procedure so far. It's a way -- the other injections just sort of tested the general area of where the pain was coming from. This discography is a test to see if the disc itself is injured, compromised or even torn and maybe how to fix it. It's another injecting procedure, but it's designed to give the doctors a look basically at the disc itself to see if that's where the problem is that is causing the pain.

So what happens in a discography, here's the discs, here's the various vertebrae. It's an injection procedure into the disc. The first thing they do is an anesthetize track, they basically give you pain relief -- local pain relief just along the place where the injection is going to go, and they put in what is called a guide needle. It holds other needles that you're going to put inside it in place, at two separate levels.

The next thing they do is they take a needle and it goes through this guide needle all the way into the center of the disc, that nucleus pulposus, and it has dye in it, it has

001466
001466
001466

contrast in it, and it basically pressurizes the disc and they do it at several different levels. For Mr. Simao they did it at three different levels, C-3/4, because this would be C-3, C-4, so that's C-3/4, they did it at 4/5 and 5/6, and they inject right into the center of the disc and pressurize it.

Now, if you -- and the patient -- again, they're doing this with fluoroscopy too, so they can see exactly where the needle is going. The patient is sedated, he's out, and they basically bring him out of it just enough to ask him whether there's pain. If he just feels a little pressure when they pressurize the disc, that's a normal disc. If he feels pain, the same kind of pain he has on his worse day, then it's what they call concordant pain. They have created the same pain that he feels at his worst and it's because when they inject things into the disc, maybe there's a tear, there's a problem with the disc, and that's how they tell. They call that a positive response to discography.

So again, the first thing that happens is the -- they anesthetize along the track level -- let me go back. They give you a pain medication along the track that they're going to go in and they have a guide needle that's anchored to hold it in place at -- actually did three levels on William. Then they send a needle through, all the way into the disc, and they don't tell him what disc they are pressuring when they ask him if it hurts. So the needle goes all the way in

and all the way into the disc and they pressurize it.

So as a result of this procedure, August 8th, 2008, he was positive at C-3/4. That disc, there was concordant pain, ten out of ten. There was evidence that the disc was disrupted. At the next level, C-4/5, it was positive at that level. It showed a morphologically abnormal disc and there was concordant pain. So they have established that there was a problem with both of those discs themselves, that the discs were injured or torn. And, in fact, the report shows that there's a tear in each of those two discs, the one at C-4/5, the lower one, was actually a little worse tear in the disc. They also did it at the next level down, C-5/6 and it was negative -- it was negative.

So now he's had the discography and here, there's a -- at C-3/4 there's a grade four annular -- remember the annulus is the outside of the jelly donut or the disc, fisher -- a fisher is a tear, at the 4:00 position. The way they look at it, that's where the tear is, sort of at 4:00. Now there's a scale for how bad tears are. One is not too bad; grade five is the worst. There's a grade four tear in this disc. At the one below it, there's a grade five tear.

So he goes back to see Dr. Grover, he still has neck pain, and here's a mistake in the records, which you see sometimes, out of thousands and thousands of patients, obviously it's not a discography of the lumbar spine, it's

cervical. Discography of the cervical spine confirms disruption at C-3/4 and C-4/5. I have counseled William today at length as it relates to his condition, the risks, benefits, limitations and alternatives of care. We've spent extended period of time with he and his wife. He states that he's at his wits end and I believe at this point he has approached the point where he is considered to be a reasonable candidate for an inter-body fusion, reconstruction and decompression at C-4 -- C-3/4 and C-4/5.

So if you've had basically parallel tracks here. You've had Dr. McNulty who thought, you know what, we may need surgery here, but I'm going to send him out, do pain management, find out and when it comes back they say yep, you need surgery. He gets a second independent opinion from Dr. Grover, who sends him out to see Dr. Rosler, does injections, does discography, comes back and comes to the exact same conclusion that a fusion is necessary.

There's another MRI of his spine in November of 2008. By January of 2009 he goes back to see Dr. McNulty. Mr. Simao now has confirmation from two separate spine surgeons that confirmed what Dr. McNulty said originally, that you may need major surgery, a fusion, you're a candidate. Dr. McNulty has all of his results from before and when he gets him back in January of 2009 -- remember, he hasn't seen him since the end of 2007 Dr. McNulty. Dr. McNulty says okay,

but before I do it I want to do one more injection to make sure. And so he wants to confirm that the pain status is still what he thought it was a little over a year earlier at C-3/4 and C-4/5. And he does, on both sides left and right, those epidural injections, the ones that we talked about originally, you saw the animation of those, and he does them on both sides at C-3/4 and C-4/5.

And he does them himself so that he can see for sure that this is the right place. And Bill has 65 to 70 percent pain relief right after the injection, for that first six, eight hour period while the pain medication works and that confirms for Dr. McNulty that we're in the right place and everything is as it was a year-and-a-half earlier.

On March 24th, 2009 Dr. McNulty sees Mr. Simao. This is the final procedure consideration visit for an anterior front cervical neck reconstruction C-3 to C-5. The patient was made aware of the nature of the problem, the risks, the benefits, the options and consents to the procedure, as well as indicated procedures. The patient knows that there are no absolute guarantees and anything can happen. The next day, on March 25th, 2009, he's admitted to UMC for an anterior cervical discectomy, two levels at C-3/4 and C-4/5, with anterior instrumentation.

Now, the surgery itself is performed by Dr. McNulty. to remove two painful discs, C-3/4 and C-4/5. He's actually

001470

001470

001470

admitted to the hospital for this surgery because of the nature of the surgery. And what happens -- and you're going to see an animation of it in a moment -- essentially they enter through the front -- in fact, let's start it. They enter through the front, because as you can see it's so much easier to get to the discs from this side than from this side. There's an incision, and it's not quite as clean as this would show.

They are going to retract it to open it. They have to make sure once they go in that his esophagus, his carotid artery are out of the way. And they go in. And they remove portions of the damaged disc until it is all gone. They make sure they've gotten all of it. They go to the second level. They remove the actual esophagus. Obviously for this procedure, he's completely sedated. Make sure they got all of it.

Now, they cannot just leave it the way it is. Sometimes they've got to fill in this area otherwise everything would just fall down, crumble down. Sometimes they use actual bone grafts to fill the areas in between the discs. In this case they used a little cage. It's got some metal in here, but it's also got some bone putty in it so that eventually this will all grow together and fuse into one piece. Since it doesn't fuse at first, they've got to basically screw it into place. So they take a

001471

001471

001471

plate, a metal plate with screws in it and screw it in to the pieces of bone that the vertebral bodies.

This is an actual X ray of my client. Here's the metal plate that the screw is going in. In between is the area of the cage so that eventually this would all fuse together. Here's the plate, two screws on each side and each three bone levels to try to hold it all in place.

Understand when this fuses together, since there's no discs there anymore, there's no movement in those areas. There's no cushioning. It is just solid bone eventually these solid substance for those areas of the neck. And there are restrictions that come with that.

So here's the post-operative report. Going in his diagnosis, Dr. McNulty was symptomatic level disc herniation at those two levels, a problem with both discs. Post-operatively, what did he see? Exact same thing. They do X rays always shortly after to make sure that everything is holding and staying in place. He's discharged from UMC after two days in the hospital.

He sees Dr. McNulty again about a month, maybe three weeks after the surgery. Okay. He's two weeks post-status reconstruction. Doing well. Already notices significant improvement in his pain compared to before the operation, follow up in six weeks.

They do continuous X rays to make sure the fusion

001472

001472

001472

is holding. He goes back to see Dr. McNulty in May of 2009. We're now two months after the surgery. And, by the way, this is medical visit number 90 as a result of this crash.

The patient is two months post fusion, doing well. We can discontinue the neck collar that he's been wearing for two months, and he can start physical therapy. He can go back to work as tolerated and follow up with us in four months. So far, so good.

He begins physical therapy. He goes consistently. He comes back to see Dr. McNulty in July of 2009. So we are March to July, three months about post -- almost four months -- post surgery. Three and a half months post fusion. He has had left upper-extremity numbness down to the hand for approximately a week. We're going to get a new MIR of the spine. Things are starting to concern Dr. McNulty.

He comes back August 18th. He sees now a neurologist by the name of Jesus Hernandez. His migraine headaches have diminished to approximately once a month. Now complains of neck pain that radiates down to the left arm causing numbness into his fingers. He's undergoing evaluation with orthopedic surgery for possible disc disease.

You will hear, and as you saw from the note the

001473

001473

001473

day before the surgery, that success in such things is never a guarantee. A certain percentage of patients the surgery doesn't always work, and it doesn't always take away the pain forever.

He sees Dr. McNulty again. He turns to Southwest Medical and sees Dr. Hernandez again. He's now having migraine headaches two to three times per week with neck and shoulder pain and these trigger headaches. There's tenderness even in the lower cervical region in his lower neck below where the fusion was. He needs to be referred back to pain management for possible intervention. Pain management is the people who did all those injections over the years.

In January of 2010 he still has a history of neck pain on the left side. Sometimes the tightness in the neck region, which has been in existence prior to his surgery, triggers his migraine. He claims that the surgery resolved his neck pain but not the migraine headaches. Some days it hurts; some days it doesn't.

They put him back into physical therapy. And just a week or two later when he's had physical therapy, he has pain in his neck and down into his left upper extremity just as he had before.

He has -- the arrow down is decrease. He has a decrease in his cervical spine R-O-M, range of motion,

001474

001474

001474

obviously because he has a fusion, but he also has additional problems. He'd a good candidate for physical therapy, according to the physical therapist.

He comes back and sees Dr. McNulty March 23rd, 2010. We are about a year after the surgery, about five years after the accident. Dr. McNulty says, "His patient follows up and is still having primarily left-sided neck pain with trapezial radiation" -- or, yeah -- "that radiates down into the trapezius area just as it did before the surgery."

He says, "I wouldn't recommend physical therapy because he's done plenty of it. So I'll refer him back to pain management."

He finishes up the course of what's prescribed for him. Dr. McNulty sends him back to Dr. Sible [phonetic], one of those pain management doctors. He does a medial branch nerve block, another separate type of injections near the area of the medial branches of nerves as they come out from the cervical spine with a pain medication to see if that can help isolate and still is a problem.

In June of 2010, September of 2010, they do more of those injections that they did at the very beginning, those epidural blocks, some pain management, some pain medication, some steroid involved, but it doesn't cure the

001475

001475

001475

problem.

September 27th, 2010, Mr. Simao presents to the clinic for neck pain. He wants to get a referral to yet another orthopedic surgeon to try to find out what in the world is wrong with [indiscernible] and continues to hurt.

He comes in today for a follow up of neck pain. Continue to follow up with pain management and put a new referral in to orthopedics.

In October of 2010 he has initial visit with another spine surgeon, Dr. Daniel Lee. He says this is a 47-year-old who is status post fusion with what appears to me to be old left C4 radiculopathy. It occurred even before the surgery.

Dr. Sible who did those injections, thought he was symptomatic. He may be so. I would recommend left C3-4 trans foramina selective nerve root blocks, more of those injections to try to isolate the pain.

As another one of those procedures, medical visit No. 134, in November of 2010. He sees Dr. Lee again in January of this year, the end of January of this year. "He's post fusion. He did get some significant relief with that selective nerve root block injection. We'll see him back again. Most of his pain is in the trapezius, but I think it's referred pain from his neck."

There's a new MRI. It's about his fourth or

001476

001476

fifth of his neck since the incident. He sees Dr. Lee again February 24th, a month ago. MRI was re-reviewed. It shows no significant stenosis. Stenosis is actually a narrowing of the place where the spinal cord is. You can see pain management. There's no surgical indications at this time.

Essentially Dr. Lee is telling you that he's going to need pain management, something, injections, something because of what has been done, they haven't gotten everything. They haven't cured him as a result of what happened in this accident.

So he has had, with all those injections, 14 separate invasive surgical procedures. The nerve-root blocks, the epidural injections, the discography, more injections, a cervical fusion, more nerve blocks, more steroid injections.

Now, through all of that medical history that's taken place over 199 visits in almost six years, Defendant's response is it will be -- I expect the evidence to establish that they will say that he had pre-existing degenerative disc disease in his spine. And he had a problem that was there even before the accident happened. So it's not our problem.

Everyone knows degenerative disc disease, not necessarily a disease like the mumps or like cancer,

001477

001477

degenerative disc disease is basically age-related changes. As we all get older our spine tends to degenerate somewhat. It happens because we've been on the planet and using it for 40, 50 years. That's what it means. They're age-related changes.

Now, most people who have degenerative changes in their spine have no symptoms. They are asymptomatic. They have no symptoms. And that's what my client was before this accident took place, no neck pain symptoms before April 15th, 2005. And the medical evidence in this case will show that the accident, the Defendant, caused severe neck injuries, caused this degeneration to become symptomatic in his neck. And that the need for all -- well, underscore the need for all of the medical treatments and the invasive procedures, the need for the surgeries and future medical treatments, medications and pain that he's going to endure for the rest of his life.

The defense has hired a medical expert by the name of Dr. Wong. He will agree that none of the medical records show that William had any symptoms of neck pain before this accident. The other expert -- another expert hired by the defense in this case, Dr. Fish also from California, and he will say that he seen no medical records that show that William had any symptoms of neck pain prior to the April 15th, 2005 crash. So the response that

001478

001478

001478

somehow this disc disease, this degeneration, these age-related changes in his spine caused what he has now is simply not true.

Another response. His headaches weren't caused by the crash because he had a history of migraine headaches and was taking medication for migraine headaches.

MR. ROGERS: Objection. Your Honor, Counsel is not only getting into argument, he's actually misstating the defenses.

THE COURT: Counsel, approach, please.

[Bench Conference Not Transcribed]

THE COURT: The objection is overruled for the record. Please proceed.

MR. WALL: Thank you very much, Your Honor.

Migraines before the crash and was taking medication for it prior to the crash.

The evidence will show that he did have a history of migraines prior to the crash. He's not claiming that the crash caused his migraine headaches. That's not a claim that we're making. The medical evidence will show that his migraine headaches where made worse by the crash, and that is a claim.

May 4th, 2005. He complains of occipital head pain that he feels that's inside his head a deep pressure. He does have a history of migraine headaches; however,

001479

001479

these feel different to him. This is May 4th, 2005, within weeks after the crash.

May 12th, 2005, head pressure. Blurred vision. Facial numbness for two weeks post motor vehicle accident head trauma.

May 26th. He has a history of migraine headaches. He did experience a change in his headache intensity after the crash.

July 27th, 2006, about a year and a half after the accident, he has a history of chronic recurrent migraine headaches. However, approximately a year ago he was involved in a rear-end motor vehicle collision and since then he had noticed increasing frequency of his migraines.

And the medical evidence is also going to show that in addition to migraines, a special type of headache, the crash caused muscle-tension headaches.

October, 2005, he has a history since the accident of both migraine and tension-type headaches.

March, 2006. Episodic tension headaches and migraine headaches.

May, 2006, tension-type headaches, migraine headaches.

June, 2006. Migraine headaches and tension-type headaches.

001480

001480

June 20th, 2006, same thing.

October, 2006. November, 2006. June of 2007. December of 2009.

He has disc issues in the cervical spine that sometimes act as migraine triggers for his migraine headaches based on neck and shoulder pain.

March, 2010, tension headaches, migraine headaches. June, 2010.

The evidence will show that this response is not justified by the medical evidence.

Another response. He just sustained a soft-tissue injury to his neck in the accident. Soft tissue may be a muscle strain in the left shoulder that would have resolved within a few weeks.

As you know by now, he had continuous complaints of neck pain. His neck pain didn't resolve after a few weeks. From the day of the crash he continued to experience pain in his neck and the occipital region of his head.

The day of the accident, neck, back and left-shoulder pain. Tender to palpation to the touch in the occipital area.

Three weeks after the crash now having recurrent occipital pain. He complains of occipital-head pain, tenderness over the occipital area.

001481

001481

Five and a half months after the crash, neck pain. Pain radiates from his shoulder up into his neck.

Six months later, X rays of his neck and left shoulder because of the pain he's having. They do X rays of his cervical spine because of the pain six months after the crash, eight months after the crash.

Complaining of neck and shoulder pain off and on for months. Nine months afterwards.

He sustains injury to his neck and upper trapezius region when he was involved in a motor vehicle accident.

Eleven months. This is the one you saw before. Chronic neck pain. That means it's been going on for longer than six months.

Twelve months, neck pain. And on and on and on.

The medical evidence will show that this response is not justified by that evidence.

I told you that they hired Dr. Wong from UCLA as an expert in this case. He examined Mr. Simao one time in February of 2009. So that's about six weeks before the surgery took place. He can't recall if the exam was as short as 15 minutes or as long as an hour. And his examination revealed that he had tenderness, pain in his neck and left shoulder and it radiates into his left shoulder indicative of some nerve problem. Remember at the

001482

001482

very beginning it radiates.

Dr. Fish, Defendant's expert also from UCLA, not an orthopedic spine surgeon, has never performed a fusion surgery that refers patients to some spine surgeons in Las Vegas. I'm not sure if he referred one to Dr. McNulty, but he may. He examined Mr. Simao the same day as Dr. Wong.

Those two experts don't agree with the medical records. They don't agree with one another. Dr. Wong says William sustained a whiplash injury from the motor vehicle collision. Dr. Fish says neck pain, but no whiplash injury.

Dr. Wong says 25 percent of all the treatment after May of 2005, that first five or six weeks, he gives him all of that. And after that, 25 percent of it is related to this crash. He doesn't know what the other 75 percent would be, but 25 percent of it is related to the crash. Dr. Fish says none of that medical treatment is related to the crash. Dr. Wong says that the MRI of Mr. Simao showed degenerative changes in the spine. Dr. Fish looked at the same MRIs and said they're normal. There's no degeneration to be seen.

I told you at the outset that this case is not only about responsibilities, who's to blame, but also accountability.

You'll hear from Kathleen Hartman [phonetic]

who's a registered nurse and a certified life-care planner. She takes what's in the medical records and determines what his future medical needs are going to be because of the injuries.

MR. ROGERS: Objection, Your Honor. You entered a foundational order on Ms. Hartman.

THE COURT: Counsel, approach, please.

[Bench Conference Not Transcribed]

THE COURT: Please proceed.

MR. WALL: As a certified life-care planner, what Ms. Hartman will do is take what's in the medical records and what's deemed to be possible future treatment for Mr. Simao and establish essentially what the costs are for those things, whether it might be future surgeries, whether it might be physician care, pain counseling, pain management, physical therapy, prescription medications. If Mr. Simao requires those in the future, she'll tell you exactly what they cost and what -- based on what's in the medical records from the medical providers will be necessary.

You'll also hear from Dr. Stan Smith who is an economist from Chicago. He's going to calculate the present value of William's future medical expenses. He's not a doctor. But he'll take what the doctors communicated to Ms. Hartman about what's going to be necessary, and she

relates what that cost is. Because if he needs something in 20 years or 30 years, there's economic formulas, accounting formulas to determine what it would cost today to make sure those things are paid for in the future. The present value of money. There's a discount value. And I can't explain to you exactly what the formula is, but he explains what those things will cost to provide future medical treatment to Mr. Simao for the rest of his life.

He's also going to calculate using that same formula what the present value of his loss of enjoyment of life is. The present value of the loss of household services. There will be things that Mr. Simao cannot do in the future. There's a cost attributed to that.

Also calculate the present value of the claim that Cheryl Simao has for the loss of society and relationship of her husband as a result of these injuries.

And you do that, all of that, based on a life expectancy. At age 47 his average life expectancy is 31 more years. That takes into account -- that would put him at 78. That takes into account the statistics prepared by the government in establishing what an average age is -- it won't make it to 78 and instead the law allows that you can use this table of information from the government to determine what a life expectancy would be for someone like Mr. Simao.

001485

001485

The evidence will establish that the past and future medical expenses, for the loss of household services, Cheryl Simao's loss of society and relationship will be in excess of $1 million.

The evidence will also establish that there's almost six years of past loss of enjoyment of life and pain and suffering, thirty-one years of future pain and suffering and loss of suffering of life.

There is no -- as the Court will instruct you at the end of case -- there is no formula to determine that. That's up to you. So your responsibility using the burden of proof that the Court will give you more likely than not who's to blame for the crash. It's your responsibility to determine more likely than not what are all of the harms and losses caused by the Defendant's negligence to Mr. Simao. And just more likely than not, it's your responsibility only considering the harms and losses and nothing else, it the full value of those harms and losses, and that is what this trial is about.

Thank you very much, ladies and gentlemen.

THE COURT: Thank you, Mr. Wall.

Let's take a brief break before we hear from defense.

I'm reminding you, ladies and gentlemen, of your obligation not to discuss this case, not to form or express

001486

001486

001486

any opinion until this case is given to you. Not to do any research on any subject connected with this case.

Actually, let's take about a 15-minute break.

Thank you.

[Recess]

[Outside the Presence of the Jury]

THE MARSHAL: Please remain in order.

THE COURT: Please remain seated. I understand there's something outside the presence of the jury.

MR. ROGERS: Yes, Your Honor. Very briefly, there's two things. Number one, we want to confirm for tomorrow that it's going to be Doctors Arita and Rosler that are going to be testifying for the plaintiff. That was initially the plaintiff. We just wanted to make sure that that's still the case.

THE COURT: Is that the case, Mr. Wall?

MR. WALL: I just mentioned that to trial counsel, that is who we will be calling.

THE COURT: That is the case?

MR. WALL: Yes.

THE COURT: Okay.

MR. ROGERS: Number two, Your Honor, I believe, according to the open-door or invited-error doctrine, we are now allowed to comment upon the magnitude of the crash and I'll explain why.

001487

001487

The open door doctrine, in Taylor versus State, that's a Nevada case, 1993. It also cites Lala versus People's Bank & Trust of Cedar Rapids, that's the 420 N.W.2d 804, that's an Iowa case, it's 1988. What the doctrine is, it says that even when evidence is ordinarily inadmissible, rendered admissible when the complaining party, who first raised, and during the opening statement, counsel, he used the term crash; and as we know from Webster's Dictionary, crash is, it's violently, noisily. So he's stating to the jury that this impact was violent and noisy. And because he's given the jury this impression about the nature of the accident, he has opened the door to us, in our opening statement, giving our version of what the nature of the impact is, whether that -- whatever adjective we should use. But, you know, counsel could have said there was simply an impact. He chose to discuss the nature of the impact, the violence of it, that the head of the plaintiff struck the cage of the inside of the van. And so because of that, he has opened the door to us being able to argue our version of the events.

THE COURT: Well, Mr. Wall.

MR. WALL: Well, I won't -- I've got to be honest with you, I was here, and I did speak, but I don't remember talking about the nature of the impact or the violence of the impact, which is what he just said that I said. So unless there's a transcript that proves that I don't remember saying it, but

001488

001488

said it, I would suggest that that's not correct and that it's, in fact, absolutely incorrect. I never discussed that it was a violent impact. I never discussed that it was a noisy impact. I never even discussed that the impact was violent enough, according to the medical providers, that because of how violent it was, it must have caused A, B, and C; none of the things that would open the door to a minor-impact defense.

MR. ROGERS: Your Honor, he used the word crash like I said. I'll cite the Webster's: That means, violently and noisily. And when you use an adjective or a term you're trying to describe for the jury what happened, and he used the word crash, the jury gets an impression in their mind of some big collision. They could -- he could have said that there was an impact, but he had to use a term that, in their mind, would think of it as a major accident. And I think we are allowed to, thus, in our opening argument, give a term that would show that it wasn't or, at least from our standpoint, wouldn't be such a major collision.

THE COURT: The motion is denied. Are we ready for our jury panel?

MR. ROGERS: We are, Your Honor.

[Jury In]

THE COURT: Please be seated, ladies and gentlemen. Counsel, stipulate in the presence of the jury?

001489

001489

MR. ROGERS: No, Your Honor.

MR. WALL: Yes, Your Honor.

THE COURT: Very well. Mr. Rogers, are you prepared to proceed?

MR. ROGERS: I am. Thank you.

Good afternoon, everyone.

JURORS: Hi.

MR. ROGERS: All right. This is now Mrs. Rish's time to describe what we anticipate the evidence will show. This case is about -- was brought out in the plaintiff's opening statement, a car accident that occurred in stop-and-go, bumper-to-bumper traffic; both parties drove home.

The plaintiff claims a traumatic neck injury, but as we study the records closer, you will see that he had no complaints of neck pain for nearly six months following the accident. He did have a history of pre-existing migraines and tension type headaches, both of which can result in neck pain.

Following the car accident, he had extensive diagnostic testing; plaintiff's counsel went through it at length with you; MRIs, and CT scans, and so forth, none of it shows evidence of a traumatic cervical disc injury.

And, finally -- oh, yes, very good. The discs, as plaintiff's counsel pointed out, are these two right here. Remember plaintiff's counsel talking about pain generators and how this surgery was done because someone along the way

determined that these two discs were pain generators. The evidence will show that that is not so and that is why the plaintiff's symptoms continue today. The discs that were removed were not injured in this accident and they were not pain generators.

Now, let's talk about the car accident and precious little time was spent discussing that, so let's refocus it. As I stated, bumper-to-bumper, stop-and-go. Mrs. Rish had just arrived in town from Hill Air Force Base. She had decided to drive her daughter-in-law and her grandchildren down to her home in Gilbert, Arizona. Her daughter-in-law, Linda, drove from Ogden, Utah, where Hill Air Force Space is, to Las Vegas. And then just outside, they stopped at a restaurant and got a bite to eat, and they got back in the car, and Jenny Rish drove.

They got on the freeway and it was traffic time and she pulled up behind the plaintiff. And several times over, stopped, went, stopped, and went. She will testify that on the final go, she was stopped behind the plaintiff, who moved a few feet in front of her; she lifted her foot up off the brake; she went forward; she saw the brake lights on his vehicle; she applied her brakes, only just not quite hard enough; and the accident following.

No one in this accident claimed loss of consciousness. No one sustained cuts, or bruises, or

001491

001491

abrasions. Both drivers pulled off to the side of the road because of the traffic; paramedics arrived, but they were refused by everyone; the plaintiff got out of his vehicle; went back and spoke with Jenny Rish; and then both parties got back in their vehicles; the plaintiff drove home; and Jenny Rish, and her daughter-in-law, and her four grandchildren continued on their drive, six hours to Gilbert, Arizona. And until a lawsuit was filed, years later, that was the last the Jenny Rish ever heard of this event.

I want to show you right now, because you've heard enough from counsel describing what's coming, you will be receiving evidence soon, as soon as we're done here. Jenny Rish was examined under oath by plaintiff's counsel.

MR. WALL: May we approach, Your Honor.

THE COURT: Yes.

[Bench Conference Not Transcribed]

MR. WALL: For the record, the objection is sustained, Your Honor?

THE COURT: Yes.

MR. ROGERS: For the record, we will wait, I suppose --

MR. WALL: I'm sorry, counsel.

MR. ROGERS: -- to hear from Jenny Rish.

THE COURT: I couldn't hear it either. I couldn't hear what you were saying either, Mr. Rogers.

MR. ROGERS: Oh, I just said, you'll -- you must now wait

to hear from Jenny Rish. But she will describe this accident for you. You will what this is all about. All right. I'm very much looking forward to her opportunity to do that.

One thing that will be brought up, and counsel alluded to it, is that, at her deposition, she admitted that she was at fault. She was asked, "Are you at fault for this accident," and she said, "Well, yes, I rear-ended him." And counsel pointed out that the answer to the complaint denies liability. As you will see, if you study the entire pleadings, pleadings are like a boiler plate contract. They're designed to protect all rights. Jenny Rish testified under oath, she never once shirt from her responsibility.

All right. Now, what we do is, we turn to the medical records right at the time of the accident. And you will see, when you study these records, that they do not support the plaintiff's claim of a traumatic neck injury. He presents -- pardon me. At the scene, you'll recall, he denied the paramedics. They actually came and he turned them away as did everyone else. He did not go to an emergency room, instead he drove his vehicle home. That evening, he went to Southwest Medical Associates, actually, where his wife works. And there, he complained of left elbow pain and headaches.

Now, the chief complaint was elbow pain. A full exam still was performed, of the entire body. They examined the head and they noted that he reported tenderness, but there

was no deformity on the exam; no bumps noted. He complained of tenderness at the neck, as well, but he had full range of motion; no abnormal finding. He complained of tenderness at the elbow, but there, again, no deformity. The neurological exam was normal. The strength exam was normal. No cuts, or bruises, or abrasions were noted. Still, the doctors ordered X-rays, just to make sure. The elbow X-ray showed what: Degenerative changes and no joint infusion; no swelling. The neck X-ray showed alignment maintained, soft tissues, meaning muscles, and tendons, and ligaments are normal. There was no evidence of any abnormality on the neck X-rays.

And the plan, at that time, was to return in seven to ten days if the symptoms resumed or if, otherwise, needed and the plaintiff did not return in seven to ten days. He did not return for three weeks. He did return to work in the flooring trade, a labor intensive trade, certainly more so than a desk job. When he returned three weeks later, he presented, to a physician's assistant, who's name you heard in plaintiff's opening. His name is Britt Hill. Britt Hill had treated the plaintiff before the incident and he treated him quite a bit after. On this visit, three weeks after the accident, the chief complaint was headaches. There was no mention anywhere of neck pain, three weeks after the incident.

Still, a full exam was done. On the head, no masses or defects were found. On the neck, everything was normal

001494

001494

001494

again, just as before. The musculoskeletal exam, full range of motion in all extremities, that's the arms and the legs. Strength was normal. The neurological exam was normal. Again, no mention of any bumps, or bruises, or abrasions. The plan was to refer him out for a CT scan and continue his normal chronic medications. Plaintiff counsel pointed out earlier, that chronic is far longer than three weeks, so to continue the medications you've always been taking.

They refer him out for the CT scan. It's done a week later and it comes back normal. He follows up the next day, he goes back to Southwest Medical Associates and what are his complaints at that time: Headaches, numbness to upper lip and nose. No mention of neck pain anywhere. And as to the facial numbness and vision changes, we learned something interesting and that is that the plaintiff had those exact same problems before the car accident. Here in February 2003, he's treated for headaches, facial numbness, cheek numbness, teeth numbness. These symptoms are nothing new for him.

Back to May 12, 2005. At this point, remember, we're right after that CT scan that came back as normal. They did a full exam, this time the head was non-tender and, again, there was no deformity. The neck, again, non-tender, full range of motion. The neurologic exam was normal. The course note reads, no signs of acute process. Acute, meaning traumatic. Here we are three weeks out from the accident and

no signs of acute process. The assessment at this point was, tension headaches, again, nothing new. The plan was nothing more than over-the-counter Tylenol.

Going back to the course note; the plaintiff, the provider reported, was persistent in questioning about every test or discussion that had taken place since his accident. And he insisted on further evaluation, he's not satisfied with the negative CT results. So the provider refers him out for a brain MRI. What we learned from this is that the plaintiff is not the type to shirk form insisting on medical help, that there is no mention of anywhere of an insistence, or even a mention, of neck problems. If there were neck problems, wouldn't he have insisted on that, as well?

Then we go to the brain MRI, just like the CT scan; grossly unremarkable, absolutely normal. He returns to Southwest Medical three days after this normal MRI and what is his problem this day: Headaches, again, no mention of neck problems. The doctor notes, the CT and the MRI were normal, and then in the plan, he states that he explained these normal studies to the patient, and he was okay with that and did not seek further treatment. He will continue current meds, remember the chronic meds that he'd been taken from before the accident, he will schedule a routine follow-up, as needed, in the next six months.

Now, this brings us to one -- a month-and-a-half

001496
001496
001496

after the car accident. In that month-and-a-half, the plaintiff has been examined four times. Every examination, a normal finding. He had two X-rays, they were normal. He had the CT scan, it was normal. He had the MRI of the head, that, too, was normal. During this entire time, he was never taken off work. He never even requested time off work. His only complaint, since the date of the incident, has been headaches. Aside from that single visit on the date of the incident, there's never once been a mention of neck problems.

What we know for certain, at this point, is that there is no evidence anywhere of a cervical disc injury; only that the plaintiff returned to his normal medications. The medical experts in this case will get on the stand and they will explain medicine as doctors understand it. You've just heard quite a treatise on medicine as personal injury lawyers understand it. The doctors will clarify everything. They will say, at this point, when the plaintiff was returned to his previous medications, that if the plaintiff was injured at all in this accident, this is when the condition resolved. This is when he was back to whatever he had before.

In part, that is because what follows this visit, a month-and-a-half after the accident, is a four month gap in treatment. The plaintiff doesn't see anyone for four months. During this time, however, he does continue to work in the flooring trade.

001497

001497

The questions that you will need to answer when this case concludes, include: Does a person with a traumatic injury to the discs in his neck not -- pardon -- he had not complained of pain for nearly six months after the injury; the next, does a person with a traumatic injury to his neck not treat with anybody for it for nearly six months; and finally, do they not ask for time off a labor job? Do they just continue working without consulting any medical providers about it?

The evidence will show that the answer to each one of these questions is no, that that is not how a cervical -- a traumatically induced cervical disc injury presents. Counsel used the example of someone striking your thumb with a hammer, you know it right then. That's not the way the plaintiff's presentation played out at all.

This brings us to five-and-a-half months after the accident. At this point, something did change, only it wasn't neck pain, because he didn't present with neck pain. Again, the exam was normal, supple meaning, no abnormal findings. But what did occur here, after all this time of work and never complaining of neck pain, is the plaintiff is assessed or diagnosed with something new, a shoulder sprain. No one before had ever diagnosed that and this is five-and-a-half months after the accident. And, also, in this note, there's no mention of the car accident.

001498

001498

001498

We turn, now, to the X-rays that were ordered because of that shoulder complaint. The shoulder X-rays were normal. There was a repeat X-ray of the neck, just like the first time, it was normal. And then there's another gap in treatment, this time for two months. We're within eight months of the accident right now, a four month gap already, and now a two-month gap. The plaintiff continues to work, but he's not treating with any providers.

That brings us to December 21, 2005. At this point, the plaintiff reports that he has neck pain that has gotten worse for the past couple of weeks. This is eight months after the accident. For the first time since the car accident, there is some slight abnormality in the physical exam and it's on the trapezius, this muscle that goes from your neck to your shoulder. It's just a slight tension. In this note, plaintiff counsel point out that this was one of, if not the first M.D. that the plaintiff saw at Southwest Medical. At this point, there's no mention of the car accident anywhere in the record.

Eight months have passed, six-and-a-half months of which are gaps in treatment, and all eight months in which the plaintiff continued working in the flooring trade. And now we move to January 16, 2006. Plaintiff cited this record to you, this was the first time that the plaintiff presented to a physical therapist after the accident. And he reported that

he was struck from behind on the freeway, at best, and the other vehicle was going 55 miles per hour.

The medical evidence provides no evidence whatsoever of a traumatic cervical disc injury. The medical doctors will clarify that for you when they're on the stand. I won't attempt to explain to you anatomy and medicine, I will let the doctors do that. And one way that we've gotten their assistance in this case is, we've taken their depositions, too, not just Jenny Rish, but the doctors' as well; sit them down, have them under oath, and say, okay, explain what all this means. And we are going to hear from various different kinds of doctors in this case. One of them are doctors who appear down here regularly in court, as often, if not more than trial lawyers. Doctors McNulty, and Grover --

MR. EGLET: May we approach, Your Honor.

THE COURT: Yes.

MR. EGLET: We ask that that screen be taken down.

THE COURT: Take it down, please.

[Bench Conference Not Transcribed]

THE COURT: The jury will disregard the last slide presented by counsel.

MR. ROGERS: Doctors McNulty, Grover, and Rosler, you will learn, at least if they remain with the testimony that they've given already, don't know the first thing about this car accident and they didn't see the plaintiff for quite some

001500
001500
001500

time afterwards.

Now, there will be some doctors, you will see, who were, also, treating providers of the plaintiff; doctors that it was my first time to encounter them in this case: Britt Hill, actually not an M.D., but a physician's assistant. As I said before, he treated the plaintiff before and after the accident, so he has a unique insight into this case. Before the accident, he treated him for headaches; he treated him for --

MR. EGLET: Your Honor, may we approach and that slide, it needs to be taken down immediately.

THE COURT: It does.

[Bench Conference Not Transcribed]

THE COURT: Sustain the objection for the record.

Ladies and gentlemen, I'm instructing you to disregard the last slide that was previously shown to you. There was a pretrial ruling which reads, it is hereby ordered that plaintiff's request to exclude and prior and subsequent unrelated accidents, injuries, and medical conditions, and prior and subsequent claims or lawsuits is granted in all respects. And that specifically dealt with a 2003 motorcycle accident.

MR. EGLET: Your Honor, counsel needs to review his --

THE COURT: We need to take a -- probably about a ten-minute break, ladies and gentlemen. I'm reminding you of

001501

001501

001501

your duty not to discuss this case, not to form or express any opinion, not to do any research on any subject.

[Recess]

[Outside the Presence of the Jury]

THE COURT: For what reason?

MR. EGLET: Your Honor, we, first of all, we viewed Mr. Rogers' slides during the break and we want to make a full record of what occurred in the first few minutes of his opening statement. Which quite frankly, to be honest, Your Honor, is what we projected, what we figured. We knew this was going to happen, we knew it was coming. We actually prepared these little books for each one of us with the outlines of all the orders because we knew he was going to systematically violate the Court's pretrial orders.

Within 10 minutes of his opening statement he violated, clearly and unambiguously violated two of this Court's pretrial orders. I don't know how you unring the bell with this jury with the stuff that he's done. Now I understand you admonished the jury, you've asked them to disregard. As the Court knows, it's very hard to unring the bell. I think at this point he has already tainted this trial.

Then in the break, during the break, after you sustained those two objections, admonished the jury, told him to take the slides down, we went through some other slides.

001502

001502

001502

There were multiple other slides that had the same type of problems in them. Most of them Mr. Rogers agreed with and took those statements out of the slides, but again, if we hadn't done that, there would have been three to four more clear violations of these -- this Court's pretrial orders.

As Mr. Wall said at the bench, I think it's clear -- I think it's abundantly clear that Mr. Rogers is going to try to mistry this case. I think it is abundantly clear that that's what's going on.

I told the Court at the last bench conference that that was two. If there were any additional ones, we were going to start asking for monetary sanctions and other potential sanctions in this case for this type of systematic refusal to comply with pretrial court orders.

I expect his experts are going to do it as well. I can assure this Court that they are going to violate a number of the orders in their testimony, just like Mr. Rogers did up there say oh, I -- I didn't realize that that was a, you know, I didn't realize that was the Court's order. I was confused, I guess.

So additionally, there are some other slides. Can I have your young man over there put the slides --

MR. ROGERS: Yeah, Dan.

THE COURT: -- that we were talking about one at a time.

MR. ROGERS: Which ones -- now just so --

MR. EGLET: Just put them up in order.

MR. ROGERS: -- that we can clear this up, I offered to bring them over and said you guys look through them. Whatever you object to, write it down and let's just bring it up to the judge. There's no effort to hide anything going on here.

MR. EGLET: Well, let me point out that that's not entirely true what happened, because he agreed that some of the items on the slides were a violation of pretrial orders and he had his tech assistant remove them.

MR. ROGERS: I disagree with that, but we'll get to that later. So can you see these from your screen?

THE COURT: Yes.

MR. EGLET: That's not everything that was on the slide.

DAN: No, I know. They're -- which ones specifically would you like to see?

MR. EGLET: I don't know.

DAN: Oh, okay.

MR. EGLET: You were supposed to keep track of them for us.

DAN: I was.

MR. ROGERS: 168.

MR. WALL: Actually Adams did.

MR. EGLET: No, I saw him writing them down.

DAN: I took -- kept track of some, but not all of them, because you didn't instruct me to do that.

001504

001504

001504

MR. ROGERS: Well, okay. Let me --

MR. EGLET: All right. Well, this is at the end of his. Ask yourself -- this is argument, Your Honor. This is closing argument stuff. This is not proper for opening statement. He is not telling the jury these are what the facts of this or the evidence will show in this case. He's asking them -- he's -- this is argument. It's improper and we would ask that these be not permitted, this slide not be permitted and not be able to phrase as ask yourself, ask yourself this, ask yourself that. It's argument.

THE COURT: Mr. Rogers?

MR. EGLET: It's --

MR. ROGERS: Well, the --

MR. EGLET: It's like say -- it's basically saying did he prove, did he prove. Yeah, you say did he prove. That's argument, Your Honor. That's argument. It is not this is what the evidence will show.

MR. ROGERS: Well, counsel has already engaged in what I objected to as argument by projecting what they believe the defenses were going to be. Set aside the fact that they were mistaken and focus on the fact that they were characterizing our arguments, which is virtually, by definition, argument.

And what we are doing here is saying look, these are the plaintiff's theories. And the question that you're going to be charged with answering at the conclusion of this case is

does the evidence support their theory of the case. And at the conclusion of the case we'll say we believe the evidence will not. And that's what the point of this slide is. It's not to argue as you would in closing. It's saying these are the plaintiff's claims, does the evidence prove it. Ask yourself that as the case is presented.

MR. EGLET: If this was in -- slide was in closing argument it would be fine, because it's argument, ask yourself did he prove this, did he prove that, did he prove that, did he prove this. This isn't what the evidence will prove.

When Mr. Wall was talking about defense counsel's defenses, what he said was -- and it, contrary to what counsel said, every one of them was right on the money of exactly what his medical experts have said. So he's saying their evidence that they will present from their medical experts are this, Mr. Simao had preexisting degenerative changes or age related changes in his spine, the -- prior to the accident.

The evidence at the trial will be that yes, everybody his -- virtually everybody his age does. They weren't causing any symptoms prior to the accident and after the accident he had this constellation of symptoms and injuries. That's what the evidence will present. That's the difference.

That's not what this is doing. This is nothing but pure, unadulterated argument, Your Honor.

001506
001506
001506

THE COURT: Well, I agree that this is argument, what's contained on this slide. And I also think that when plaintiff's counsel anticipates what the defendant's affirmative defenses are, I don't see that there's anything wrong with doing that in opening statement. So that's the ruling. Are there any other slides we need to look at?

MR. EGLET: There are, Your Honor.

MR. ROGERS: So remove that --

MR. EGLET: The -- your Britt Hill, your physician's assistant where you give her giving an opinion on medical causation.

DAN: Give me one second.

[Pause]

DAN: That's the first of one, two --

MR. EGLET: You have one where it's the last bullet point.

DAN: Okay.

MR. EGLET: Okay. Right here, the last bullet point on this. Britt Hill, he is a physician's assistant. He is not a medical doctor. He's not qualified under Nevada law, under Morsicato and a whole line of cases in this jurisdiction that says when you talk about medical causation, it is a medical expert who must give the -- a medical doctor who must give the opinion regarding causation.

This is clearly a causation testimony. There's no

way that Britt Hill is going to be qualified to give that opinion in this trial.

THE COURT: Britt Hill is a physician assistant?

MR. EGLET: He's a PA, yes, a physician's assistant.

THE COURT: Mr. Rogers?

MR. ROGERS: Right. This is actually the same problem that we dealt with with Nancy Hartman [phonetic] when I approached. Your Honor does have an order on that. On the slide, she is projecting treatment that she has no expertise to recommend or project.

In this case, we have Britt Hill saying -- if he didn't say it's not related, he's saying, "I never even heard of neck pain before 11 months after the accident." And he might have added so no, I didn't think it was related. So I can change that to say that his neck symptoms -- he never complained of neck symptoms until 11 months after.

MR. EGLET: Well --

THE COURT: This one --

MR. EGLET: -- that would be an incorrect --

THE COURT: This --

MR. EGLET: -- statement of the facts, because the medical records show he complained of neck problems prior to that. But the point is I don't know -- I don't even understand his argument with the life care planner, who's simply saying this is what the cost of future medical care is

based on what the doctors say that the plaintiff is going to need. And that's all Mr. Wall said when he presented that slide. That's all. And that's all the slide said.

What this says, this is a PA giving a medical causation opinion in Nevada, which is not permitted.

THE COURT: I agree. The last sentence needs to be removed.

MR. ROGERS: Okay.

MR. EGLET: Could we have the Dr. Sible slide where you have this issue about smoking? I --

DAN: Sure.

MR. EGLET: Okay. This right here, they've got this slide, Dr. Sible. And they say, last bullet point, smoking can contribute to degeneration.

And in fact, this is the deposition testimony of Dr. Sible on this area. That's just an absolute incorrect statement. Okay?

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

There's an objection to form and foundation. And the witness says, Dr. Sible:

"I think that calls for more of an expert

001509

001509

witness on this, not as it pertains to this patient. I don't have any reason to believe that this particular finding on here is caused by him smoking."

So that's just an absolute misstatement of the record. Dr. Sible didn't testify to that, didn't say smoking can contribute to degeneration. That was the question that was asked, but the answer was no, I can't say that with this patient.

THE COURT: Mr. Rogers?

MR. ROGERS: Yes, I obviously don't have the Keebler tree that Mr. Eglet's law firm has here. I can tell you that there were other discussions in that deposition that I don't have in front of me right now that did address smoking as a cause of degeneration in the spinal disks. However, if you want me to strike it, I'm --

MR. EGLET: Well --

MR. ROGERS: -- with you and want to get this thing moving, and I'm ready to just get it done with.

MR. EGLET: Here's the point. I don't care if smoking can potentially, maybe, hypothetically, one in a million chance cause degeneration or an acceleration of degeneration in a spine. Point is in this case did smoking, to a reasonable degree of medical probability, accelerate the degenerative process in his spine. Which I would find it very

001510

001510

001510

hard for them to argue since their own doctors, one of them says there's not even any degeneration in the spine, period, from his review of the MRIs. And the other guy says well, there is degeneration, but doesn't relate it to smoking.

So there's no evidence to a reasonable degree of medical probability that Mr. Simao's prior smoking is what caused his degenerative condition. If you believe one of his experts, he has no degenerative condition whatsoever.

THE COURT: Well, based on that, my understanding then, this last sentence needs to be removed as well, Mr. Rogers.

MR. ROGERS: Okay. Dan. It's done.

[Counsel Confer]

MR. EGLET: Do you have any other ones written down?

DAN: Yes. It's Arita; correct, Dr. Arita?

MR. ROGERS: Arita. Oh, the exaggeration. But that was -- you asked and that was taken out.

DAN: That was taken out. Then 68 and 69, I believe are the last ones.

MR. EGLET: Can we see those.

DAN: But that was the ask-yourself stuff, and that's out.

MR. EGLET: Oh, all right.

MR. WALL: What was 68? I thought I remembered 68.

MR. EGLET: Ask yourself. That was the ask yourself.

MR. ROGERS: That is 68.

MR. WALL: Okay, 69.

MR. EGLET: All right.

MR. ROGERS: Well --

DAN: I'll just need a few minutes to make these edits.

MR. EGLET: That's fine.

MR. ROGERS: He said he'll need a couple minutes just to make these revisions, then we can get --

THE COURT: Do you think we can finish closing today, or are we going to have to finish it tomorrow?

MR. ROGERS: I think I'm -- I don't have that much longer. All I have are -- I'm walking through the providers now, Britt Hill, Sible, Arita. Am I pronouncing Sible right? Wong and Fish, and then I close. I'm just saying these are who these people are who are coming.

THE COURT: Do you think you can do it in 20 minutes?

MR. ROGERS: I believe so, very close to it.

THE COURT: Because I haven't made arrangements with Jury Services for any overtime work for the court staff.

DAN: I'm done.

MR. WALL: All right.

MR. ROGERS: Let's go.

THE COURT: Bring our panel in then please.

[Pause]

THE COURT: Counsel approach please.

[Bench Conference Not Transcribed]

001512

001512

[Jury In]

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

MR. ROGERS: Yes, Your Honor.

MR. WALL: Yes, Your Honor.

THE COURT: Are you ready, Mr. Rogers?

MR. ROGERS: I am, yes.

We left off with this fellow, Britt Hill, physician's assistant. As I said, he treated the plaintiff before and after the accident. When he first met the plaintiff after the accident -- remember this was after the three-week gap in treatment. So accident is tax day, April 15th, this three-week gap passes, we're about May 4th.

When he examines him on that day, there were no signs of any trauma. The plaintiff complained only of headaches to him. Throughout the entire course of the plaintiff's treatment with Britt Hill there were no requests for time off work and no time off given.

At a deposition we discussed with him well, here are these MRI findings and he said well, those are typical for people in their 40s. Asked can people have those findings on their MRI and not have any symptoms at all? He said sure, sure. Most everybody does have those conditions after a given -- sort of like hair goes gray. It doesn't mean that you're sick, it just means that's how you age. That was the

condition of the plaintiff's spine.

Next we go to Dr. Sible. He was the first pain management physician who the plaintiff visited. And Dr. Sible it appears is no slouch. He did his residency in anesthesia at Stanford. He did his fellowship in pain management at Stanford. He's dual board certified in anesthesia and pain management. He testified -- and remember this is one of the treating providers. This is not an expert who the defense has hired and is paying for. This is one of the plaintiff's treating providers.

He said those MRIs don't show evidence of trauma. And again, that the plaintiff's spine looks age appropriate, that the plaintiff's symptoms can be the result of degeneration or age. Said that the injections, all the injections that plaintiff's counsel just walked you through never isolated a pain generator. And you may remember a discussion about a particular injection called discography. In Dr. Sible's view, cervical discography is not reliable.

Also in Dr. Sible's opinion, surgeons should not do their own spine injections and make surgical decisions based on them. In this case, the plaintiff's surgeon did. Dr. McNulty administered injections twice. Dr. Sible, one of the other treating providers, says they shouldn't be doing that.

He also said that the plaintiff's pain after the

001514

001514

surgery was exactly the same as it was before, both in severity and in location. This surgery did not work because there was no injury caused to the cervical disks in this accident.

Next is Dr. Arita. The plaintiff brought him up as well. Again, appears to be a qualified doctor, went to medical school, residency and internship at USC. Did a fellowship in pain management and in cardiac anesthesia. He testified that the plaintiff's complaints following this accident were inconsistent with his examination findings. Said, just like Dr. Sible and just like Britt Hill, the MRIs do not show evidence of trauma. The MRIs are typical for people the plaintiff's age, that people typically have the same findings on MRI without symptoms or complaints. Again, the injections did not isolate the pain generator; again, surgeons should not perform their own injections.

He testified that the plaintiff's neck complaints and symptoms are not likely caused by this car accident. He also testified that he warned the plaintiff against surgery and said you're not a good candidate, don't do this.

Plaintiff's counsel pointed out the UCLA medical professors that the defense has brought in to examine all of these records and to make sense of them, to give us their opinions and conclusions about the meaning of it all.

First is Dr. Wong. He's a UCLA professor of

orthopedics and neurosurgery. He's also a professor of biomedical engineering. He's the chief of the spine service there. He's a full-time spine surgeon. He works in the trauma center. He teaches medical students, teaches people how to perform these surgeries.

He's a keynote speaker all around the world on these issues, most recently for the British Association of Spine Surgeons. He was the recipient of the 2010 American Academy of Orthopedic Surgeons achievement award. He's the chairman of the National Association of Spine Surgeons spinal biologics and research section. He is a scientist and a clinical practitioner. He's reviewed this case, he's examined the plaintiff. And his opinion, no injury was caused to the plaintiff's cervical spine disks as a result of this accident.

Dr. David Fish, also from UCLA. He is a pain management physician there. He's licensed in both California and Nevada. He was trained at Johns Hopkins. He worked in the physician -- pardon me, as a physician in the military, where he rose to the ranks of captain. He teaches pain management to the fellows and the students at UCLA, teaches them how to perform injections and how to administer nerve testing.

He works, in addition to UCLA, at the L.A. Veterans Hospital, where he does trauma. He's on boards of applied

001516

001516

001516

anatomy and pharmacology. He's reviewed this case and he has examined the plaintiff, and in his opinion, the alleged injuries were not caused by this accident.

All the doctors will admit that the plaintiff's surgery was elective. They'll all admit that -- and this is an obvious proposition -- that before you do surgery you have to exhaust all less invasive measures. And you also have to make sure that the area that you're going to operate on is actually the pain generator. They'll also admit that this surgery that the plaintiff had generally has a good outcome.

Ladies and gentlemen, the plaintiff is still complaining of pain. He evidently did not improve with surgery. There's a pain diagram that the plaintiff filled out before the surgery and after. This is the one, on the left, that he filled out in that physical therapy visit where he reported a 55 mile per hour impact. You can see right here, the neck and the left arm, where he complained that he had symptoms.

Remember in those eight months after the accident, never saw that. Here it is now, nine months after the accident; he's complaining of these symptoms. After surgery it's the same [indiscernible]. That's because there was no injury to those disks that the doctors removed in the surgery as a result of this accident.

001517

001517

At the conclusion of this case, nothing short of proof that this car accident caused the neck injury that the plaintiff alleges requiring the surgery that he had will support his burden of proving that Mrs. Rish is responsible for -- excuse me. At the conclusion of this case, the plaintiff will not meet that burden of proof and we will ask you to return a verdict in favor of Mrs. Rish.

Thank you.

THE COURT: Thank you, Mr. Rogers.

Ladies and gentlemen, I'm going to ask you to return tomorrow promptly at 1:00 and excuse you for the evening, reminding you of your obligation not to discuss this case with anyone, not to form or express any opinion until this case is given to you, not to do any research on any subject connected with this case. Thank you. Have a nice evening. See you tomorrow.

[Jury Out]

THE COURT: Who are the two witnesses we're going to hear from tomorrow?

MR. WALL: It's Dr. Jorg Rosler and Dr. Arita.

THE COURT: And you think we'll be able to get through both of them tomorrow afternoon?

MR. EGLET: Yeah, we should.

MR. WALL: I do.

THE COURT: Okay. Anything else we need to discuss

before we adjourn?

MR. ROGERS: No, not that I can think of.

MR. WALL: No.

THE COURT: Okay. See you tomorrow at 1.

MR. EGLET: Okay, Your Honor.

[Proceedings Concluded at 4:45 p.m.]

001519

001519

001519

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

Kelley Grijalva

KELLEY A. GRIJALVA, Transcriber

Stephanie McMeel

STEPHANIE MCMEEL, Transcriber

Rebecca M. Breitenbach

REBECCA BREITENBACH, Transcriber

ERIN PERKINS, Transcriber

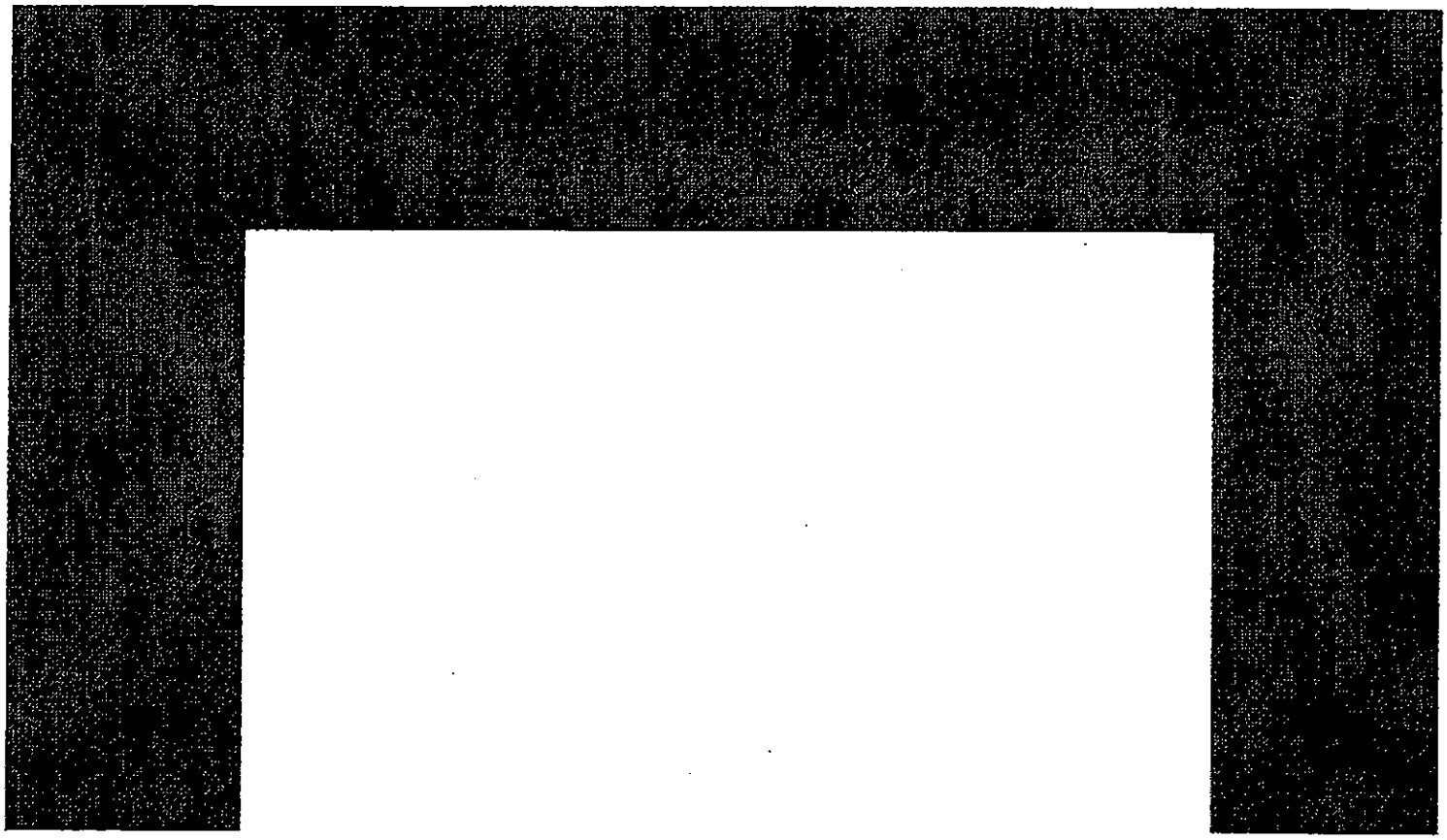
Erin Goold

ERIN GOOLD, Transcriber

001520

001520

001520

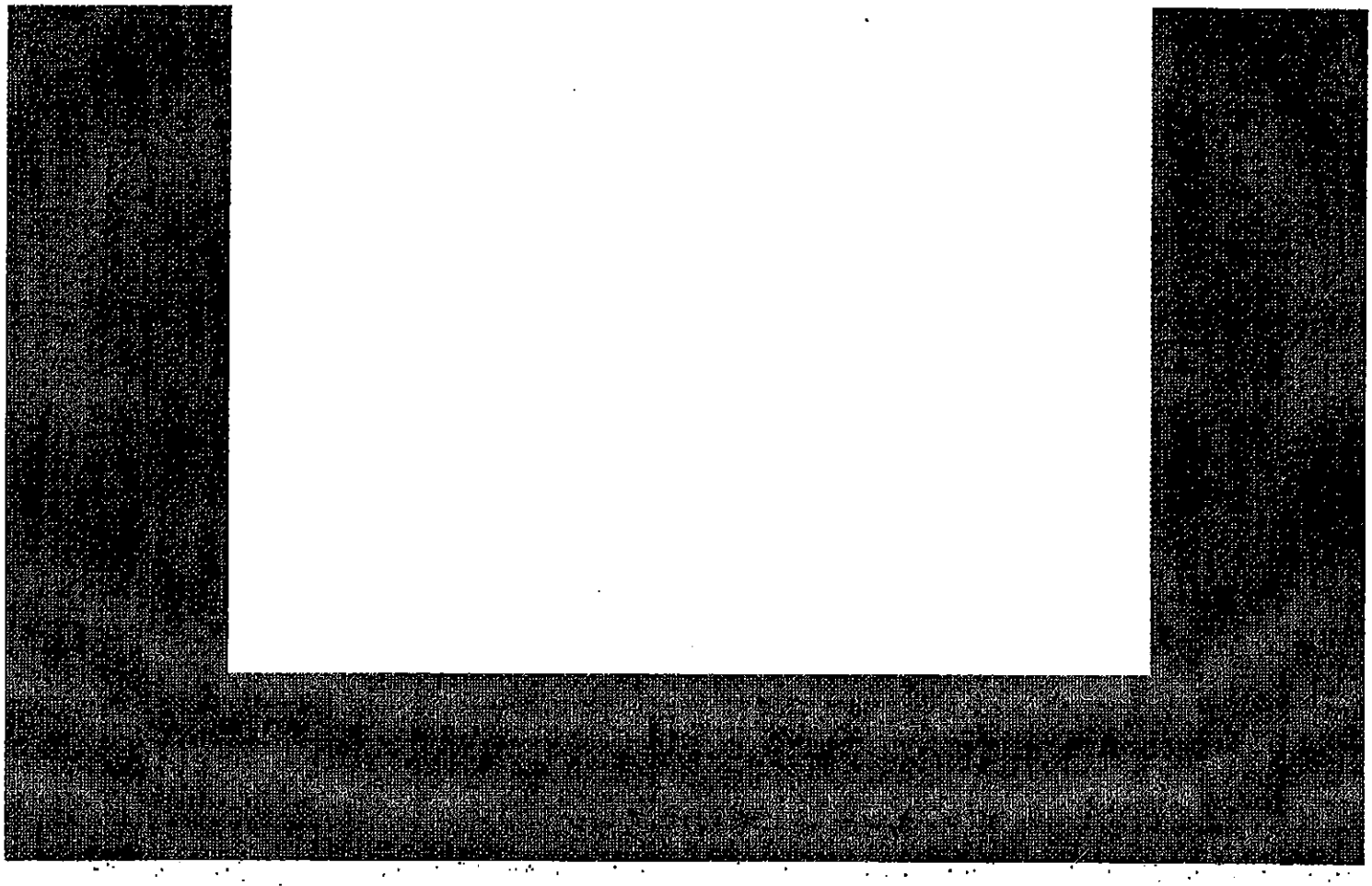


57

57

001521

001521



25

ORIGINAL

TRAN

DISTRICT COURT

CLARK COUNTY, NEVADA

CHERYL A. SIMAO and WILLIAM J. SIMAO, Plaintiffs,	)	CASE NO. A-539455
v.	)	DEPT. X
JAMES RISH, LINDA RISH and JENNY RISH, Defendants.	)	

BEFORE THE HONORABLE JESSIE WALSH, DISTRICT COURT JUDGE

TUESDAY, MARCH 22, 2011

REPORTER'S TRANSCRIPT
TRIAL TO THE JURY
DAY 2 - VOLUME 1

APPEARANCES:

For the Plaintiffs:	DAVID T. WALL, ESQ. ROBERT M. ADAMS, ESQ. ROBERT T. EGLET, ESQ. Mainor Eglet
For the Defendants James and Linda Rish:	BRYAN W. LEWIS, ESQ. Lewis and Associates, LLC
For the Defendant Jenny Rish:	STEVEN M. ROGERS, ESQ. Hutchison & Steffen, LLC

RECORDED BY: VICTORIA BOYD, COURT RECORDER

001522

001522

TABLE OF CONTENTS

001523

001523

EXHIBITS

TUESDAY, MARCH 22, 2011 AT 1:01 P.M.

[Jury Present]

THE MARSHAL: Okay. Please come to order.

THE COURT: Please remain seated.

THE MARSHAL: Remain seated. Department 10 is back in session.

THE COURT: Good afternoon, members of the jury.

[Jurors Reply]

THE COURT: Counsels stipulate to the presence of the jury?

MR. LEWIS: Yes, Your Honor.

MR. ROGERS: Yes, Your Honor.

MR. WALL: Yes, Your Honor.

THE COURT: I think we're ready to proceed then.

Mr. Wall, who's the first witness?

MR. WALL: The first witness is Dr. Rosler, Your Honor.

THE COURT: We'll ask him to come forward to the jury, or witness box.

HANS-JORG ROSLER, PLAINTIFFS' WITNESS, SWORN

THE COURT: Whenever you're ready, Mr. Eglet.

MR. EGLET: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. EGLET:

Q Good afternoon, Dr. Rosler.

A Good afternoon.

001525

001525

Q Dr. Rosler, would you please tell the jury the specialty in medicine you practice?

A I'm a pain management anesthesiologist.

Q And can you describe your educational background for us?

A Well, I was born in Germany, hence, my somewhat strange accent. Came over here in 1997. Finished medical school in Germany and proceeded then with my post-graduate education in anesthesiology and pain management at the University of Indiana, Indianapolis.

Q And is that where you did your internship?

A My internship was done at Michigan State Blodgett Hospital.

Q All right. And you said you did your residency at Indiana University --

A That is correct.

Q -- department of anesthesia. How long is an internship following medical school?

A One year.

Q And how long is the residency?

A Three years.

Q Okay. And did you do a fellowship following your residency?

A Yes sir.

Q And where did you do your fellowship?

001526

001526

001526

A At the University of Indiana.

Q And can you explain to the jury what a fellowship is?

A A fellowship is a subspecialty training in a field that is closely related to your main field. In anesthesiology, you can train in critical care medicine. You can train in pain medicine. In internal medicine, for example, you can train in cardiology, in gastroenterology. It's a subspecialty of your main specialty.

Q And what did you do your fellowship in?

A In pain medicine.

Q And are you board certified?

A That is correct, sir.

Q What does it mean for a doctor to be board certified?

A Board certified means that you have achieved certain standards that are set forth by a society or board of specialty, and typically that to fulfill these standards that compromises a training in your specialty as well as an examination which can be a written examination and/or an oral examination. Once you have successfully passed those examinations, you are then admitted as a diplomat of the respective board of your specialty.

Q And in what areas are you board certified, Doctor?

A I'm board certified in anesthesiology with the

001527

001527

American Board of Anesthesiology, and in pain medicine with the American Board of Pain Medicine.

Q Do you belong to any professional memberships?

A Yes I do. I belong to the largest body of professional membership, that's the AMA - the American Medical Association. And then I belong to the American Society of Anesthesiology, the American Academy of Pain Medicine as well as the North American Spine Society.

Q Do you belong to the International Spine Intervention Society?

A Yes sir.

Q And what --

A The International Spine Intervention Society - or ISIS - is a separate society.

Q And what is ISIS?

A ISIS is a society comprised of many members, international members all around the globe which emphasizes in the teaching of and the treatment of spinal pain, spinal injections.

Q Okay. And could you detail for us the scope of your practice as a pain management specialist?

A As a pain management specialist, I see patients who complain of pain. And mainly in my practice, I see patients who complain of symptoms of spinal pain, pain that's coming from the vertebral column, the cervical spine, the thoracic

spine, and the lumber spine. So my practice is rather focused on spinal pain.

Q Okay. And do you have any hospital privileges?

A Yes, sir.

Q And where do you have hospital privileges?

A Well, let me see if I can get them all together, but it's the Sunrise Hospital, University Medical Center, Valley Hospital, Spring Valley Hospital, Mountain View Hospital, Summerlin Hospital, Southern Hills Hospital, and St. Rose Hospitals which is several - Rose de Lima, San Martin and Siena. And North Vista Hospital.

Q And what does it mean to have hospital privileges?

A Hospital privileges means that you have fulfilled a certain criteria set forth by each hospital to work as a consultant physician in that hospital, to see patients in that hospital, to admit patients in that hospital, to practice in that hospital.

Q Okay. Doctor, have you been qualified as an expert in the area of pain management and anesthesia in the courts of Clark County, Nevada?

A Yes, sir.

Q Okay. Any other jurisdictions?

A Not to my knowledge.

Q Okay.

MR. EGLET: Your Honor, we would offer Dr. Rosler as an

001529
001529
001529

expert in anesthesia and pain management.

THE COURT: Any objection?

MR. LEWIS: No, Your Honor.

THE COURT: So ordered.

BY MR. EGLET:

Q Dr. Rosler, would you please describe for us what the practice of pain management consists of?

A Well, the practice of pain medicine consists of the diagnosis and the treatment of pain. That's a very global definition.

Q Okay. And can you tell us specifically what you do on a normal day with patients?

A Well, I --

Q What kind of clinical problems do you evaluate and treat on a routine basis?

A Well, I see patients who complain of spinal pain, neck pain, mid back and low back pain. I see these patients in my clinic. I evaluate those patients. I come up with an impression with a diagnosis and then, subsequently, with a treatment plan in an attempt to improve the patient's condition.

Q Okay. Now are you one of Mr. William Simao's treating physicians?

A That's correct, sir.

Q Okay. In preparation for your testimony today, what

001530

001530

documents have you reviewed and brought with you?

A I have reviewed the documents of our clinic, the Nevada Spine Clinic.

Q And have you brought those documents with you?

A Yes, sir.

Q Okay. Now, Doctor, can a person have neck pain and still have a normal range of motion?

A Yes, sir.

Q Okay. So if someone hypothetically stood in front of this jury yesterday and said, well, Mr. Simao couldn't have had neck pain because he had normal range of motion in his neck during certain examinations, would that be accurate?

A I think that would not be necessarily an accurate statement.

Q Why is that?

A Because patients do have, can have cervical symptoms, neck pain, and can have full range of motion. That doesn't preclude the fact that the patient is suffering from pain.

Q Okay. Does a normal plain film of a cervical spine, an x-ray performed within hours of a patient being involved in a motor vehicle collision and presenting with neck pain rule out an injury to the cervical spine?

A No.

Q Okay. And why not?

001531

001531

A Well, first of all, the x-ray or the radiograph is typically taken after an accident to see any gross abnormalities, to see is there a fracture. In this case, if there's a fracture of the cervical spine which would then warrant immediate care. However, the x-ray does not show you any underlying soft tissue injury. It can show you any bony abnormalities, it can show you a fracture of the bone, a dislocation, but it cannot show you any underlying soft tissue abnormalities.

Q Okay. Now, does the initial diagnosis of a cervical sprain or strain rule out the possibility that a disc or facet injury occurred to the cervical spine?

A It does not.

Q And why not?

A Again, cervical strain and sprain pertains to the soft tissue to the overlying muscles and ligaments, and often the underlying injury can be also a result of the same impact that resulted in a cervical strain or sprain.

Q So hypothetically, if someone stood in front of this jury yesterday afternoon and told this jury that Mr. Simao could not have had any injuries to his discs in his cervical spine because his cervical x-rays were normal, would that be an accurate statement?

A This would not be an accurate statement, sir.

Q All right. Doctor, when did you -- could you put up

001532
001532
001532

-- hang on a second.

MR. EGLET: The Court's indulgence?

THE COURT: Sure.

MR. EGLET: Your Honor, may we approach?

THE COURT: Yes.

[Bench Conference Not Transcribed]

MR. EGLET: Thank you, Your Honor.

Okay. Brendan, could you put up Exhibit 32, page 2 please?

BY MR. EGLET:

Q Doctor, can you see that screen in front of you?

A Yes I can.

Q If it's easier to refer to that screen or your chart, whichever is easier, and if you need to circle something with your finger on that screen you can.

Now, when did you initially evaluate Mr. Simao for pain management consultation?

A I saw him initially on April 15th of 2008.

Q Okay. And who referred Mr. Simao to you?

A Dr. Grover.

Q And what specialty does Dr. Grover practice?

A Dr. Grover's a orthopedic spine surgeon.

Q And what was Mr. Simao's chief complaint at that time?

A His chief complaint was at that time neck pain with

001533

001533

001533

radiating pain in his left upper extremity.

Q Left upper extremity means what?

A Left arm.

Q And some of you -- doctors say extremities, they're talking about the arms and legs?

A Correct, sir.

Q Upper extremities are the arms, lower extremities are the legs?

A Correct, sir.

Q Okay. Now what history did you obtain from Mr. Simao at that time of your initial evaluations of him?

A As stated in my record, I evaluated and elicited that the patient was presenting with these chief complaints of neck pain, left upper extremity pain, and he stated that these symptoms were a result of a motor vehicle accident two to three years ago.

Q Okay. And did he note to you that he hit the back of his head on a metal cage of the vehicle upon impact?

A Yes, sir.

Q And did he indicate that he had been suffering from neck pain, interscapular pain and left parascapular pain radiating into his left extremity as well as the osipit [phonetic]?

A Occiput.

Q Occiput?

001534

001534

001534

A Yes, sir.

Q Okay. And he had been suffering from this pain since the motor vehicle accident?

A Yes, sir.

Q Now what is interscapular and left parascapular pain? Could you explain that to us?

A The scapula is the medical term for shoulder blade. So interscapular pain means pain that is in between the shoulder blades. Parascapular pain is pain that surrounds the shoulder blade. So the patient was having pain in between the shoulder blades and surrounding the left shoulder blade area.

Q What is the occiput? Where is that located?

A The occiput is the back of your head, the occipital region - occiput.

Q Okay. Does it extend down to the top of the neck?

A Yes, sir.

Q Now, what evaluation and treatment did you document that Mr. Simao received before your initial evaluation of him?

A The patient had undergone physical modalities including physical therapy and had also undergone injection therapy.

Q Okay. And would you please review for us --

MR. EGLET: Could you put up Exhibit 32, page 1 please, Brendan?

///

BY MR. EGLET:

Q Could you review for us the pain diagram that was filled out by Mr. Simao on April 15th, 2008?

A Yes, sir. On the pain diagram on the right side, you'll see the posterior view or the view from the back, and on the left side you see the front view. The patient was marking on the back view pain in between the shoulder blades radiating up into the back of his head, and then pain that was coming down on the left side around the left shoulder blade and into his left upper extremities.

Q Okay. And what does -- what is this scale on the bottom like a numbered --

MR. EGLET: Can you shift this a little bit to the right, Brendan? Reduce it a little bit maybe? A little bit more. I think you're paper's off center. There you go.

BY MR. EGLET:

Q I see this scale on the bottom below the pain diagram of one to ten with a circle around the seven. What is that?

A It's the visual analog scale, VAS scale, which is the easy to, for the patient to grade his com symptomatology, the severity of the symptoms. And typically I say zero is the no pain and ten is the worse pain you can imagine.

Q Okay. And so you have them grade it and then you have the patient fill out, I guess, scribble on the front and

001536

back of the bodies there depicting where they're having their problems?

A Yes, sir.

Q And what is the purpose for this document?

A Well, it gives us an estimate in what condition the pain is in terms of his pain intensity which is very important. Some patients, you can't necessarily tell by looking at them in how much pain they are so you have to allow them to explain in an easy way how severe their pain is.

Q Okay.

MR. EGLET: Now, could you go back to page 2 please, Brendan?

BY MR. EGLET:

Q Now, Doctor, by way of review of the records available to you in obtaining a history for Mr. Simao, did you reach any conclusions as to whether he had, Mr. Simao had had any previous clinically significant neck pain or upper extremity symptoms that required evaluation or treatment before this April 15th, 2005 motor vehicle crash?

A To my knowledge, there weren't any symptoms of neck pain prior, and left arm pain prior to this motor vehicle accident April 2005.

Q Now, under the paragraph on page 2 of your chart, under the paragraph titled Past Medical History, in your initial evaluation you do not have documented that Mr. Simao

001537

001537

001537

had a history of migraine headache syndrome. Did you subsequently become aware that Mr. Simao had a history of migraine headache syndrome that predated the April 15th, 2005 motor vehicle crash?

A Yes, sir.

Q Now does the fact that Mr. Simao has a medical history of migraine headaches impact your clinical assessment, differential diagnosis or plan of treatment for him?

A No, sir.

Q Okay. As an experienced pain management physician, do you believe that occipital pain, axial neck pain and/or upper extremity symptoms can trigger, exacerbate or aggravate pre-existing migraine headaches?

A Absolutely, sir.

Q And why is that?

A Well, we all know, and perhaps one of our jurors is suffering from migraines, that migraine type symptoms can be aggravated by stress, by sometimes different smells, by lack of sleep, by pain, of a pain that can trigger and exacerbate and worsen the underlying migraine symptomatology.

Q Was Mr. Simao working at the time of your initial evaluation of him?

A I believe so, sir.

Q And do you know what he did?

A I believe he was in the floor cleaning business.

001538

001538

001538

Q Okay. Does the fact that Mr. Simao remained gainfully employed following this April 15th, 2005 motor vehicle crash rule out the possibility that he sustained a significant cervical spine injury as a result of that accident with the development of chronic pain syndrome?

A No, it does not rule it out, sir.

Q And why not?

A Well, for one, people are, like we all have to pursue a gainful employment to support our families, and the fact that somebody has pain does not necessarily rule out that he or she is not working due to the fact that one has to make a living.

Q Okay. So if someone stood in front of this jury yesterday afternoon and told them that the fact that Mr. Simao returned to work after this motor vehicle accident so he must not have had a disc injury, would that be accurate?

A No, sir.

Q Do you see patients in your practice who have significant disc injuries who because of various reasons are required to continue to work?

A I would say the majority of my patients with pain pursue gainful employment and continue to be employed and continue to work despite the pain.

MR. EGLET: Could you go to page 3 please, Brendan?

///

001539

001539

001539

BY MR. EGLET:

Q Now, Doctor, what positive physical examination findings did you document on your initial evaluation of Mr. Simao?

A Well, first I did a general exam to just to rule out that there's something underlying that might be a little more pressing such as a cardiac problem, a heart problem or a lung problem is always important that you cover your bases there and make sure that the patient is okay in that respect. And then I did a problem focused examine pertaining the cervical spine, and there was, upon inspection, there was a loss of the normal lordotic curvature of the spine. Lordosis or lordotic curvature means there's a -- the normal cervical spine has a curve and that curve --

MR. EGLET: May I approach, Your Honor?

THE COURT: Yes.

BY MR. EGLET:

Q Could you, using this spine, explain what you mean?

A As you can see the --

THE COURT: If you need to step down, Doctor --

THE WITNESS: Sure.

THE COURT: -- feel free to do so.

BY MR. EGLET:

A As you can see, this is the vertebral column, and when you look at it from the side you see it's not straight.

001540

001540

It's rather curved. It's an S shape. And so the cervical spine, the thoracic - the mid back, thoracic spine, and the lumbar spine - the lower back, it's all in an S shape. So in this case with Mr. Simao, the curvature of the cervical spine was reduced. He had a straightening of the cervical spine, and that was evident on physical exam. So rather than having an S shaped or rather than having a curve in the cervical spine, the patient had a straight cervical spine.

Q In your experience, what causes that?

A That is typically caused by an injury to the soft tissue underlying a spinal injury where you have a protected reflex of the musculature where the musculature pulls the spine in a more straight position.

Q Okay. What else did you find on your physical examination at that time?

A Well, the patient had tenderness to palpation to --

Q What does that mean?

A When I palpate, I put pressure in the area of the cervical spine in the, we call it paraspinous area that means in the side of the cervical spine as well as in between the cervical spine, in between the shoulder blades and across the shoulder blades, there was tenderness elicited upon pushing so to speak. We call it palpation.

Q All right.

MR. EGLET: Could you go to page 4 please, Brendan?

001541

001541

BY MR. EGLET:

Q Doctor, did you perform provocative testing on Mr. Simao's cervical spine at the time of your initial evaluation?

A Yes, sir.

Q Okay. And what is provocative testing and what is the purpose of provocative testing of the cervical spine?

A Provocative test, the purpose of provocative test is to elicit or reproduce the patient's symptomatology under a stress. In his case, in the patient's case, I performed an axial compression test where I pushed down on the head of the patient and asked the patient while I was doing this whether this causes him to have any symptoms. And the patient was at that time was reporting symptoms of all icky, exacerbation of his normal symptoms, neck pain, pain in between the shoulder blades, pain in his left shoulder blade area and left arm pain. So the axial compression test was thereby positive, or therefore positive. I also performed a spurling sign. A spurling sign is a test of the nerves that come out of the vertebral column. I had the patient look up to the ceiling and turn the head as he looks up, turn the head to the side. And what I do I narrow the canal where the nerve travels through, and if this canal is already compromised by a disc, if the canal is already more narrow, if there's already an underlying spinal nerve irritation, that will exacerbate this

001542

001542

symptomatology. That's the spurling sign. And both the axial compression test and the spurling sign were positive in Mr. Simao.

Q Okay. Now, Doctor, can a patient with neck pain and upper extremity symptoms have a normal non-provocative -- a normal non-provocative examination of the cervical spine with a supple neck and without tenderness and still have positive provocative physical examination findings in the cervical spine like you found here?

A Yes, sir.

Q Okay. And so if Mr. Simao's previous medical providers had documented his neck to be supple without tenderness but did not document provocative testing of the cervical spine, would that necessarily mean that he had a normal examination of his cervical spine?

A Well, it does not. It's not a complete examination. It's a -- I can make an analogy. If I try to evaluate the patient's heart and I just feel for the peripheral pulse, I cannot make any conclusion whether the patient may have a murmur or not so I have to do some more testing or more examinations. So this would not be a complete physical exam to rule out an underlying cervical spine injury.

Q And if the physical examination is not complete or is incomplete, it's inconclusive?

A Correct, sir.

001543

001543

001543

Q Okay. And does that mean that no meaning can be drawn from this examination absent a provocative physical examination testing?

A Yes. It's an inconclusive examination. It's not a thorough examination.

Q Okay. And you, I think you described that you performed provocative axial compression at the time of your initial examination?

A Correct.

Q Okay. And you listed provocative spurling signs in your initial examination of Mr. Simao?

A Correct, sir.

Q Okay. And have you explained to us what spurling signs are?

A Yes, sir.

Q All right. What is the clinical significance of a positive axial test and a positive left spurling sign in Mr. Simao?

MR. EGLET: Could you highlight that please, Brendan, the axial compression and the spurling signs?

BY MR. EGLET:

A As I have pointed out, with a positive spurling sign, there is a -- a positive spurling sign is indicative of the nerve root irritation. Nerve root is the spinal nerve that comes off the spinal cord that goes, in our case, goes

001544