A "Patient followed up on" -- I'm sorry, I got August 25th. Did you say 11th?

Q I'm sorry, August --

A Oh. I saw him on July 14th in my follow-up note.

Q I have a date of service on the report for this MRI --

A Yeah, that's when the MRI was done. He followed up with me on the --

Q Right, okay. So what my question is -- and we have the MRI --

A Okay.

Q -- report up here. What were the results of the MRI performed on that day?

A Okay. Well, I'm just going to refer to my chart note here on the 25th when I see him back. So again, I'm looking at the MRI and the report. I briefly summarize, "MRI and CT show excellent maintenance of reconstruction," basically saying the C3-4 and C4-5 levels don't have any problem. Again, I make out -- I make a point of stating how the C4 nerve root does not typically give you symptoms down the arm, especially below the elbow. Now he's having symptoms going to his hand. Therefore, I state "The issue of C3-4 foraminal stenosis is not a clinical player," meaning it's not contributing to his problems.

I also state that -- again, this is where the

radiologist makes a read and I simply disagree. He's stating that the uncovertebral joint arthropathy causes mild to moderate stenosis. When I pointed out to those previous pictures it wasn't the uncovertebral joint, it's the facet. And that's important to make a distinction, because technically when I do the surgery I can do something about the uncovertebral joint. That's something I can nibble away and take care of, and feel and say I'm happy. But the facet joint or if there's a bone spur coming off the facet joint, I can't get to that unless I turn him over and make another incision and nibble from that side.

So I mean that's just a technical point that, again -- and I make that distinction how I state it's primarily due to facet problem. But again, I say "Clinically I don't think it's really a problem because C4 wouldn't be causing symptoms down the arm to the hand.

MR. EGLET: Page 62 please, Brendan.

BY MR. EGLET:

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

A Let's see. I also state how the CT shows that the fusion, even at four months out, looks solid. So I recommend we get an EMG nerve conduction study to get a better idea of what's going on.

Q And did you place him on Neurontin?

A I did.

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Q And what is Neurontin?

A I also mentioned Lyrica, but basically those are two medications that are -- Neurontin especially is technically used for seizures, but the simple concept is it's a medicine that calms down overexcited nerve impulses. So there's a potential scenario that when you do surgery, even though everything structurally is okay, just the simple process of manipulating nerves, gently moving them around can irritate them. So the Neurontin basically simmers down these irritates nerves, but also simmers down potentially irritated nerves like the ulnar nerve or the median nerve.

Q And what is an EMG, a nerve conduction study? You mentioned you ordered that.

A Well, EMG stands for electro myography, which is basically putting a needle in a muscle and seeing how the electrical activity is. A nerve conduction study is where you're specifically starting a little nerve -- electrical impulse and you're measuring how fast it conducts down a given nerve. So those two tests together allow you to evaluate whether or not there's any issues with the cervical nerves or the radicular problem, or whether or not there's any issues with the peripheral nerves or the ulnar nerve, the median nerve.

Q Could the --

A Meaning in the arm.

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Q Could either the median or ulnar neuropathy account for Mr. Simao's residual left trapezial pain you documented and the paresthesias involving his left upper extremity?

A Oh, classically if you're having trouble with your ulnar and median nerve at the elbow, at the wrist, they would explain potentially symptoms from the elbow down. Classically they really wouldn't cause symptoms with the trapezius though. As far as the numbness going down his arm, it could easily explain that.

MR. EGLET: Page 65 please, Brendan.

BY MR. EGLET:

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

A We ordered the tests. Then on 9/17/2009 he came back for the EMG nerve conduction study. And I state there that it shows median and ulnar neuropathy.

Q Is this the --

A Yeah, that's --

Q That's the right report? Okay.

A Yeah, we -- this is the next chart note after we order the test --

Q Okay.

A -- he's following up with the results.

Q Thank you.

A So basically it confirms that he's not really having

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-- EMG nerve conduction study results that show any problems with the spinal nerves or radicular problems with the neck, showing issues with the median and ulnar nerve, or neuropathy as they're traveling in the arm. Specifically I think it has a chart note by Dr. Taylor potentially at the wrist. I say "The patient has some left trapezial pain. Again, state that there doesn't appear to be any structural issues with the fusion. And the plan at that point was to refer him to upper extremity specialist, who turned out to be Dr. Taylor, to further look into the neuropathy.

MR. EGLET: And page 69 please, Brendan.

BY MR. EGLET:

Q What interval of history did you obtain from Mr. Simao when you saw him six months later on March 23rd, 2010?

A I've got Dr. Taylor's notes. You'll need to -- I'll just refer to it if I may. So March 23rd, 2010. Comes back six months later, "Having primarily left-sided neck pain, trapezial and periscapular radiation." Gives me a secondhand of being seen by pain management, who mentions to him that he still has some C3-4 foraminal stenosis. Again, I go into the discussion about how his pattern does not fit a C4 dermatomal pain pattern. I briefly mention was seen by Dr. Taylor.

Just to quickly look at Dr. Taylor's notes on 2/10/2009, Dr. Taylor basically reviews the EMG nerve

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conduction study, says that he has evidence of carpal tunnel syndrome, which is the median nerve being irritated at the wrist, felt the median nerve was a more significant issue and offered the patient a carpal tunnel release, didn't think the ulnar nerve was much of a problem. As far as I know, the patient chose not to have that carpal tunnel release.

So he follows up with me. I briefly mention Dr. Taylor's note. We took x-rays, everything looked good. Technically no significant thenar changes at the physical exam finding. That's briefly to evaluate whether or not he was any -- having any major dysfunction from the carpal tunnel syndrome. Technically the median nerve is right here at your wrist. And if you get severe involvement, you lose this muscle pad on your thumb. That's called the thenar eminence. So it was me just briefly making sure he wasn't having any significant motor problems or muscle problems from the carpal tunnel.

At that point in time, since I didn't see any structural issues, I thought he may be having some facet pain. Again, I did not think that, in a general sense, typically C3-4 foraminal stenosis in and of itself would be giving him left-sided neck pain, trapezial periscapular pain. And I also stated how the surgery itself would have addressed that if it was a significant problem. The plan was to send him back to pain management to try some facet blocks, basically below the

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fusion.

Q Okay. Why did you not feel there was any clinically significant residual stenosis at C3-4?

A Again, because we're talking about classically that is a pattern of pain that radiates down to the anterior chest wall right here. So I mean not everything's 100 percent, but it's like any clinical decision, you make decisions based on what's most likely and go from there.

Q Would that also be as a result of the fact that at the time of the cervical reconstruction, that the C3-4 normal disc height was restored by the use of the cages?

A Right. And base -- I'm sorry.

Q Go ahead.

A Basically there are studies that show if you go in and just back open that disc, that maneuver by itself will improve the nerve exit holes. So there are some people who don't even bother trying to do anything else other than that because it's reasonably supported by studies. So again, when we did the surgery that's what we did. Again, clinically the patient was having primarily what I would deem not major symptoms or obvious symptoms of the pinched C4 nerve in and of itself.

Q Okay.

MR. EGLET: Your Honor, you have looked at me a couple times like I had the feeling you wanted to take a break. Is

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this --

THE COURT: Yes.

MR. EGLET: -- a good time?

THE COURT: How did you know, Mr. Eglet?

Ladies and gentlemen -- that's right, I think we all probably need a break. Reminding you of your obligation not to discuss this case, not to form or express any opinion, not to do any research on any subject connected with this case. Ten minutes please.

[Recess]

[Within the Presence of the Jury]

THE MARSHAL: Remain seated, come to order. Department 10 is back in session.

THE COURT: Okay, we're back on record.

Counsel stipulate to the presence of the jury?

MR. EGLET: Yes, Your Honor.

MR. ROGERS: Yes, Your Honor.

THE COURT: Mr. Eglet.

MR. EGLET: Thank you, Your Honor.

DIRECT EXAMINATION CONTINUED

BY MR. EGLET:

Q Okay, Doctor, did Mr. Simao follow your recommendation and return to the pain management center at Southwest Medical for further diagnostic and therapeutic injections in his cervical spine?

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A So, just to make sure, we're starting again from 3/23/2010, correct?

Q Yes.

A Okay. At that point I recommended going back to pain management, trying some medial branch blocks to see if there's potentially some facet mediated pain below the fusion. It appears at that point in time that was the last time I saw him.

MR. EGLET: Put up page 202, please, Brendan.

BY MR. EGLET:

Q What procedure was performed by Dr. Siebel on April 20th, 2010?

MR. ROGERS: Your Honor. Objection. We're getting beyond the doctor's --

MR. EGLET: May we approach, Your Honor?

THE COURT: Yes.

[Bench Conference Not Transcribed]

MR. EGLET: Okay. Are we on page 202, Brendan?

BY MR. EGLET:

Q So the question was, what procedure was performed on Mr. Simao by Dr. Siebel on April 20th, 2010, Doctor?

A Appears that he had a left C3, C4, C5, C6 medial branch nerve block.

Q And what is the purpose of that procedure?

A Well, in general it's to predict the potential pain-

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relieving effect of doing a medial branch oblation. The simple concept is the medial branch is a specific nerve --

Q Can you come --

A Yeah.

Q Come down and explain what you mean? And using the model if you could show and explain what a medial branch nerve block is in the cervical spine, as performed by Dr. Siebel.

A So, basically what we're trying to do is trying to see if there's anything else going on structurally that would have caused Mr. Simao to still have some symptoms. So again, we talked about having discs in the front, facets in the back.

There's a specific nerve that comes off this nerve that goes and travels on the side of this bone. Okay, those are called medial branch nerves. And those specific nerves enervate or provide the nerve supply to the facet joint. So the whole idea is that if you do a block of that nerve and that temporarily gives you significant pain relief -- most people would say at least 50 to 70 percent -- then that does two things. A, it confirms that you have facet-mediated pain, and B, it also says it would be a reasonable thing to do an oblation. Oblation is where you selectively destroy the nerve. So the concept is, if you knock out the nerve and that connection to the body is no longer there, then you shouldn't feel the pain.

So they do the medial branch block, and then while

the numbing effect of the anesthetic's working, they ask the patient to relate how much pain relief they get. If they get good pain relief, then you can do a procedure -- and these are all done via needle sticks -- where you put some type of probe onto the nerve. It can either be a freezing probe, a heating probe, that in a controlled fashion knocks out that nerve.

When you do that, that potentially can give you pain relief that lasts up to two years, depending on the technique. If they do get -- if the patient gets good relief, it comes back, if you repeat the procedure, typically it works 85 percent of the time. So it is a good option, potentially, for people who have facet-mediated pain. That avoids any major procedure.

Now, technically my thought process was simply if you have facet pain at C3-4 or C4-5, that should be adequately addressed by the fusion we already did. Because it's taking away the motion, just like we used to do with hip fusions for hip arthritis in the old days. So that's why I specifically asked them to do C5-6. For whatever reason, I chose to do a few extra.

Q Okay. Thank you, Doctor.

[Witness Resumes the Stand]

MR. EGLET: Now, Brendan, would you bring up page 206.

BY MR. EGLET:

Q Doctor, what were the results of the medial branch

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nerve blocks performed by Dr. Seidel?

A Appears that he had only 30 percent --

MR. ROGERS: Excuse me -- Doctor, excuse me.

Your Honor, same objection, as this is beyond the doctor's treatment --

THE COURT: Noted for the record; overruled.

THE WITNESS: This is a chart note where the patient follows up after these medial branch blocks, and he has 30 percent relief.

BY MR. EGLET:

Q Now, what is the clinical significance of that response?

A Well, that would not justify doing a medial branch oblation, and that would essentially eliminate any significant ongoing facet pain at C3-4, C4-5, or C5-6.

Q What did Dr. Seibel recommend for Mr. Simao on April 22nd, 2010?

A Well, technically it's Terry Robichaud [phonetic] who's the physician assistant that works with Dr. Seibel, but recommended a left C3-4 transforaminal dural object -- I'm sorry, transforaminal epidural injection.

MR. EGLET: Put up page 214, please. Brendan.

BY MR. EGLET:

Q When did Dr. Seibel perform this procedure on Mr. Simao?

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A June 10th, 2010.

Q And what was -- page 224, please.

A I'm sorry, I didn't see the procedure part of that. Can you flip back to that? There it is, down at the bottom. Okay. Thank you.

Q Okay. And --

MR. EGLET: Page 224 now, please, Brendan.

BY MR. EGLET:

Q What was Mr. Simao's clinical response to that left C3-4 transforaminal epidural injection?

A Would you mind actually going back to the other note, and go to the technical part where it actually describes the procedure?

Q Sure.

A Those are important details I like to know about. Was there another page, the second page of that?

[Pause]

THE WITNESS: Can I read this real quick here?

[Pause]

THE WITNESS: Okay.

MR. EGLET: Okay. So now go to page 224, please, Brendan.

BY MR. EGLET:

Q What was Mr. Simao's clinical response to the left C3-4 transforaminal epidural injection?

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A Looks like this is follow-up. Patient had a 50 to 60 percent reduction in his symptoms.

Q And did he want to schedule another procedure to try to improve his current pain?

A Yes.

MR. EGLET: Put up page 231, please, Brendan.

BY MR. EGLET:

Q When did Dr. Seibel repeat the left C3-4 cervical transforaminal steroid injection?

A September 2nd, 2010.

MR. EGLET: And page 236, please, Brendan.

BY MR. EGLET:

Q What was Mr. Simao's response to the repeat left C3-4 transforaminal --

A I'm sorry. Not to be technical, but can you show me the next page of that procedure note? Just so I can briefly read it?

[Counsel and Witness Confer; Pause]

THE WITNESS: Let me just read it real quick, please. Can you scroll down?

Okay. Thanks. Well, actually, a very important point.

So this is point two-five percent marking. Can you go back to the first one? Because I think the other one was point five percent marking. So go back to the first one, the

second page.

[Pause]

THE WITNESS: Okay, still point two-five. Okay. Thank you.

MR. EGLET: So now go to 236, please, Brendan.

BY MR. EGLET:

Q What was Mr. Simao's response to the repeat C3-4 transforaminal epidural injection?

A He states 40 percent reduction. If I was looking at this objectively I would simply want to ask is that the immediate anesthetic phase or is that the long-lasting phase. I don't think he makes that distinction.

MR. EGLET: Put up 262 -- page 262, please, Brendan.

BY MR. EGLET:

Q Doctor, who performed Mr. Simao's transforaminal injection November 11th, 2010?

A Let's see. Can you scroll down? Or scroll up? Because I don't see a -- oh, there it is. Nader Helmi. Nader Helmi.

Q Dr. Helmi.

MR. EGLET: And page 265, please, Brendan.

BY MR. EGLET:

Q What was Mr. Simao's documented clinical response to the November 11th, 2010, left C3-4 transforaminal epidural steroid injection, as documented by the physician assistant,

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Terry Robichaud, on November 23rd, 2010?

A Again, let me just briefly read the procedure part. Because it's a different physician here, so.

Okay, he follows up, and he states he has 75 to 80 percent reduction in his left upper extremity pain.

Q And what did P.A. Robichaud document during that encounter with respect to Mr. Simao's evaluation by your partner, Dr. Daniel Lee for a second opinion orthopedic spine consult?

A Said he'd been seen by Dr. Daniel Lee for a second opinion. Stated that apparently some rather severe stenosis, and discussed with him possibility of surgical interventions. Should not get better with procedures at this office.

MR. EGLET: Page 78, please, Brendan.

THE WITNESS: I'm sorry. Can we just go back to there? Just one more little thing I want to --.

Now, the little technicality here is we got 75 to 80 percent reduction of the left upper extremity pain. And again, when -- is it not -- to make sure I'm accurate. He's having mainly persistent left-sided neck and scapular and trapezial pain, correct?

BY MR. EGLET:

Q Well --

A And then we got paresthesias --

Q But it says, after -- "upper left extremity," he

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said he was "and left-sided neck pain."

A Right. And then he adds that down lower, so I just want to make sure we're good to go on that. Okay.

Q Okay.

MR. EGLET: And so now page 78, please, Brendan.

BY MR. EGLET:

Q What did Dr. Lee document on his evaluation of Mr. Simao on January 27th, 2011?

A Looks like he follows up, notes how he got relief -- significant relief of the left -- I would assume a typo -- C3-4 transforaminal epidural, looks like a nerve root block. Physical exam unchanged, most of his pain in the trapezius. I think this refer pain for the neck. I re-reviewed the CT scan and MRI of the cervical spine. It shows no cervical stenosis on the MRI. The stenosis that they are calling at the left C3-4 is really minimal.

Q So Doctor Lee in fact is noting no cervical or significant cervical stenosis, is that correct?

A I would state he's saying it's really minimal.

Q Okay.

A Yeah.

Q Now, what did Dr. Lee recommend at that time? Your partner, Dr. Lee?

A New MRI.

MR. EGLET: Page 41, please, Brendan.

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BY MR. EGLET:

Q What were the results of the repeat MRI of Mr. Simao's cervical spine performed on February 3rd, 2011?

A Okay, so this is the radiology report, which may be different from Dr. Lee, but basically states mild narrowing of the left C3-4 neural foramen, minimal retro stesis [sic] C5-6, right para -- mild right paracentral disc bulge at C5-6. Mild narrowing right lateral recess, C6-7. Minor narrowing of the right compared with left neural foramen.

Q Now, do any of the findings on Mr. Simao's most recent cervical spine MRI explain his symptoms of left axial neck pain, left trapezial pain, or left upper extremity radicular symptoms?

A The MRI in itself, no.

Q Why not?

A Well, they're basically stating it's mild. And again, as I've stated before, the typical radicular pattern of a C4 nerve pinch in the nerve exit tunnel or the neural foramen would be radiating down to the anterior chest wall.

MR. EGLET: Page 79, please, Brendan.

BY MR. EGLET:

Q What was Dr. Lee's assessment of Mr. Simao when he re-evaluated him on February 24th, 2011?

A Follows up. States he can see pain management, no surgical indications at this time, physical exam motor and

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

Q And what did Dr. Lee recommend to Mr. Simao at that time?

A Sounds like plan as above, and it looks like -- I would assume that his plan is pain management, no surgical indications.

Q Now, after having done well in his immediate post-operative --

A Can I --

Q Sure, go ahead.

A Is there a way to see that MRI? That was done? Because I've never seen it. I mean, since we're taking the time.

[Pause]

THE WITNESS: I mean, we've already had one example where the radiologist and I disagree.

[Counsel Confer]

MR. EGLET: I guess we can't do it right now. Sorry, Doctor.

THE WITNESS: I got a laptop in my car.

MR. ROGERS: We have an extra one here, if that --

MR. EGLET: You could play it over there?

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MR. ROGERS: Of course, over the earlier stated objection that it exceeds his treatment, but we'll --

THE WITNESS: Well, I would just simply like to -- I mean, I've already had one example where the radiologist and I disagreed, and this --

THE COURT: Why, Mr. Rogers, how magnanimous of you.

MR. ROGERS: What was the -- ?

[Counsel Confer]

THE WITNESS: And then could we pull up that report so I can make potentially any comments where if I disagreed.

[Counsel Confer]

MR. EGLET: It's Exhibit 19, page 41.

THE WITNESS: All right, I got the report.

[Counsel Confer]

THE WITNESS: Do you want me to flip through them?

MR. EGLET: Yes.

THE WITNESS: I'll do it.

MR. EGLET: Is it okay, Your Honor, if he comes out of the box and --

THE WITNESS: Why not.

MR. EGLET: -- save a little time.

THE COURT: We probably should go off record for a moment.

[Off the Record]

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BY MR. EGLET:

Q Do you want to look at him on the big screen, to talk about him, Doctor or --

A Sure. Are you going to be able to link it onto the monitor?

Q We're going to put it on this monitor, it should be there. Here they are.

A Okay. So let's start with number three. Okay. That looks okay. So let's go down to four, five. Okay. Go back to that level, five.

Q Five.

A Could you skip to the next --

Q Here's five.

A Okay. So this actually C-3,4 as best as I can tell. So there's still a little bit of narrowing of that nerve exit hole. Okay. So, six, is with our technique.

[Pause]

Q Did you want to look at another one?

A Six.

UNIDENTIFIED SPEAKER: Six, oh, I'm sorry, I didn't hear that. Six.

THE WITNESS: Because I haven't really seen this, we just need to scroll down --

Q Okay. Fine.

[Pause]

A Yeah. I would have to say. This is a little difficult, because they're sequenced in I can tell they're out of sequence.

Q Okay.

A So --

Q That's fine.

A But let me look at on more thing. Just one more sequence.

[Pause]

A Okay. So briefly looking at his -- can you pull that up on here?

UNIDENTIFIED SPEAKER: Sure. It locked up on me. It's not going to happen.

THE WITNESS: Number?

UNIDENTIFIED SPEAKER: It locked up on me. I'm going to actually start apologizing.

THE WITNESS: Okay. Well, let me just summarize it --

BY MR. EGLET:

Q Yes.

A -- I was able to see some.

So the things that would take a little disagreement with the report, is I did not see any retrolisthesis at C5,6. I did not see any significant -- and then, again, it only says mild disc bulge at C5,6 or narrowing at C6,7.

And I would say the for foraminal narrowing at C3,4

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may be a little improved. And that can be explained by simply the fact once you fuse a segment bones spurs and stuff actually can go away. So --

Q All right. Now, Doctor, after having done well in his immediate post-operative course following your cervical fusion surgery, why has Mr. Simao developed chronic left axial left pain, left trapezial pain and intermittent left upper extremity radicular symptoms?

A Well, I would say the potential causes that would be reasonable as far as the residual left-side at neck, periscap or trapezial pain can simply be the fact that he went so long before definitive treatment.

And then you start getting issues of chronic pain, and then you start getting intrusion, pain. And what that means in a simple sense, is the nervous structure from the brain all the way out to the little receptors in your body, when you have chronic pain issues going on the internal architecture of the neurological system can be altered.

So what happens is, as the pain becomes more chronic, and I use, you know, I would say that you're at more risk for these neuropathic chronic persistent pain syndromes. Once you start getting beyond a year that the internal architecture of these pathways gets changed.

Now what happens is as time goes on, even though you potentially take care of the structural cause of the pain,

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because the change in these internal pathways of the nervous system the patient still perceives pain.

And patients are at risk for this. Technically any time you're at risk for this. But in general once you have chronic pain syndromes that go beyond a year gradually that risk gets higher and higher.

So what happens is, is that there's a potential where even though you take care of the structural issues the pain is persisting.

So technically with Mr. Simao, his accident was what, April of '05, surgery wasn't until March of '09, well, we're talking about almost four years.

So that's one reasonable explanation.

Q So --

A The other explanation is he can still have a component of occipital pain, or occipital neuralgia. And that's any time -- again, I've mentioned it, but this occipital nerve you've got basically two that come out on each side, you've got a greater and a lessor, but these nerves are coming out of the spine and they're going through various layers of muscle.

And when someone has chronic pain and spasm these various muscle layers are spasms and kind of shearing this nerve as it's punitrating [sic] through.

And over time if you have a chronic pain problem

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where the spasm component is aggravating this nerve you can get what we call occipital neuralgia. Now that potentially is a real entity that could be contributing to his ongoing pain as well.

Q Is the development of neuropathic pain syndrome post-operatively considered a surgical failure?

MR. ROGERS: Objection, Your Honor. On this one we do need to make a record.

THE COURT: All right.

[Bench Conference Not Transcribed]

BY MR. EGLET:

Q All right, Doctor. The question is, was pending, is the development of neuropathic pain syndrome post-operatively considered a surgical failure?

A Well, I would definitely say it's considered less on a desirable outcome. Surgical failure in a general sense I think would imply that something technically with the surgery went amiss. The fusion didn't take, the hardware broke, something like that.

Q Do you believe that any surgeon that is -- strike that.

Do you believe that surgery that is unsuccessful, means that it was not indicated and/or unnecessary?

A No.

Q Why?

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A Well, I mean, if you take a simple example that's fairly black and white, when you look at what surgeries orthopedic surgeons do, one of the best operations we do are hip replacements. That's a great job of a patient having an operation, feeling better, having more function, less pain. But even that operation is successful about 90 to 95 percent of the time.

So I mean, by definition, so what does that mean? That means five to ten percent of the time because it wasn't successful it was unnecessary or not indicated; absolutely not.

I mean, in fact it's so extreme that I think even in Nevada it's actually against the law for a doctor to make a guarantee as far as outcome for a surgical procedure.

So I mean, anything we do, I mean nothing is a hundred percent. I wish it was, it would be awesome, but it's not.

Q Do some patients who have a good indication for cervical spine, a reconstruction in fact, not experience any relief of their symptoms, or have worsening symptoms following surgical reconstructions?

A Well, it can occur, and there's all kinds of reasons. Worsening I'd say typically would be because of more likely structural issues with the surgery itself. No relief. And again, it's a spectrum, but I'm sure it's possible.

Q Why do some patients either not improve, continue to have pain or get more symptomatic following surgical reconstruction of the chronic spine?

A Well, the answer is basically a spectrum again. You can have the one extreme where technically everything is fine, but things are not improved and you probably have neuropathic pain.

Technically you could have, if the surgery was done correctly, but maybe something else has started to become a problem. Or you've got another more definitive down spectrum where the surgery technically has issues; the fusion didn't take, hardware broke, screw went in the wrong place, something.

Q What percentage of patients that undergo this multi-level surgery that you perform do not improve?

A Well, I would say the vast majority do improve. But at the same time I would say the vast majority of patients don't -- you know, I think what was the timeframe when I actually recommended surgery to when he eventually got it; wasn't it like '07?

Q Yeah.

A You know, so I would say the vast majority of my patients, because they've gone through a reasonable treatment and we've tried reasonable things, and it's been a reasonable period of time, the vast majority will not delay surgery

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another two years.

So for that reason in my hands I think a lot of my patients do very good, good, well. Sure, do you I have patients who don't improve, sure.

Q What criteria do you use to make surgical recommendations for cervical spine reconstruction in your patients that gives them the best chance of having good outcomes from surgery?

A The question one more time, please?

Q What criteria do you use to make surgical recommendations for cervical spine reconstruction in your patients that gives them the best chance of having good outcomes in surgery?

A Well, I think we've already touched on a lot of it. I think you want to make sure that you've given patients a chance to get better who are going to get better. But once they reach that branch part in the road where chances of improving are low, and that's usually 6 to 12 months once you're into that, then I think that's the time to intervene and take care of the problem.

Studies shows, a good example would be spinal stenosis which is an age-related degenerative thing as people are just getting older where there's a gradual narrowing of the spinal canal. And people when they try to stand up and walk they get pain going -- tingling down their legs, studies

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show that if you wait more than a year to do surgery the outcomes of the surgery go down.

And when you think about it intuitively, I mean, if a nerve is getting squashed, you know, over time there's going to be chronic irreversible changes. I mean, it's just commonsense.

Q Now was --

A So -- I'm sorry.

Q I'm sorry.

A So that's one thing. You want to make sure you're intervening at appropriate effective branch points in the timeline, just because you want to, at the beginning you want to give them a chance to get better, because odds are good they're going to get better.

But once they get to that three to six months, and as long as they've done reasonable, conservative things, your odds are stacking up against you.

Q Was Mr. Simao at increased risk for not responding well to surgical reconstruction of the cervical spine?

A I would say yes simply because of the four-year delay.

Q If Mr. Simao were at increased risk for not having a good surgical outcome, why do you offer him the surgical reconstruction?

A Well, I think it's fair to say it was very dogmatic

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to make sure the workup was as fresh as it could be. So every time he came back after a delay of a year, of a year and a half, we always said, okay, well, things could have changed. Let's make sure we get a new MRI. Let's make sure we repeat injections. Let's just don't assume that things haven't changed.

So then the scope of what's reasonably possible, I think that commitment to being dogmatic and making sure the workup is recent and fresh minimizes that chance. Does it eliminate it? No.

Q All right. You've explained to us that you believe that he has the development of neuropathic pain syndrome, as well as potentially you have occipital neuralgia, which you explained to us.

What is the treatment for neuropathic change syndrome?

A Again, there's a whole spectrum. Some people make it better just taking Lyrica or Neurontin. But for those that are persistent and non-improving, the treatment's typically a spinal cord simulator or some type of neuro modulation.

Q What is a spinal cord stimulator?

MR. ROGERS: Oh, objection, Your Honor.

MR. EGLET: May we approach, Your Honor.

THE COURT: Yeah. Sure, come up.

[Bench Conference Not Transcribed]

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BY MR. EGLET:

Q Okay, Doctor. The question that was pending is what is a spinal cord stimulator?

A Well, the general answer is you have these electrodes which do neuromodulation. The simple concept is you have a device that's low profile and it has multiple electrodes and it lays on top of neurologic structure. It can lay on top of a nerve, it can lay on top of a spinal cord.

And what it does, it has multiple programming capabilities that's typically attached to a very complex internal device called a pulse generator. What it is, is a mini-size computer with a battery or a power source and it can do all these configurations to modulate the electrical impulses as they're traveling through these neurologic structures; either the nerves or the spinal cord.

So the whole idea is that these altered neurologic pathways basically need to be calmed down. It's like listening to the radio but there's too much static, it's just annoying. So what it does is it changes that perception from pain to typically a gentle buzz or vibration.

So what it's doing is technically in a layman's term kind of down-regulating or simmering down these over-excited inappropriate impulses that are traveling through these pathways in the nervous system.

Q Okay. And would come out of the box, Doctor, and

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using the spine, if you could explain to the jury how a spinal cord stimulator, a Texas 5 [phonetic] cord stimulator, we're talking for about Mr. Simao, would be surgically placed?

A So the spinal cord stimulators are placed in the spinal canal. They sit on top of the spinal cord. So if you -- can you pull up a -- that's okay.

Q Do you want the animation?

A No. No, it's okay. I was just going to show them a spinal cord.

So when you look at a spinal cord the pathways that are going back up towards the brain, providing sensation and pain, primarily on the back side.

So what we do, is you make a small opening to get into the spinal canal and you insert this device. Okay. And that device sits on top of the spinal cord. Technically it sits on top of the spinal sac, and then there's usually a thin layer of fluid and then the spinal cord.

And then it's connected via a cable to this pulse generator which classically is put on the patient's right butt cheek. Those are separate incisions. Sometimes you need to make an additional incisions just to connect the cables. And then it's placed wherever it's deemed to be appropriate, to get good coverage.

Typically you'll get a trial done first, or extembula [phonetic] needle sticks. Pain management will

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place what they call percutaneous leads, which are smaller leads. They're basically in the shape of small cylinder tube, and they can be placed in various configurations.

The idea is that's done awake and the patient's able to give feedback saying: Oh, yeah, that's the spot, that's not it. And then the pain management doc will move that around until he gets what we call the sweet spot. Meaning it's getting good stimulation in the area we want it.

And then the patient -- they will make temporary connections to an external version of the pulse generator, and then that's typically you want at least a five-day trial where they're adjusting it, and getting a chance to really use it, so they can be in a good position to say: Yeah, that was really helpful, or, you know, it didn't really make a difference.

Q And this is a pain management device?

A Yes. By definition it's to manage, but -- yeah.

Then if this trial is successful then they'll come to me and I'll place the permanent one in.

Q Okay. All right. Thank you, Doctor.

And if you could take a look at this animation we have, and tell us, is this, I know in simple forms, how the stimulator is placed and how it works? Is this the battery stimulator, if it's placed surgically in the hip to the butt?

A Yes.

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Q Okay.

A There's the connection cables. Most commonly it's placed in the lower thoracic or mid-back, but selectively it can be used up in the neck. There's a good picture of this electrode, and it's basically spread out; it looks like a paddle sitting in the spinal canal.

And typically this can be a device that has a remote programmer so the patient can have multiple settings.

Q That's what this is, the program?

A Yes. And newer the devices the patients can have up to 16 different settings, and they can adjust the intensity, turn it off, turn it on. I had several patients where it's very helpful, the lives for those who need it.

Q Okay. Now is a neurostimulator also an effective treatment for occipital neuralgia?

A It can be. Typically the treatment will be try some injections, first. Pain management may try some blocks to -- do long-term blocking of the nerve. They may try ablation, but they can also, it's very common to use these percutaneous leads as well.

Q And is it your opinion, as one of Mr. Simao's treating physicians that he needs placement of a neurostimulator to most effectively treat his neurogenic pain?

MR. ROGERS: Objection, Your Honor, foundation, and the disclosure issues that we discussed.

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MR. EGLET: Same argument, Your Honor.

THE COURT: Noted for the record. Do you want a continuing objection, Mr. Rogers?

MR. ROGERS: Absolutely.

THE COURT: Very well, I'll note it for the record.

THE WITNESS: Answer?

THE COURT: Overruled. Yes.

THE WITNESS: Repeat the question, please.

BY MR. EGLET:

Q Is it your opinion as one of Mr. Simao's treating physicians that he needs placement of a neuro or spinal cord stimulator to most effectively treat his neurogenic pain?

A Well, the clinical answer would be he at least would need placement of a trial.

Q Okay.

A And the trial is important, because the trial tells you whether or not to do the permanent.

Q Okay. What I want you to do for us now, Doctor, is if you key in, I'd like you to outline for us the cost associated with the surgical placement of this spinal cord stimulator.

A Do you want to tilt that a little bit so I can -- it's not important, I guess.

Q Yeah. I'm just -- this is for the jury --

A Okay, good.

Q -- to see, and I'm going to just write on it and have you -- so you mentioned a trial stimulator would be the first thing.

So what would be the costs for the trial stimulator, including the surgeon's costs, anesthesia fees, surgical center, supplies, all of that?

A And the facility --

Q The facilities.

A -- basically everything?

Q Yeah.

A So, I'm sorry, for the trial?

Q For the trial of the stimulator?

A Approximately $84,000.

Q Eighty-four thousand?

A Yes.

Q Okay. And then the permanent placement of the stimulator by the spine surgeon, what are the total costs; the surgeon's fees, the anesthesiologist's fees, the hospital or surgery center's fees, the cost of the stimulator and equipment and all of that?

MR. ROGERS: Objection, Your Honor. The doctor's testified only to the trial not the permanent --

MR. EGLET: Your Honor, he has testified to both this trial and the stimulator, we're entitled to outline the cost.

THE COURT: Overrule the objection.

THE WITNESS: If the trial is successful and a permanent implant is indicated those costs altogether would be approximately 212,000.

BY MR. EGLET:

Q $212,000?

A Yes.

Q All right. Now, the -- is there normally a revision of the pulse generator battery that is done?

A On general the pulse generator, depending on how the patient uses it, may be replaced anywhere from three to seven years. I think a reasonable average is five years.

Q So the stimulator would have to be surgically replaced?

A We were just talking about the pulse generator.

Q The pulse generator.

A Which is basically the, you know, which is the power source and the computer.

Q And you said --

A Average, five years.

Q Every five years on average. And what's the cost of that?

A Approximately 141,000.

Q Okay. Now is there usually in people Mr. Simao's age, a revision that has to be done for the leads, at least once?

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A Well, the leads typically aren't as durable in the cervical spine, because there's simply a lot more motion. So there is a higher incidence of needing to replace the leads or revise a connection cable.

Typically if there's a problem it's usually right where it's going in. So on average that revision is approximately every two to three years for cervical. And --

Q Every two --

A Every two to three years. So say every two years.

Q And what's the cost of that?

A Approximately 103,000.

Q And then is there a requirement, any requirements if there's any follow-up? I mean, is this thing programmed with a computer or something?

A Typically what happens is, the patient, the first initial period over the first three months may need more frequent follow-ups to just fine-tune the programming.

So basically that involves seeing the doc and then having the clinical specialist from the respective company that makes the implant and altering the programming.

Q Okay.

A So average costs for that, including everything, it's typically about a thousand dollars.

Q And then you said that's how often?

A I would say in the first three months, it's twice.

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Q Okay.

A And then after that it varies. I would say I typically would see a patient back maybe every six months.

Q Okay. The follow-up is for programming in the first three months, you say how many times?

A Twice.

Q Twice, at --

A Approximately a thousand dollars.

Q One thousand dollars per visit?

A Yes.

Q So $2,000. And then you said -- then the reprogramming is every six months?

A On average, yes.

Q So that would be $2,000 annually?

A Yes.

Q Now, these neurostimulators, or spinal cord stimulators, are these something that normally are placed in, those are placed in the patients, these are lifetime things?

A Typically they keep them a long time. Yes.

Q All right. Now, is the need for the placement of the spinal cord stimulator in Mr. Simao directly and causally related to the motor vehicle crash of April 15, 2005?

MR. ROGERS: Same objection, Your Honor.

THE COURT: Same, duly noted for the record. Overruled.

THE WITNESS: Assuming, based on everything we've talked

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about on the issue of chronic pain, a four-year interval, yes.

BY MR. EGLET:

Q Based on -- Doctor, based on your experience in your treatment of this patient over the last number of years, and your understanding of his chronic pain, is it more likely than not that he's going to need the permanent placement of the spinal cord stimulator?

A Again, I would -- the permanent is contingent upon the trial. I'd say it's definitely more likely than not, he at least needs the trial.

Q I understand. But my question is this, Doctor: based on your experience and your understanding of his chronic pain, and your treating patients like him in the past, and this type of neuropathic pain, and understanding his problems, and based on year's experience, is it more likely than not that he will end up having a permanent placement of a stimulator?

MR. ROGERS: Objection; asked and answered. The Doctor already --

THE COURT: Noted for the record.

MR. ROGERS: -- responded to this.

THE COURT: Overruled.

THE WITNESS: I would say over my experience most of the patients I send for trials do have successful trials; so the answer is yes.

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BY MR. EGLET:

Q Thank you. Now, after your extensive evaluation, your treatment, your surgical interventions with Mr. Simao, have you reached any conclusions with respect to what injuries he sustained directly and causally by the April 15th, 2005 motor vehicle crash?

A I would say --

MR. ROGERS: Objection; foundation.

THE COURT: Overruled.

THE WITNESS: I would say that in a simplistic sense he injured the C3,4 and C4,5 levels, with the least significant component being discogenic.

BY MR. EGLET:

Q As well as intractable post-operative neuropathic pain syndrome?

A As well as what appears to be neuropathic pain.

Q And occipital neuralgia?

A And/or occipital neuralgia.

MR. ROGERS: Objection; leading, Your Honor.

THE COURT: Sustained.

BY MR. EGLET:

Q Are your conclusions regarding causation more likely right than wrong, Doctor?

A Yes, they're more likely right.

Q And beyond that are you certain?

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A Yes.

Q And could you please -- strike that.

Hypothetically, if someone told this jury -- well, I think I've already asked you. You answered that. You've already asked and answered that.

Has the medical care and treatment rendered by you and all of the physicians at Nevada Orthopedic and Spine Center, all of the treatment from University Medical Center and PBS Anesthesia, been necessary and reasonable and causally related to the injuries Mr. Simao sustained from his April 15th, 2005 motor vehicle crash?

MR. ROGERS: Objection; compound and the doctor hasn't been identified as an expert to comment on other providers.

MR. EGLET: Your Honor, speaking objection. You ruled on this --

THE COURT: I agree. I agree.

MR. EGLET: -- he's a treating physician.

THE COURT: Overrule the objection.

THE WITNESS: Yes.

BY MR. EGLET:

Q Now was the billing associated with all of the above treatment that you have described for us and provided to Mr. Simao, customary and reasonable for patients in Clark County Nevada?

A Yes.

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

A Yes.

Q Okay. And beyond that are you certain?

A Yes.

Q And 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 you mean that your conclusions are based on medical reasoning?

A Yes.

MR. EGLET: Thank you, Your Honor. I pass the witness.

THE COURT: Mr. Rogers.

MR. ROGERS: If the jury would like -- it's up to you, Your Honor.

THE COURT: Could counsel approach, please.

[Bench Conference Not Transcribed]

MR. EGLET: Oh, Your Honor, could I do one more thing, I'm sorry, before I pass the witness? He hasn't started yet.

THE COURT: Sure.

MR. EGLET: Your Honor, I would ask that this be marked as Plaintiff's next in order. And I would move this into --

UNIDENTIFIED SPEAKER: 65.

MR. EGLET: 65, move and have it admitted into evidence.

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THE COURT: Okay. It should be marked as proposed 65; any objection?

MR. ROGERS: Sure. All the objections are stated.

THE COURT: Your objection is noted for the record, 65 will be admitted.

MR. EGLET: Thank you, Your Honor.

[Plaintiff's Exhibit 65 Received]

THE WITNESS: There actually is one mistake on the bill there. It's two-pages, not one. Two levels, that's all.

MR. EGLET: So it's not the right amount?

THE WITNESS: Yeah. They just gave one, it's like two.

MR. EGLET: Your Honor, if we could go back on the record, the doctor's noted there's a mistake on the bill?

THE COURT: Sure. Back on record.

BY MR. EGLET:

Q Is this referenced -- do you have this referenced anywhere else? What exhibit number is the bills? Is this your bills?

A Exactly, it's basically the surgical bill. There was two pages and they only billed one.

MR. EGLET: The surgical bill, Robert?

MR. ADAMS: From University Medical Center is 9.

MR. EGLET: No, for Nevada Orthopedic and Spine Center?

MR. ADAMS: 6.

THE WITNESS: On the letterhead.

BY MR. EGLET:

Q 6.

A Yes. So 22851, that's just for one page, so it's two. So that should be 1900 times two.

Q Okay. Can you point that out? Okay. Right here?

A Yeah. Right here.

Q All right. So for the record, Doctor, you're identifying Exhibit 6, page 1, date of service, March 25th, 2009. It says "cage interior" and it's only billed for one cage --

A Correct.

Q -- at 1900 and should be two cages?

A Correct.

Q So that should be 3800; is that right?

A Yes.

Q Okay. Thank you.

MR. EGLET: Thank you, Your Honor.

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

[Bench Conference Not Transcribed]

THE COURT: All right. It seems, ladies and gentlemen of the jury, that we cannot conclude the examination of this witness, so we're going to have to ask Dr. McNulty to return another day. Tomorrow is apparently not the day he can return because of the scheduling of the witnesses.

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Mr. Rogers will be calling a witness out of order tomorrow afternoon, so that's what all the discussion was about, scheduling matters. And what that means is, we don't know yet when Dr. McNulty can return, so you'll have to remember what he said and wait until he's concluded his testimony.

There are a couple of questions that some of you asked. I'm going to read to him. He may be a proper witness to answer these questions. I don't know. The first one is photos of discs before surgery, question.

THE WITNESS: Photos?

THE COURT: Photos of discs before surgery.

THE WITNESS: What's the surgery?

THE COURT: I would -- I would imagine it means, are there photos of discs before surgery?

THE WITNESS: You mean like, taking a picture with a camera?

THE COURT: I don't know. You know as much as I do.

THE WITNESS: Okay. I would say that photos of the discs before surgeries on the MRIs, if you look at the x-rays and pictures when Dr. Rosler did the discograms, those are other pictures that show how the dye is going into the discs, plain x-rays. Those would be the closes thing to photos --

THE COURT: Okay.

THE WITNESS: -- because obviously, I mean, not to be too

simplistic, but I can't really take a picture of the disc unless you expose it surgically, and so --

THE COURT: Okay. I think that answers the question. The second one reads, how can two discs have the same fissure in about the same location, that one is painful and the other has no pain?

THE WITNESS: Well, I think there were three discs -- well, you had two discs that were painful. I assume we're talking about the discogram? Because we're able -- are we not allowed to ask a question to clarify?

THE COURT: No.

THE WITNESS: Okay. Assuming it's the discogram, where it talks about the fissures, basically when you talk about a fissure, you're injecting dye into the disc, and you're seeing the dye leak out of the disc and you're assuming it's a fissure. So I made the comment that the cervical discs are different than the lumbar discs. Lumbar discs are more common.

A discography is also done of the lumbar spine, the lower spine. Anatomically, that structure is more of a classic disc that's encased with a tough, essentially watertight, seal all around, whereas the cervical discs are a little different. At the sides of the cervical discs, they have these things called uncovertebral joints.

And I can actually show you. And these joints --

you see from the front, there's a little prominences of bone that go up, whereas a lumbar disc, everything's fairly flat. So the anatomy and the structure of a cervical disc is a little different, where it's not completely encased in a watertight, tough outer covering.

So even in the normal disc, if you put dye in it, you can have some leakage of dye out of the sides. So what's specific about that is that when they did the discogram, they tested three discs, C3-4, C4-5 and C5-6, the painful discs that were reproducing -- this was the mouth pain.

We're at C3-4 and C4-5. C5-6 did not cause pain, even though there was leakage of dye. So you can explain the leakage of dye just by understanding that subtle but important difference to anatomy.

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

THE WITNESS: I'm sorry. Let me --

THE COURT: Sorry.

THE WITNESS: But I think the question --

THE COURT: Sorry, Doctor. I thought you were finished.

THE WITNESS: Read your question once more so I make sure I answer it correctly.

THE COURT: How can two discs have the same fissure in about the same location, that one is painful and the other has no pain?

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THE WITNESS: Well, I'm at a little bit of a disadvantage because I haven't been -- technically been shown those pictures. But just because they have them, quote, unquote, in the same location doesn't mean it discredits or makes it confusing. It just happens to be that way.

THE COURT: Any follow-up questions by counsel?

MR. EGLET: No, Your Honor.

THE COURT: I'm going to be asked that these questions be marked as Court's Exhibits next in order.

THE CLERK: Yes.

THE COURT: There were a couple of other questions submitted by the jurors, but this witness is probably not the one to answer these questions, so I'm going to ask the Clerk to mark these and just hang onto them for now in the event that we get a witness who can answer them. Then we'll address the questions to that witness, whoever that might be. So I need those two back.

With the thanks of the Court, ladies and gentlemen of the jury, you may be excused. I remind you of your obligation not to discuss this case with anyone, not to form or express any opinion, not to do any research on any subject connected with this case. Please return tomorrow promptly at 1:00.

THE WITNESS: Friday at 1:00 start as well?

THE COURT: No. Friday's a noon start.

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[Jury Out]

THE COURT: Okay. You may be excused if you wish or you can stick around. It's all the same to me, sir.

UNIDENTIFIED SPEAKER: I'll talk to you after.

THE WITNESS: Okay. Well, I think, for what it's worth, I can make Friday at noon. I think I can do that.

MR. EGLET: We have to -- we have to -- and I'll talk -- I'll call you tonight. We have to coordinate with Dr. Grover.

THE WITNESS: Okay.

MR. EGLET: And it may very well be at noon, so -- but I'll let you know.

THE WITNESS: So you will try to affirm that this evening?

MR. EGLET: I'm going to try to firm that up.

THE WITNESS: Okay. All right. I'll get all my stuff.

THE COURT: Thank you. Okay. Outside the presence of the jury, Mr. Michalek?

MR. MICHALEK: Yes, Your Honor. I understand that the doctor was allowed to give a future care opinion. We are entitled under 26G to a computation of damages. We filed a motion in limine specifically on this issue.

And Your Honor, during the hearings on the motion in the limine, specifically said that you hadn't heard anything new, hadn't heard any discussion of any future care. This was a surprise today, that without any prior disclosure, certainly

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from a former member of the bench who would know that such documents would need to be disclosed under 26, we haven't got a copy of it.

It hasn't been produced to us and certainly not a listing of those damages. And the doctor should not be entitled to give a future care discussion when you violate rule 26 in -- regarding the computation of those damages. There are a listing of another ton of issues that the doctor should not be allowed to testify about.

I was beginning to discuss those earlier. We moved onto have his testimony, but the veracity of the witnesses -- Your Honor, there was a motion in limine that we filed that said experts, even medical experts, are not allowed to discuss or vouch for the credibility of their witnesses.

THE COURT: Mr. --

MR. MICHALEK: You granted our motion.

THE COURT: Mr. Michalek, I need to stop you there because now, you're repeating argument you made in a previous hearing, in a previous objection. You've already lodged your objection with respect to that. The Court's already ruled on it. I don't intend to allow you to revisit issues that you've already addressed. You've already made your record and the Court's already ruled on it.

MR. MICHALEK: Your Honor, my understanding was, when I tried to make that issue earlier, I was prevented from doing

so when you moved onto the other issue. I will note, for the Court, however, that every time there is an objection, three members of the Plaintiff's firm are up there, giving their ideas as to, you know, what should be or should not be allowed into evidence, only two of which are trial counsel.

I think the Defendant should be allowed the same leeway. I'm making my objections now. Otherwise, we're going to have a cavalcade of people coming up to the bench, making their arguments all the time. And I don't think that is what the Court wants, either. There was an issue regarding relationship between the doctors and the Plaintiff's counsel. And I believe there was an issue that was raised during the motion in limine.

And the Court actually said that there's two separate issues. You prevented us from making an argument about the medical build-up. But you said that the bias of the witnesses was certainly fair game. And I can point to that, actually, in the transcript, Your Honor.

THE COURT: Mr. Michalek, now, you're rearguing issues that the Court's already heard. Whether you made the argument or whether someone from your firm made the argument, the Court has carefully considered all of the motions, all of the briefs, all of the arguments and all the objections lodge. And the Court's made a ruling and I don't intend to revisit issues we've already discussed and addressed.

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MR. MICHALEK: The reason why I'm going over this, Your Honor, today, is because yesterday, there was a miscitation to the record. I'm pointing out in the transcript what Your Honor actually ruled. There were arguments made by the Plaintiff's counsel, while these motions were denied, that, that is not -- just because there is a minute order that says hey, your motions are denied, that does not accurately reflect what the Court ruled. And if I could --

THE COURT: Wait a minute.

MR. MICHALEK: If I am allowed --

THE COURT: Wait a minute. Wait a minute. Wait a minute. Let me address one thing, because you have misstated what the Court ruled. You said that the Court denied your motion regarding medical build-up. And what happened is, when I specifically asked counsel what evidence do you have that there -- that this case was -- that there was any sort of medical build-up, or that this case was attorney driven, counsel could not respond to that question.

MR. MICHALEK: I'm not --

THE COURT: You couldn't --

MR. MICHALEK: I'm not --

THE COURT: -- tell me -- you couldn't tell me one way or the other. And I realize it wasn't you making the argument, but from the Court's perspective, it really doesn't matter whether it's you, or Mr. Rogers or another defense attorney.

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It doesn't matter whether it's Mr. Wall, or Mr. Adams or Mr. Eglet. The point is, you've already made your record.

MR. MICHALEK: Sure. Your Honor, I think that -- I think I misstated or you must have misunderstood what I was trying to say. I'm not asking for argument about medical build-up. What I'm discussing is, during the discussion of the motion in limine on medical build-up, there was a discussion of bias of the witnesses.

And on page 34 of our transcript, we were discussing, Mr. Rogers and the Court, about medical build-up. And we were talking about there, the bias or the prejudice of the witnesses, that they may have some relationships, that had some prior relationships with counsel.

And the Court said that we would allowed to go -- would be allowed to go into that. You said, okay. The motion, as it was granted, i.e., talking about medical build-up, was granted. With respect to the other issues that you've raised, which I think are important issues for trial purposes, relating to bias of expert witnesses, how many times they've testified for example, for a certain firm and what kind of compensation they've received for their time, I think those are all fair game.

And yesterday, there was an argument about, well, the Court's ruling was, we couldn't get into bias or relationships. That's not true. The issue that you granted

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the motion in limine on, and I agree with the Court's ruling, was on medical build-up. It had nothing to do with bias or relationships. You said that those things were fair game. And we were prevented from doing that.

THE COURT: And I think they are fair game.

MR. MICHALEK: And -- well, Mr. Rogers --

UNIDENTIFIED SPEAKER: Well, we don't know he's -- she's said --

MR. WALL: That's absolutely incorrect. That is absolutely incorrect. What it -- was said in a hearing about relationships between lawyers and witnesses -- you said, if you want to make a specific point on that, file another motion in limine on that point specifically and the Court would consider it and rule on it after we had a chance to opposite it. Nothing has been filed.

THE COURT: That's my recollection.

MR. MICHALEK: So you're saying, because there wasn't a specific question brought up during pre-trial, we're not allowed to raise it during trial? Motions in limine, Your Honor, are certainly for the Court's benefit and I understand that. But if there's a specific question that comes to our attention, we should be able to raise that issue during trial, not just because we haven't brought that issue in a motion in limine.

Motions in limine certainly speed things along, but

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there's going to be issues that come up during trial that just can't be raised in a motion in limine, questions we discover through discussions with other counsel or through other witnesses.

Just because we didn't raise it before doesn't mean we shouldn't be able to raise it now. I think Mr. Rogers was attempting to ask that yesterday and he was simply precluded from asking any questions regarding bias or relationship.

THE COURT: Well, that's not true, Mr. Michalek. You're not really accurately representing the record. Mr. Wall's statement of what occurred is accurate. And the fact of the matter is, if the parties aren't going to comply with the rulings the Court makes in these pre-trial motions in limine, then what's the point of any of them being drafted and argued before the Court?

So I really don't appreciate the fact that you are rearguing issues the Court's already heard. The Court's taken a lot of time. I never cut any of you off. I let you argue to your heart's content on each one of these motions in limine and then we made a record. And now, you're revisiting the very issues the Court's already taken the time to hear and rule on, so I wish you would move onto some new material, if you have any.

MR. MICHALEK: Your Honor, look, I've been raised for 15 years in this jurisdiction and I've been taught by appellate

001835
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counsel how to make a record. And I will say, I'm just trying to do my job, which is preserve the appeal. Just because a motion in limine has been filed does not mean the objection should not be raised during trial. It does not mean that the Court can't have an opportunity to change their mind.

And what I'm trying to do is twofold. One, preserve the objection. Even though it was filed in a motion in limine, the Supreme Court tells me to raise the issue again during trial, to make the objection. And second, maybe my argument is going to change your mind, in which case I don't have that issue on appeal, I win that issue. And so that's what I'm trying to do. I'm not trying to waste the Court's time. If I bring something up, it's because I'm doing my job.

MR. WALL: Well, I don't think it's part of his job, whether trained by appellate counsel or not, to misstate what's in the record.

And I bet I can go back through this transcript, just in the last 48 hours, probably, and find eight to ten complete misstatements from Mr. Michalek about what's in the record, absolute misstatements, including the one that he's just -- the several that he has just made today, not even taking into account the ones he made on jury selection after not having been present during jury selection.

There are -- to my knowledge, there was not a single question yesterday of Dr. Rosler about any personal

001836
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relationships, that Mr. Rogers tried to make, that there was -- that we objected to that wasn't allowed to go into. I don't think there was a single question on that, and that wasn't the subject of what was brought up in the motion in limine. So --

THE COURT: Well --

MR. WALL: I probably shouldn't have even stood up, but I got to just -- I got it -- if the point of this, from their perspective, is to make a record to preserve it, you know what? That's fine. But don't misstate what happened in this courtroom.

THE COURT: Well, I agree, and here's the thing. When Mr. Michalek says that Mr. Rogers was prevented from exploring issues of bias with respect to witnesses that the Plaintiff called, that is simply not true. That is not true.

MR. MICHALEK: I'll move on, Your Honor. If that's your recollection of it, I will certainly accept the Court's recollection of it. There was discussion today by Dr. McNulty that he was more concerned with the patient, the Plaintiff, being more concerned about his head symptoms, and that, that overshadowed his neck symptoms. Now, we raised this issue and this came up at the pre-trial motions in limine. And it's on page seven.

Well, I'll start earlier, Your Honor. I'll start back at page four. And this is discussion about Mr. Rogers

001837
001837
001837

and he's raising the issue to the Court. And he's talking about it in the context of the motorcycle incident and aggravation of migraines. And he says, it didn't have anything to do with it and if the Plaintiff's doctors are going to get on the stand and testify, that in some fashion, this car accident aggravated migraines, well, the question is how?

What kind of migraine is it? Where does it come from? What's the generator? And if this accident could do it, did the motorcycle accident do it? And if the motorcycle accident did it, what's the difference between the two? We need to, now, explore this masking claim that's been made.

Essentially, what Dr. McNulty said was, well, the patient was more concerned about the head symptoms. This overshadowed the next symptoms, so there's this masking going on. And on page seven of the transcript, Your Honor said the motion is granted, although if Plaintiff's expert witness identified, and Mr. Rogers has indicated, then I think that's probably fair game for purposes of cross-examination.

MR. WALL: That's not correct. We were talking --

MR. MICHALEK: It's right --

MR. WALL: We were talking about the motorcycle accident. That was the motion regarding the motorcycle accident. Nobody has said that the motorcycle accident caused a migraine or even exacerbated a migraine. This is what I'm talking about,

about misstating the record. That motion -- and I didn't even look at the transcript, but I know what he's talking about. And the motion was on the motorcycle accident. Dr. McNulty never even mentioned it.

THE COURT: Well --

MR. MICHALEK: Well, Your Honor, the issue is --

THE COURT: And again, you know, it was Mr. Rogers who was here arguing it. Maybe that's -- part of the problem is that Mr. Michalek was not here arguing. Maybe that's why you don't recall what happened.

MR. MICHALEK: Your Honor, I'm reading directly from the transcript. The issue that Mr. Rogers is raising is this masking claim, this issue that, well, the Plaintiff did not make any complaints of neck pain because it was overshadowed or more concerned about his head.

And that specifically was what Mr. Rogers was raising on page four and specifically what the Court said yeah, I think that that's probably fair game. And now, I'm being told that that's inaccurate. Well, I'm reading directly from the transcript.

THE COURT: You're reading it, but I don't think you understand it.

MR. MICHALEK: Well, Your Honor, I can have Mr. Rogers come up here and tell you what his understanding was of the issue, and what we wanted to preserve and the claims we want

to make. I will tell you that this doctor has testified as an expert. He's vouched for the credibility of the Plaintiff. He's made these arguments about masking, about how -- about how the concern for the head pain is overshadowing the neck symptoms.

And I think, as with the motion in limine, if you were saying, well, you know, I'll consider it if someone's made that claim, well, he's made that claim now. So I would ask you take a look at that issue and say well, I think we're allowed on cross-examination to explore that.

MR. WALL: This is so confused. Here's what happens. He has a history of migraines. We accept it. We told them that. And then he has this injury. We discussed at the motion in limine that the fact -- you know what? He had migraines before. That's coming in and we agreed. And that's fine. And if they were exacerbated or any head pain is exacerbated by this accident, they can explain that.

And if they want to bring in the fact, you know what, he did have migraines before, absolutely, there's -- they're entitled. And that was the extent of the motion. So I don't know -- I don't know where you get from the motorcycle accident to masking because they're at polar opposites and none of them were even -- were even relevant to the discussion that we were actually having in the motion in limine.

MR. MICHALEK: Your Honor, I'll read from --

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MR. ROGERS: Your Honor, just a second.

MR. MICHALEK: I'll read from page three.

MR. ROGERS: Charles, just a second.

MR. MICHALEK: I'll read it.

MR. ROGERS: If I might, I remember in the opening, that the Plaintiff took great offense at the fact that I included the motorcycle accident in the record or on the display. And the truth was, I didn't have the transcript at that time, but that was -- my understanding was that if -- that the Court had a qualified position on the motorcycle accident.

And that really was the reason that I put it on there. There was no intent to sneak anything in. What Mr. Michalek is saying right now was that maybe the confusion that Dave's pointing at, that --

MR. WALL: I'm not confused.

THE COURT: I'm not confused.

MR. ROGERS: I'll --

MR. WALL: None of the court's confused.

MR. ROGERS: Your Honor --

MR. WALL: I believe Mr. Michalek's confused. And there was --

MR. ROGERS: Your Honor, I was --

MR. WALL: There is no medical person who can, or has or would ever say that the motorcycle accident has anything to do with any claim we're making in the case.

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And so when the order says your motion to prevent unrelated accidents, injuries, conditions is granted in its entirety, one of those things was, specifically, the motorcycle accident because there's no one to testify that it has any relationship to any injury claimed. It is unrelated and that was, in my mind, perfectly clear at the time of the hearing. It is perfectly clear in the order.

THE COURT: That's precisely my recollection.

MR. MICHALEK: Your Honor, I don't know what in -- what's in counsel's mind. On page three, it says -- this is Mr. Rogers, factually, what's going on in the case is, there's a 2005 car accident and the Plaintiff claims that the accident aggravated his pre-existing migraines, which in turn, masked a new injury of cervical problems, for which he later had surgery.

That's exactly what Dr. McNulty was saying, that there were more concerns over -- about his head. It overshadowed his neck symptoms. It's -- this is exactly the issue that was raised on page three. I'm not reading this transcript wrong. It's right there. Now, if that -- if the Court's going to deny it, that's fine. I'm not making this stuff up. It's right here in the transcript. I don't know what counsel's recollection is.

I'm reading, directly, the words. And he's talking specifically about an accident that aggravated his pre-

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existing migraines, which in turn, masked a new injury. So I resent the implication here that I'm coming up here without knowledge of something. I'm looking directly from the transcript.

Every time I've appeared in front of this Court, Your Honor, I've had a case citation to back up what I've said. I'm looking at the transcript and reciting it. So I resent these implications and the interruptions, you know, during my argument. You want to deny my motion, that's fine, but I'm reading directly from the transcript.

I'm just trying to make a record here and make it clear from the words used, not from someone's recollection, not from someone's understanding, the transcript. And this is the exact issue Mr. Rogers was raising.

THE COURT: Defense counsel was never able to link the motorcycle accident to any of the injuries that Plaintiff sustained. You were never able to do so before and I haven't heard you say anything today, that you can now do so.

MR. MICHALEK: I'm not trying to link the motorcycle accident. I'm trying to link the issue of, well, is there a -- is there a concern that this head pain is overshadowing neck symptoms? Well, if there is, then why is this being caused? How is this occurring?

MR. MICHALEK: Well, guess what? The head pain's caused from this accident. There is some pre-existing migraines, but

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the head pain is caused from this accident and that which they treated in April or May of 2005 may have masked some of the neck pain at that time, but it's not -- it's not from a motorcycle accident. It's from the accident in question.

MR. MICHALEK: Well --

THE COURT: Let's move onto the next issue. We've talked about this one enough.

MR. MICHALEK: I have raised that. Fine, Your Honor. The last issue is jury questions. I know that you're marking some that have been given and some that have been not given. I don't know if that occurred yesterday. I know you made a note of exhibits, or I guess, questions that are going to be read at some future point in time. Are those going to be marked for some purpose or --

THE COURT: All of the juror's questions -- whether they're read into the record and answered by a witness or whether they're not read into the record, they're all marked and included in the file.

MR. MICHALEK: Okay. So even if those -- will those just be held until a witness comes to the stand, apparently, that can answer those?

THE COURT: Well, as I told the jury, if it's a proper one to be given, to be asked and inquired into, then I'll ask, and inquire into it and if we have a witness who hasn't already been excused by the Court. We received -- one of the

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questions we got today had to do with migraine auras and that related to a witness that was excused yesterday afternoon, but we didn't get the question in until today.

As soon as we began, I think, is when we got the question. So I don't know whether we're even going to have a witness who will be able to answer that question. If we do, I'll ask the question of a witness. Counsel'll have to help me keep track of that one. The other one -- I don't even know if it's an appropriate question to ask, but in any event, they're all being marked and included in the record.

MR. MICHALEK: So I just, for clarification, Your Honor --

THE COURT: Which I told Mr. Rogers at a sidebar.

MR. ADAMS: Your Honor, I would just like to address one issue real quickly. And that's basically reiterating my argument that I made at the bench with regard to the spinal cord stimulator as a treatment option for Mr. Simao. As I pointed out at the bench, the Defense took several depositions in this case, many of which were treating physicians. In fact, they deposed Dr. McNulty earlier twice. Okay?

They deposed Dr. Seibel on August 20th, 2010. At that time, they asked him several questions about his treatment that he had provided and was providing. At the time of his deposition, he was still treating, and even through this day, by the way, is still treating Mr. Simao. One of the

questions that counsel asked him is, do you have a future treatment plan for the Plaintiff? And he responds at page 53, line 20 through 22, I don't right now in front of me.

He's asked further questions of why he doesn't have a future treatment plan right now. He keeps using that phrase, right now. And he says, well, from a diagnostic standpoint and based on the last time I saw him, I would pursue, again, a selective nerve reblock at C4 level. In other words, he needs to do a diagnostic block. In fact, right above that, he says for diagnostic purposes, he needs to do a diagnostic block before he can know what his next treatment plan and future treatment plan is of Mr. Simao.

Later on through the deposition, he's asked more refined questions with regard to his future treatment plan. And basically, he's asked a question from an associate at my office, who says okay, assuming that he has a positive outcome from that pain management procedure, what would your treatment options for or your treatment recommendations be for him?

And he answers, at page 68 of his deposition, lines one through 17 through 25, again from my perspective -- I'm not the spine surgeon -- but my job is to provide some diagnostics, but also some therapeutic interventions, which range from modalities we mentioned before.

Would it be medication management or repeat story injection or considered re-referral back to a surgeon to see

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if he felt that he was another surgical -- or other surgical interventions that could help alleviate, just based on those diagnostic results?

Then he's asked, again, by my -- by my associate. It says, okay, let's assume that it was negative. What would be your next step? And he says, well, if the results were negative, I'd probably continue to do myofascial treatments for him, medication management. He may not have any further intervention or surgical modalities.

Then he's asked, with regard to these modalities, what does he mean by these modalities and he's asked a specific question. At this point in time, is it foreseeable to you that he would be recommended for, say, an implant of an electronic stimulator or other type of pain relief modality such as a morphine pump for -- the response from the doctor was, I could see where some might consider that an option.

I don't consider it an option for an intrathecal device right now, again, going back to right now because, he goes on to say, he hasn't done that diagnostic test. Well, guess what, Your Honor? In fact, he does do the diagnostic test in November of 2010. That diagnostic test, as you heard today from Dr. McNulty -- my client received 75 to 80 percent relief. Okay?

Based on Dr. Seibel's deposition and his testimony, the fact that he had a positive outcome from that diagnostic

001847

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test means that -- now, that spinal cord stimulator is not now just a viable option, but now, it's a recommendation. Why? Because now, we have the diagnostic medical basis in which to recommend it now.

The doctors do, not us. The doctors have a medical basis now, based on the diagnostic results, to recommend a spinal cord stimulator as future medical treatment for Mr. Simao. So this whole thing, that they are surprised by this, is simply not true. They learned about it first as a viable option back in August. The procedure's done. The diagnostic test is done in November.

They could have re-noticed his deposition. As we heard here today, they noticed some doctors on two occasions. They never made the nexus, Your Honor, from what they learned about in the depo and then seen on the records. If they would have, I'm sure they would have deposed one of the doctors about that.

But that being a side, there were several questions about a spinal cord stimulator, morphine pumps and other pain management devices discussed in his deposition. Not one time did Defense counsel ask what the costs of those are. Now, I understand we got to give them their damages, but we don't have to do their job, Your Honor.

I mean, he's -- Mr. Rogers is a seasoned attorney. He could have asked that simple question and that would have

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been outlined for him. But he didn't. He didn't do that with any of the treating physicians in this case.

MR. ROGERS: This one, I'll respond to.

THE COURT: Well --

MR. ROGERS: Counsel aren't meant to divine a nexus. Counsel are meant to disclose under the rules. They clearly knew this before they came today. They clearly met with Dr. McNulty. They clearly took the time to bring in diagrams and to come up a projection for future damages, never once disclosing that this was an element of damages the Plaintiff would request.

We filed the motion because we said, look, fair is fair. We are telling you everything that we're bringing. Tell us what you're bringing. The rules require you to. They didn't. And that was the basis for the objection before you. I understand you've ruled on it, but to pretend that Dr. Seibel's testimony from four months ago constitutes notice when he said, I don't know what's coming, is an absurd proposition.

THE COURT: Your response, Mr. Adams?

MR. ADAMS: Yeah. You're right. Dr. Seibel's testimony, the procedure that's been done in November, the follow-up that was -- November 11th, the follow-up that was on November 23rd, the referral back to the spine surgeon -- this time, Dr. McNulty's partner, Dr. Lee [phonetic] on two occasions and the

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001849

very last record, which was last month, says no surgical options but pain management options.

As the doctor testified here today, this is a pain management device. I mean, how many -- there's a litany there now. There's, like, five pieces of either medical records or depositions that they are aware of this.

MR. EGLET: And let me just add something, Your Honor. Dr. McNulty is a treating physician. Under the rules in Nevada, treating physicians are not required to do reports and treating physicians are permitted, under Nevada law, to talk about the prognosis, future treatment and ongoing treatment. That's exactly what Dr. McNulty did.

And Your Honor, it is -- it is so hypocritical to me that it is beyond comprehension for Mr. Rogers to get up and try to claim ambush and unfair -- when his experts in this case -- I, quite frankly, in 24 years of practice, have never seen any anything quite like this. I've never seen a moving target quite like Dr. Fish [phonetic].

You're going to hear from him tomorrow. You're going to see what a moving target defense whore this guy is, who will lie on the stand and under oath about anything. And you're going to see that, I promise you, tomorrow. But let me give you an example of Dr. Fish. Dr. Fish does a report in this case.

MR. ROGERS: Is this relevant to the issue?

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MR. EGLET: Yes. It is.

MR. ROGERS: Is this relevant?

MR. EGLET: Sit down, counsel.

THE COURT: Well --

MR. ADAMS: All right.

MR. EGLET: You've had your say. I'm going to --

MR. ROGERS: Stop.

MR. EGLET: -- have my say.

MR. ROGERS: Stop. Back off.

THE COURT: I think -- I think -- yeah. I think it's fair. I think it's fair.

MR. MICHALEK: Your Honor, that's fine and I apologize. I should haven't interrupted.

MR. ROGERS: It's not --

MR. MICHALEK: I've been interrupted from several --

MR. ADAMS: No, no. Let him finish. I want to hear this.

MR. MICHALEK: Well, I just need to say this on the record. I've had -- been interrupted several times by Plaintiff's counsel, you know, when I'm trying to make my argument. I don't need counsel to say something. If the Court wants to tell me to sit down, certainly, I will. I am shocked at the lack of respect that is being shown from Plaintiff's counsel in this courtroom.

I have never seen it where counsel is going to

threaten someone physically with violence, directing things to take things outside, to yell at other counsel to sit down, shut up. These are things that professional attorneys do not do and I am shocked at the lack of respect that's being shown.

And I would ask the Court, on both sides, to direct both counsel, that from now on, proceedings in this courtroom should be directed, and arguments directed, to you. Counsel should not be making arguments to each other, or yelling at each other --

THE COURT: That's true.

MR. MICHALEK: -- or screaming at each other --

THE COURT: That's true.

MR. MICHALEK: -- or threatening them in any manner.

THE COURT: That's true. Consider yourselves all admonished. Mr. Eglet, please proceed.

MR. EGLET: I find it incredible that Mr. Michalek would come up with -- had the audacity to make that remark after some of the things he's said over the last two days and particularly, the extremely cheap shot that he took at Judge Walsh a few moments ago.

So you know, he ought to listen to what he has said in this courtroom and have a little introspection when he starts throwing stones at other people. But it is incredible to me that they have an expert, Dr. Fish, who has -- from his first report, changes his opinions in a supplemental report,

001852

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changes his opinions again. And I'm not talking modify or supplementing his opinions. Changes his opinions again.

Changes his opinions again in supplemental reports. And then, when Mr. Wall, on the day he deposes him, he completely changes all his opinions from all of his reports with no notice to us whatsoever. Now, this is a Defense expert who is required under our rules to do written reports, unlike the treating physicians in this case.

So it is so incredibly hypocritical to make that remark when -- and act like, oh, this is unfair, you know, their treating physicians are coming up with these statements that there -- that are -- they were on notice of, as pointed out by Mr. Adams. And it's completely and totally different from what their experts have done in this case. And I can guarantee you to this Court that Dr. Fish is going to come in here tomorrow with completely new opinions that have never been disclosed, Your Honor.

THE COURT: Well, I think the record's pretty clear. Mr. Adams made a pretty good record regarding the issue of notice. I think, clearly, there's no surprise here.

Anything else you need to address?

MR. ADAMS: One last thing, Your Honor. I mean, if Mr. Michalek wants to come to the bench, I welcome him there, but the crazy thing for him to bring this up today is just -- I just can't believe it because yesterday, one of my partners

001853
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says you know, it looks like you're overpowering the Defense when you three are up there.

And so you know what? Today, I made a conscious effort to keep my butt in the chair, except for one time when Mr. Eglet asked me to come up. And that was the argument that I made, because I was well-versed with this issue. Okay? Other than that, I've made a conscious decision to abide by my partner, Tracy Eglet's, recommendation to stay there or just two of us go up there.

But you know what? If Mr. Michalek wants to come up, that's fine. I don't know what he's referencing that there's only two trial counsel. If he was here the first day, I believe all three of us made an appearance on the record and he didn't look at that transcript. On the record before the jury panel, there -- the three of us were here.

THE COURT: Ms. Eglet was here, too, on the first day.

MR. ADAMS: That's true.

MR. MICHALEK: Your Honor, I don't think the point should be a cavalcade of --

MR. ROGERS: No, no. I'm tired. Let's just leave. I'm done with this.

MR. MICHALEK: -- people coming up to the bench. I think that, that doesn't help the process to have five people huddled around there, arguing. My point was simply that if you're going to allow the Defense counsel -- or Plaintiff's

001854
001854
001854

counsel two or three people to come up there and make arguments, then I was simply asking for the same leeway.

I don't think it's appropriate to have every counsel, every time, run up to the bench and make arguments. It labors the process in front of the jury. You know, it -- the more people that are up there, the more likely it is the jury's going to overhear something. You know, typically, the objections are heard when the jury's excused.

That's simply what I was doing, making my record now. You know, I don't want to run up there, and with everybody else and have six or seven people, you know. We just call people and have everybody stand there. And that's not going to look good in front of the jury and it's not going to help the process.

THE COURT: Well, it's up to you if you want to approach the bench or not. When I ask counsel to approach the bench, it usually isn't you, you and you, it's counsel, approach the bench. So whoever wants to come up here and have a conversation, feel free.

MR. EGLET: Thank you, Your Honor.

THE COURT: See you tomorrow.

[Proceedings Concluded at 5:01 p.m.]

001855

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001855

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.

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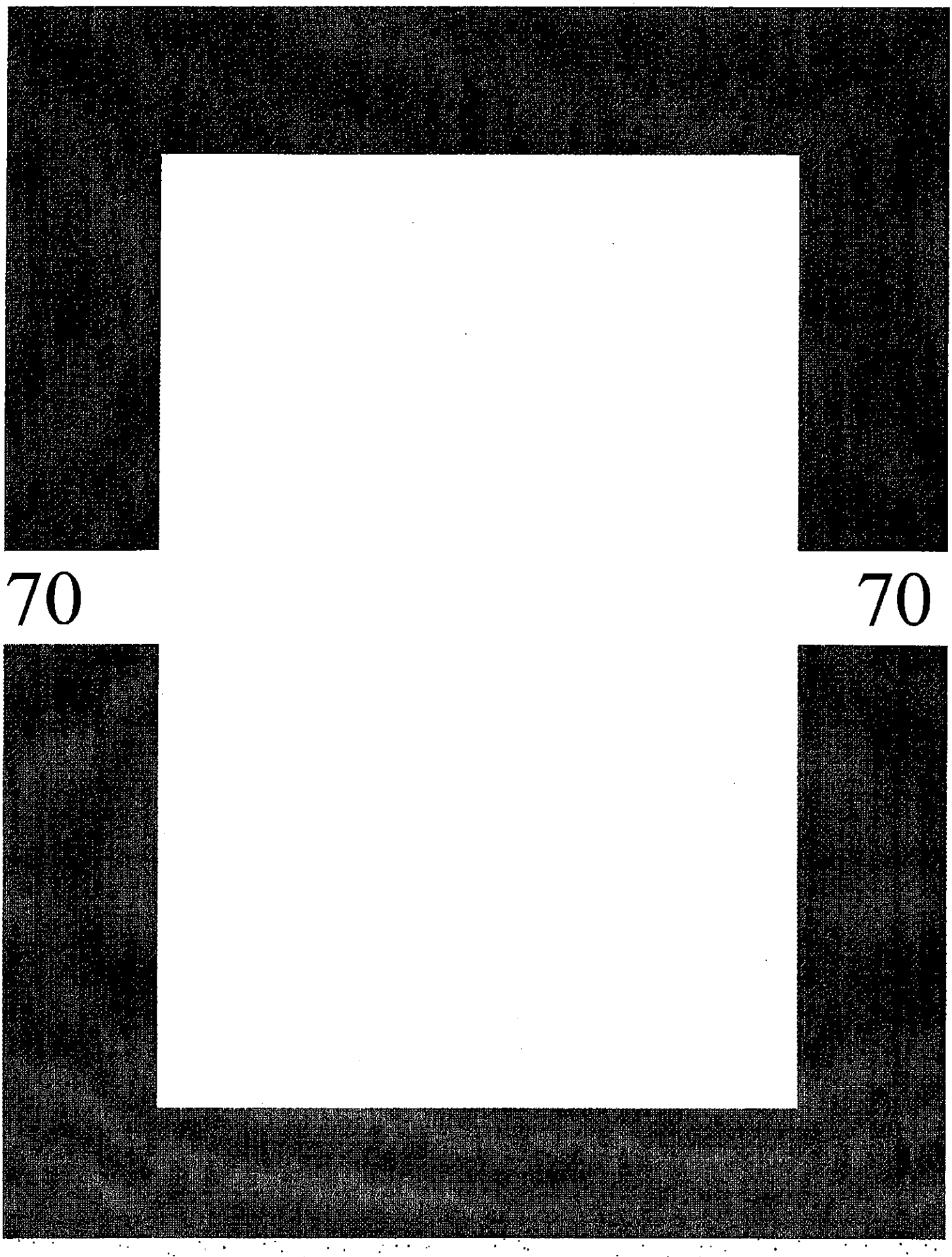

001857

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DISTRICT COURT

CLARK COUNTY, NEVADA

CHERYL A. SIMAO and WILLIAM J. SIMAO,

Plaintiffs,

v.

JAMES RISH, LINDA RISH and JENNY RISH,

Defendants.

CASE NO. A-539455

DEPT. X

BEFORE THE HONORABLE JESSIE WALSH, DISTRICT COURT JUDGE

THURSDAY, MARCH 24, 2011

REPORTER'S TRANSCRIPT
TRIAL TO THE JURY
DAY 4 - VOLUME 1

APPEARANCES:

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ROBERT M. ADAMS, ESQ.
ROBERT T. EGLET, ESQ.
Mainor Eglet

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Lewis and Associates, LLC

For the Defendant Jenny Rish: STEVEN M. ROGERS, ESQ.
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TABLE OF CONTENTS

001859

001859

001859

THURSDAY, MARCH 24, 2011 AT 1:00 P.M.

[Outside the Presence of the Jury]

THE MARSHAL: Department X is now in session, the Honorable Jessie Walsh, Judge, presiding.

THE COURT: Thank you. Good afternoon.

Okay, we ready to rumble?

Here's the thing. I don't want to hear any personal remarks directed at counsel by other counsel. It's not appropriate. I think it diminishes all of us.

I don't want to hear counsel say to other counsel, "Sit down and shut up."

And frankly, I have never, ever prevented counsel from making a record. I would hope that counsel would be able to make a record in an organized fashion, without re-arguing issues that have already been addressed.

So, what I propose is that instead of trying to do this at the end of the day, we address these issues at the beginning of the day. That won't work tomorrow, however, because we start at noon. So next week, if you have issues that we need to make a record of, we will do so at the beginning, which means you'll have to be present at 11:30 and we'll take 20 minutes; whatever you want to put on the record, we'll put it on the record. And we'll take a ten-minute break before we bring the Jury in.

Is that agreeable?

001860
001860
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MR. WALL: 11:30?

MR. EGLET: 11:30 or 12:30, Your Honor?

THE COURT: 12:30. Did I say 11:30?

MR. EGLET: You did, Your Honor.

THE COURT: 12:30 to 12:50 we'll make a record. At 1:00 we'll resume our jury trial. We cannot do that tomorrow, however, because we're starting at noon.

Are we still starting at noon tomorrow?

MR. EGLET: Yes.

MR. ROGERS: Yes, Your Honor.

THE COURT: All right. Is that agreeable with everyone's schedule?

MR. WALL: Yes, Your Honor.

MR. EGLET: Yes, Your Honor.

MR. ROGERS: It is, Your Honor.

THE COURT: Okay. Very good.

Any issues we need to address?

MR. EGLET: Yes, Your Honor.

We have a motion to make, Your Honor. The -- as the Court knows, Mr. Rogers is going to be calling one of his witnesses out of order; specifically who he is calling out of order Dr. Fish, who apparently this is the only day he's available to testify.

Dr. Fish is a pain management doctor, and so our motion addresses some of the opinions that he has attempted to

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offer in this case, particularly statements from his deposition.

Dr. Fish is not qualified to offer opinions regarding Mr. Simao's cervical spine surgeries. As the -- I hear an echo -- maybe I'm just hearing voices again.

As the Court knows, under Hallmark, two of the requirements is the expert must be qualified in an area of scientific, technical, or other specialized knowledge, and that the expert's testimony must be limited to matters within the scope of his specialized knowledge.

Dr. Fish does not have expertise with regard to spine surgery and any opinion attempted to be offered by him must be excluded as being beyond the scope of his area of expertise. And Dr. -- our motion is that Dr. Fish is prohibited from testifying regarding Mr. Simao's need for spine surgery. He's not a spine surgeon. He's never done spine surgery. In fact, he will get referrals from spine surgeons to do pain management diagnostic things, and then it is the spine surgeon along with the patient who makes the decision as to whether surgery is an appropriate treatment option for that patient.

Dr. Fish specifically opined in his deposition that Mr. Simao has never been a surgical candidate and that the cervical fusion Mr. Simao underwent was unnecessary and unreasonable. And Dr. Fish should be precluded from offering

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any opinions at trial regarding Mr. Simao's need for surgery.

Our Nevada Supreme Court has stated that and requires that expert testimony be limited to matters within the scope of the expert's area of expertise. And as the Court knows, under Morsicato, physicians must state, to a reasonable degree of medical probability, that the condition in question, i.e., the need for spine surgery, was or was not caused by the incident.

Here, Mr. -- Dr. Fish, a physiatrist and pain management specialist, is not a spine surgeon, has never performed cervical spine fusion or any spine fusion, for that matter, and actually refers his patients out to spine surgeons to make that assessment. He's unable to state to a reasonable degree of medical probability whether Mr. Simao required cervical spine surgery. That's not part of his expertise. Those decisions were made by his spine surgeons. And therefore, he's not qualified to render an opinion on that area.

And you know, the Defense is not in any way prejudiced by this because they have, in fact, another expert, Dr. Jeffry Wang, who is an orthopedic spine surgeon, who will be testifying next week, and whom we know, no doubt, will be offering opinions regarding whether he believes that Mr. William -- Mr. Simao was a appropriate candidate for the cervical spine fusions that Dr. McNulty did. But this is not

within the expertise of Dr. Fish. It's outside of the realm of his expertise. It would be improper to allow him to state such testimony.

THE COURT: Mr. Rogers?

MR. ROGERS: The extent of it, yes.

Well, Dr. Fish is qualified because he testified at his deposition that -- when asked that question,

"I'm qualified to give that opinion because I see a lot of patients that come through my door who've either had surgery, will have surgery, need surgery, want surgery, don't want it, or are candidates for surgery, and I make that decision every day."

Dr. Fish further testified that he has participated in many surgeries, including the spinal cord stimulator that Dr. McNulty testified about yesterday. The fact that he is in the O.R. and part of this process and part of the decision-making process, working along with surgeons every day, makes him more than qualified.

If you like, we can make the foundation when he's on the stand and approach this then. But at a minimum he should be permitted to discuss his qualifications before a decision is made.

THE COURT: I thought Dr. Fish was a psychiatrist.

MR. ROGERS: Oh, no. No, he's --

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MR. EGLET: A physiatrist.

MR. ROGERS: -- a physiatry specialist.

MR. EGLET: Pain management specialist.

MR. ROGERS: Yeah. Physiatry, which is a pain management also. And he does surgical procedures all the time, including, as I said, the installment of spinal cord stimulators.

THE COURT: Does he perform spine surgeries?

MR. ROGERS: That's a question I'd like to ask him on the stand. If I remember his testimony right, he said that he is involved in the performance of some spine surgeries. The extent of the involvement I don't recall off the top of my head.

MR. EGLET: He is not involved at all. And I've read ten depositions on this gentleman now, all of them where he has stated, yes, he is involved -- we're not talking about spinal cord stimulators here. That's a different issue. He may be involved with the -- with spinal cord stimulators, but in all -- every deposition, he has admitted that he is not a spine surgeon, he's not board-certified or fellowship-trained in spine surgery. He's never done a spine surgery. He's never assisted in spine surgery. He's never been in the operating room when a spine surgery has occurred.

He's not qualified to talk about spine surgery or the need for spine surgery. He refers his patients to a spine

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surgeon; specifically, Dr. Wang, who makes those decisions. And just because Dr. Fish makes this self-serving statement in his own deposition that he believes he's qualified to give this testimony or this opinion, that doesn't make him qualified or -- or to make the -- to give the testimony.

It's based on what the Supreme Court set forth in Hallmark. He is not qualified in this particular area. He's not a spine surgeon. He shouldn't be allowed to get up on the stand, someone who's never once done spine surgery, been trained in spine surgery, and we're going to allow him to get up and criticize a fellowship-trained, board-certified spine surgeon on whether somebody's an appropriate candidate for spine surgery?

I'm not saying he can't talk about pain management. That's a different issue. But when it comes to spine injury, he's not qualified. Plus, it's cumulative. They've got an expert on this. They have a spine surgeon who's testifying next week.

MR. ROGERS: Well, they -- if I can respond, Your Honor.

THE COURT: Sure.

MR. ROGERS: They have another spine surgeon they're bringing in addition to Dr. McNulty for that. So I'm not sure that there are grounds to complain about cumulative.

MR. EGLET: He's a treating physician. Totally different.

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MR. ROGERS: It'd still be cumulative, whether it's expert or treating. If it's been said before, that's cumulative.

Now, if -- at a minimum what we have now is a question of fact for the Court to consider. If Plaintiff's counsel wants to voir dire the witness right now on his qualifications to offer expert opinion testimony regarding the necessity of surgery, then let's bring him in and have that question answered before the Jury comes. And then that way we'll know there won't be error.

MR. EGLET: Well, we don't need to voir dire him on this particular issue. I'm -- that's another issue that I want to talk to the Court about, voir diring this witness, but there's no reason to voir dire him on this issue. We know what his education is, we know what his training is, we know that he's not a spine surgeon, we know he's never done any spine surgeries before.

We know that he -- that Dr. Wang, primarily, who he works with at UCLA, is a spine surgeon that he works with -- probably other spine surgeons as well -- but makes those ultimate decisions with the patients, not Dr. Fish.

MR. ROGERS: I'm not sure who "we" are. The question is, is the Court satisfied that there's a lack of foundation, and Dr. Fish's testimony on this question would answer that.

THE COURT: The motion is granted.

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MR. EGLET: Your Honor, the second issue is we would like to voir dire Dr. Fish outside the presence of the Jury.

As the Court knows, there is a significant number of motions in limine, pretrial motions that were granted by the Court, precluding the discussion they're bringing in about a great many issues. Virtually every single one of these issues, Dr. Fish talked about extensively, that the Court has precluded in his deposition.

And we want to confirm, in front of the Court, in the presence of the Judge, that this witness understands the pretrial court's rulings and will not violate those rulings, because we've already had that occur in the opening statement. I don't want to see a witness get on the stand and all of a sudden we have more of these violations, more of these things come out, and we can't unring the bell.

It would take a very short period of time for us to run through that.

THE COURT: Is Dr. Fish here?

MR. ROGERS: He is. Shall I -- I don't know where -- he was in the courtroom, and someone asked that he be removed. I'm not sure where he is right now.

MR. MICHALEK: I think they asked that he step outside until we were finished, Your Honor.

THE COURT: Let's bring Dr. Fish in.

[Pause]

THE COURT: Please come forward to the witness box, sir. You want to stand and raise your right hand.

DR. DAVID ELI FISH, DEFENDANT'S WITNESS, SWORN

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

THE WITNESS: David Eli Fish, D-a-v-i-d E-l-i F-i-s-h.

THE COURT: Whenever you're ready, Mr. Eglet.

MR. EGLET: Thank you.

VOIR DIRE EXAMINATION

BY MR. EGLET:

Q Good afternoon, Dr. Fish.

A Good afternoon, sir.

Q My name's Robert Eglet. I don't think we've met before.

Dr. Fish, I want to go through with you, to make sure it's clear in your mind on the record, what the Court's rulings on this case are, pretrial, and so you understand what you are permitted and not permitted during your testimony to discuss with this Jury, okay?

A Okay.

Q All right. The Court has ruled that Mr. Simao pulling a muscle in his low back 23 to 24 years ago while moving a keg of beer at California Beverage Company is excluded. You may not discuss that, comment upon it, infer it, or imply that it occurred to the Jury. Do you understand

that?

A Yes.

Q The Court has also ruled that a motor vehicle accident that Mr. Simao was involved in 25 years ago, wherein he was pulling a boat with his pickup truck, and another vehicle hit his boat and knocked it off the trailer, that's excluded. You can't comment about that, make any reference to it. Do you understand that?

A Yes.

Q Okay. The Court has ruled that any prior or subsequent injuries, prior injuries or subsequent injuries to this motor vehicle accident that we're here about, and accidents including, but not limited -- including, but not limited -- to the motorcycle accident in 2003 and the motorcycle acc -- and the motor vehicle accident in May 2008, are excluded. Do you understand that?

A No, I don't.

Q Okay. Well, you cannot comment upon that, you cannot -- you're not to refer to that, you cannot state if anything you say is based upon that. You cannot inform the Jury about that. Do you understand that?

A You mean the accident that we're talking about?

Q No, no, no. These other accidents.

A Oh. 2008 --

Q The motorcycle accident.

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A The motorcycle accident was in 2005?

Q There's a couple of motorcycle accidents, I believe, Is that -- yes. You cannot --

MR. WALL: There's just -- I think there's some confusion on this.

MR. EGLET: There's just one. Excuse me.

THE WITNESS: Just one, yeah.

BY MR. EGLET:

Q You cannot talk about that. You cannot inform the Jury about that. You cannot state anything about that. You cannot refer to that; imply that it occurred; reference it.

A Okay.

Q Do you understand that?

A I got the motorcycle one. What was the other one?

Q Accident in May of 2008.

A Oh.

Q You understand?

A No. I don't.

Q Well, I'm telling you that's the Court orders. Do you understand that's a Court order?

A I understand the order.

Q Okay. Are you going to comply with that order?

A I will comply as best I can. I mean --

Q Well, are you going to mention that accident to this

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Jury?

A It depends on the question, I guess.

Q Well, if you mention that accident to this Jury you'll be in violation of a Court order. Do you understand that?

A Now I do.

Q Do you understand there are ramifications for that?

A No, I don't.

MR. EGLET: Want to explain it to him, Your Honor?

THE COURT: Well, the Court would have a number of opportunities, I suppose, to sanction you. I guess the Court would possibly entertain a motion to strike you altogether as a witness and to advise the Jury to disregard any of your testimony.

I imagine there'd be a number of sanctions that might come to mind.

THE WITNESS: Okay.

BY MR. EGLET:

Q I'll ask you again. Are you going to mention that 2008 accident?

A No.

Q In front of this Jury?

A I hope not.

Q I hope not, too.

A Yeah.

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Q Okay. The Court has also ruled that any unrelated medical conditions, with the exception of a mouth tumor, cannot be mentioned or referred to or the Jury cannot be informed of. These unrelated medical conditions include, but are not limited to, high blood pressure, allergies, colds, flu, and high cholesterol.

Do you understand that?

A I can't refer to them?

Q You cannot refer to that. Do you understand that?

A Okay. I understand that.

Q You cannot -- the Court has ruled that you cannot infer or imply that there's been any improper use of prescription medications. Do you understand that?

A Yes.

Q Okay. You cannot testify, infer, imply, insinuate, or in any way suggest that Mr. Simao is a symptom magnifier, a malingerer, manifesting any secondary gain motives, or anything in that area. Do you understand that?

A No.

Q Well, you can't. That's the ruling of the Court. Do you understand that?

A No. I don't understand that.

Q Well, that's the order of the Court, sir.

A Huh.

Q Are you going to comply with that order?

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A Yeah, I'll comply, but I don't understand it.
Q You're not a lawyer, are you?
A No, I'm not.
Q Okay.
A I'm glad you pointed that out.
Q Thank you.
So. You are going to comply with that, right? You're not going to suggest any secondary gain, that he's a symptom magnifier, a malingerer, or anything in that area, correct?
A I guess not.
Q Thank you.
The Court has ordered that you can -- that you, nor anyone else, can suggest that this case is a medical build-up case, or attorney or medical-driven. Do you understand that?
A Yeah, I understand that.
Q You under -- you're going to comply with that?
A Absolutely.
Q Okay. You cannot mention any collateral source payment. You cannot mention whether there was insurance payments, whether this is covered under insurance, whether this is covered under Medicare or Medicaid, and you cannot mention whether anybody has any liens on this case, including medical liens. Do you understand that?
A Yes, I understand that.

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Q You're going to comply with that?
A Yes.
Q Okay. You cannot mention, at this time, any sub rosa vehicle -- video, any video of our client that may have been taken and shown to you. You cannot talk about that, you cannot mention it, you cannot refer to it in front of this Jury. Do you understand that?
A Not really, but I'll comply if that's what you want.
Q Well, it's what I want; it's what the Court's order is, sir.
A Okay.
Q You understand?
A I understand.
Q Okay. You cannot talk about --
A But can I -- can I clarify that?
Q Yes. Sure. You have a question?
A So there was a video taken of him.
Q Yeah, you --
A I can't say that I looked at any --
Q You cannot.
A -- of the actions within that video?
Q You cannot.
A Or motions within that video?
Q You cannot. Do you understand that?
A (Nodding) Yeah, I understand that.

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Q Okay.

MR. ROGERS: Your Honor, I'm not sure that that actually accurately states the order.

MR. EGLET: That absolutely accurately states the order.

THE COURT: Well, the video may not come in at all. If it comes in, it may come in for impeachment purposes, but we don't even know whether -- we don't know what the Plaintiff is going to testify to, so we don't know whether anything that was contained on that video will serve to impeach him.

That was my recollection of the Court's ruling.

MR. ROGERS: That's mine, as well. But there's a nuance here that I think the doctor is suggesting, that isn't being answered by these questions, and that is, if the doctor is asked how the -- what were the Plaintiff's physical abilities, for example, at the time of the independent medical examination, which was close in time to the surveillance, that he would be able to say, well, I examined him and he was able to do X, Y, and Z.

He could also say, also, I'm aware that he could do, for example, lift machinery. Something that was shown in the surveillance, but without even using it as an impeachment tool, he's simply saying, I'm aware that he's capable of doing this.

MR. EGLET: Your Honor, that is absolutely not true. Lord knows that the order of the Court is that this video is

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completely and totally excluded until the Court hears the testimony of the Plaintiff and, after it reviews the video, determines whether there's anything the Plaintiff testifies to that is inconsistent with what's in the video, and whether it's proper impeachment or not. That's the Court's order.

Here's the order, right here.

MR. WALL: At the bottom.

MR. EGLET: It is further ordered the Plaintiffs request to exclude sub rosa video is deferred until after Plaintiff's direct testimony, so the Defendant can establish how it impeaches the Plaintiff. Defendant is precluded from showing the sub rosa video or referring to it until that time.

The order is clear.

THE COURT: That is true.

MR. ROGERS: I don't think I'm being clear on this one. Because it's something aside from the reference to the video.

What it is, is knowledge that the doctor has without even disclosing the source of it. He can say --

THE COURT: You know what troubles me, Mr. Rogers. What really troubles me, listening to you. It seems like you're trying to get around the Court's previous ruling. The ruling is really clear. It's right there in black and white, as Mr. Michalek is so fond of saying. It's as plain as it can be.

And what I would hope is that there aren't any questions asked this witness or any answers given by this

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witness that would violate a Court order.

MR. ROGERS: All right.

MR. MICHALEK: Your Honor, the only thing I would ask is that maybe at the end of the day, after we've excused the Jury, just -- we won't be able to recall this witness. You know, he'll be out of town performing surgery in UCLA, but we just ask the questions off the record.

That way, at least if the video does come in and there's a later Court ruling on it, we could at least have the transcript and we could read those questions to the Jury, should the Court allow them to be read in a -- you know, at a subsequent time. Certainly, that's not going to happen --

THE COURT: What questions, Mr. Michalek?

MR. MICHALEK: Well, questions about what the doctor did see on the video. I don't know whether those will be relevant. I don't know whether the Court's going to allow them in.

But we could simply do that outside the presence of the Jury, after the testimony. Take up maybe five minutes, and if the Court does rule later on that the video is admissible, we could discuss then whether the doctor's testimony would be admissible at that point, and that can simply be read to the Jury, rather than flying him back out from California to answer those five questions .

MR. EGLET: Your Honor, we have relied on this Court's

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rulings. They're the ones who have put this witness on, on this day.

We're not prepared to cross-examine him on this area. We shouldn't have to be prepared to cross-examine him on this area.

THE COURT: Well, let me say this. It's already 1:30. We haven't even let our Jury in yet. Is this the only witness we're going to be with today?

MR. EGLET: Yes, Your Honor.

MR. ROGERS: Yes.

THE COURT: We don't have the ability to go past 5:00 because the Court has been instructed by the County not to incur any overtime costs for staff, given the economic crisis that the country and this state is in. So I doubt very seriously whether we'll have time to even address that question.

Anything else?

MR. EGLET: Yes. Moving on, Your Honor.

BY MR. EGLET:

Q Doctor, the Court has ruled that any photographs of the vehicles involved in this accident or any repair estimates are excluded. I know you were provided photographs and repair estimates. You are not permitted to refer to them, talk about them, or rely upon them. Do you understand that?

A Which specific parts again? The photos?

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Q Photographs of the vehicles involved in this accident.

A Uh-huh.

Q And repair estimates of the vehicles involved in this accident.

A What about the accident itself?

Q Yeah, we're going to get to that. You don't get to talk about the accident either. You don't get to talk about -- you've already been excluded to giving testimony as to whether this accident was severe enough or not to cause an injury. You cannot testify about that.

Do you understand?

A No.

Q Well, are you -- let me ask it this way. Are you going to comply with those Court rulings?

A Absolutely, but I don't understand them.

Q Well, I'm not asking you whether you understand the basis of the rulings. I'm just understanding -- asking you if you understand that that is the ruling?

A I mean, I was brought in here to understand the medicine, and that's a component of what I'm understanding --

Q Are you going to comply with the Court's ruling?

A I am obviously going to comply with it, but I don't understand it. I mean --

Q You are not going to --

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A -- I'm doing the best I can to --
Q Well --
A This was an accident, was it not?
Q It was a car accident.
A We can't talk about the accident?
Q You don't get to talk about this.
A That seems kind of strange to me.
Q Well --
A I don't understand.
Q We're not going to re-argue the motions in limine.
THE COURT: No, we're not.
MR. EGLET: This is the Court order --
THE WITNESS: I'm not arguing it. I'm just saying I don't want to -- I don't want to be in contempt of court. I don't want to get in trouble.

I'm just saying that it seems strange that we're talking about an accident and I can't even talk about the accident. That just seems strange to me, that's --

THE COURT: You know what seems strange to me? That this witness obviously doesn't have any idea what the Court has ruled prior to these motions in limine.

Were you about to say something, Mr. Wall?

MR. WALL: Actually I was writing a note to Mr. Eglet, to hand it to him.

Obviously, no one told him of the rulings.

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THE COURT: Yeah. That really concerns me. I hope that's not the case with the other witnesses Defense intends to call.

MR. ROGERS: If I could just clarify this question that Mr. Eglet just asked, because it was compound. It started out with photographs and property damage estimates, and that is, I believe, something the doctor is aware of.

Then it became a sort of hazy question about not discussing anything about the accident.

MR. EGLET: Well, no. I don't think --

MR. ROGERS: That is a little confusing.

MR. EGLET: I don't think it was hazy. I specifically said -- and this is a very separate court order on this -- that this witness, no Defense witness, is permitted to talk about the mechanism of injury.

You can talk about the fact that there was a motor vehicle accident, that it was a rear-end motor vehicle accident. But they don't get to suggest or imply that it was minor, that it was a tap, that it was low speed, that there was not much property damage, or anything like that, or suggest that it was such a small accident that these injuries couldn't have occurred.

BY MR. EGLET:

Q Do you under -- that is the court ruling. Are you going to comply with that?

A Absolutely I comply with it. I just don't understand it, that's all.

THE COURT: I don't know that it's necessary for you to understand the legal analysis and reason that the Court made the --

THE WITNESS: Yeah.

THE COURT: -- decisions it made --

THE WITNESS: Yeah.

THE COURT: -- after entertaining lengthy argument on both sides by counsel. I think it's only important and necessary that you understand what the Court's rulings are, so that you can follow those rulings and not be in contempt of court.

THE WITNESS: Yeah. I mean, I obviously want to do that. I just, you know, the evaluation of the medical component relies on something happening or an injury that has occurred, and it seems strange that I can't talk about the actual mechanism of that injury. It's just --

THE COURT: I'm hopeful that the questions will be narrow in their focus so that this witness can comply with the Court's orders.

MR. ROGERS: Very good.

THE WITNESS: Yeah, please. I mean, if I -- I don't want to be in contempt of court. It seems like there's a lot of rules on here that I didn't know about, and it just seems

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strange to me, that's all.

BY MR. EGLET:

Q That's why we're doing this right now.

A Absolutely. I appreciate that.

Q Next, Doctor, is you may not refer to the Nevada Highway Patrol incident report and the police officer's opinions pertaining to this motor vehicle accident. Do you understand that?

A Yes, I understand that.

Q Okay. We talked about property damage estimates. You can't refer or rely or say anything about them. Do you understand that?

A Yes.

Q Okay. We talked about the nature of the impact of the subject collision, including any reference or comment or testimony that the impact was minor, low speed, a tap, low property damage, anything like that. Do you understand that?

A Yes.

Q Okay. You may not refer to any alleged federal investigation that's going on -- well, it's over with now, but went on here in Clark County regarding some doctors and lawyers here in Las Vegas. Do you understand that?

A Yes.

Q Okay. You understand you cannot refer to yourself as an independent medical examiner.

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A What am I?

Q You are a Defense medical examiner. You are not independent. You cannot refer to yourself as an independent medical examiner. You understand that?

A Yes.

Q Okay. You cannot refer or imply or make any statements to the Jury that, well, I can't talk about this, or I can't say this or I can't mention this, because the Court has ruled in pretrial motions, or something to that effect; I can't say this.

Do you understand that?

A I understand that.

Q Okay. You cannot speculate, suggest, or imply that there may be medical records out there on Mr. Simao that you or no one else has never seen. Do you understand that?

A Yes.

Q In other words, you can't say, well, I don't know if there's any medical records prior to this accident which would document that he had a neck pain before this accident, because I don't know, I never saw them.

You can't speculate or hypothesize that something may be out there. Do you understand that?

A I understand that.

Q Okay. Okay, and you are precluded from offering any opinions regarding biomechanics or the nature of the impact of

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the motor vehicle collision in this case. Do you understand?

A Can I have a list here, so I can know what they are? I mean, I'm not -- this just seems like a very long list. I hope I remember them all. I mean --

Q Well, the truth of the matter is, you should have been informed of all this. These -- weeks ago --

A Well, I mean, I was informed of some, but I didn't realize this was such a large list. I mean, is there a way I can have it just here, so I can refer to it to make sure?

Q I -- you know -- I don't know. This, this list is --

MR. MICHALEK: Your Honor, if we could have a little leeway on direct examination to lead him through some of the minefields, so that there won't be any sort of mis-citation or misstating of any of those items, I think we'll be fine.

MR. ROGERS: The biomechanical question that Plaintiff's counsel just asked about really is the same as the minor impact and photographs and property damage statement. The doctor's aware, and we'll comply.

BY MR. EGLET:

Q You can't talk about the opinions and what kind of forces you think were imparted in the crash or anybody's body. Do you understand that?

A I understand that.

Q Okay. Any of these orders which I just told you

about that you don't understand; you want clarification on?

A No.

Q Okay.

[Counsel Confer]

BY MR. EGLET:

Q Oh. Oh, finally. The Court has ruled that you may not offer an opinion as to whether Mr. Simao was an appropriate candidate for spine surgery or not. You may not offer an opinion as to whether any of -- whether Dr. McNulty did a necessary or unnecessary spine surgery in this case.

Do you understand that?

A I, I'm not going to say anything about unnecessary spine surgery, but I --

Q You're not permitted to --

A I can't say anything about whether or not he is a candidate for surgery?

Q That's correct. You cannot.

A Okay.

Q Okay.

MR. EGLET: Thank you, Your Honor.

MR. ROGERS: And, Doctor, that was an order entered just before you walked in.

We are -- I think are ready to proceed.

THE COURT: Okay.

MR. ROGERS: Actually, though, could I have just a moment

with him to discuss the order that the Court just entered?

THE COURT: Sure. Take a five-minute break.

MR. WALL: Actually, Judge, before you depart.

Can we have an order from the Court of each and every one of those pretrial motions we discussed with each and every witness that the Defense intends to call so that we have at least some backdrop against which an expert or some other witness knows what they're to testify to and what not to?

THE COURT: Yes. So ordered.

MR. ROGERS: Okay. If Plaintiff's counsel would kindly provide this list that they just discussed with Dr. Fish, I will happily supply it to every other witness we're going to bring.

THE COURT: I would think you would have had your own copy, but -- do you have any objection, Mr. Eglet?

MR. EGLET: We'll provide him a list, Your Honor.

THE COURT: All right.

MR. ROGERS: Thank you.

[Recess]

[Within the Presence of the Jury]

THE MARSHAL: Please remain in order. Department X is back in session.

THE COURT: Please be seated. Good afternoon, ladies and gentlemen of the jury.

THE PANEL: Good afternoon.

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THE COURT: Two quick things. First of all, on behalf of the Court and counsel and the parties, I apologize for the delay. It was unavoidable. There were a number of things we had to discuss outside your presence as a matter of law.

Second thing is we have a new substitute clerk, Phyllis Erby [phonetic]. She's filling in for my regular clerk, and I appreciate her service. So I wanted to introduce you to her. I think you met Mr. Castle on the first day of jury selection.

I think we're ready to proceed, Mr. Rogers.

The new witness, we need to ask him to stand and be sworn, please.

DR. DAVID ELI FISH, DEFENDANT'S WITNESS, SWORN

THE CLERK: Please be seated. State and spell your name for the record.

THE WITNESS: David Eli Fish, D-a-v-i-d-E-l-i-F-i-s-h.

DIRECT EXAMINATION

BY MR. ROGERS:

Q Hello, Dr. Fish. Thank you --

MR. EGLET: Judge, I'm sorry to interrupt. Before Mr. Rogers begins, could we just have the Court let the jury know that we haven't rested our case but, rather, that this is a witness --

THE COURT: Right.

MR. EGLET: -- we're taking out of order to accommodate

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the defense.

THE COURT: I can't remember if I mentioned that yesterday, that this is a witness out of order. This is one of Mr. Rogers' witness. We have to accommodate these various witnesses, because some of them come from out of state. It happens with both sides. But it's true, the Plaintiff has not rested their case in chief yet.

Mr. Rogers.

BY MR. ROGERS:

Q Okay, Dr. Fish, thanks for taking time out of your schedule to come here today. Now in my opening I told the jury a little bit about you, and I'd like you to tell them a some more of the specifics of your expertise. So to begin with, if you would tell the jury where you went to medical school.

A I went to New York Medical College in New York.

Q Okay. And I understand you obtained a Master's Degree?

A Yes. At the same time I got my Doctorate in medicine I had a Masters in public health.

Q Okay. What is public health?

A Public health is how, basically, the health affects the community. It affects all of us. So it's the public component of the healthcare, the delivery system, and the administration of that system for the population and community

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at large.

Q Okay. And then, as I advised them, you served in the military as well.

A Yes.

Q What'd you do there?

A I was in the U.S. Army. I paid for medical school since it was expensive. So I spent three years in Europe. One of those years I spent in Bosnia, in 1996, as a general medical officer. So it was after medical school. I was able to go to Europe and serve my country as a physician.

Q Okay. And after completing your service in the military, did you return to school?

A Training.

Q Okay. What kind of training?

A So I -- my specialty is physical medicine and rehabilitation. And I was fortunate enough to get into Johns Hopkins for training for the residency program.

Q Okay. And I understand that you were appointed to the chief resident there.

A Yes. One person out of each class is given the opportunity to become chief resident for the residents. So it's the person who interfaces between the attending staff and the resident training.

Q Okay. And what did you do after completing your residency?

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A I secured a fellowship in pain medicine at UCLA, West LA VA, Veterans Administration in Los Angeles.

Q All right. What year did you complete your fellowship?

A 2002.

Q Are you board certified in physical medicine?

A Yes.

Q Are you board certified in pain management?

A Yes, with the American Board of Anesthesia.

Q And to pass the boards -- the jury has heard some discussion from the other doctors who've come. It's my understanding that you have to take a written and an oral test as well.

A For the physical medicine and rehab, yes, written and oral. For the anesthesia board, just a written test.

Q And did you pass these boards on your first attempt?

A Yes.

Q All right. After you completed your service in the military and you passed your boards, what did you do next?

A I was able to get a job at UCLA in the Department of Orthopedics at the UCLA Spine Center.

Q What kind of work do you do there?

A Oh, I'm a physiatrist. So I do the non-operative component, and we have five surgeons that are neurosurgery and orthopedic surgery. And my job is to work up patients who

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come in with first-time injuries or patients who have had surgery, to evaluate them for either future surgery or future care, or to help with the diagnosis in terms of what kind of therapy or what kind of treatment is going to be next involved with their care.

Q You also mentioned working at the VA Hospital. What do you do there?

A I'm a consultant for the residency program, and I work in the physical medicine and rehabilitation department at time with the Veterans Administration.

Q Okay. And describe to the jury what you do in your role as a professor.

A Well, at UCLA we have the future of medical care. So we have residents. We have medical students. We have undergrads too that come to the office, and we also have fellows, people who are trying to get specialty training in pain medicine. And so, my role is to teach the medical students as well as have them come and rotate with me and teach them clinical aspects of what I do on a day-to-day basis.

Q Okay. So in addition to your clinical practice, teaching -- or pardon me -- treating patients, you are teaching fellows, residents, and med students.

A Right. So it kind of overlaps a little bit. So if a patient comes into the room and comes and sees us, and we

have a resident and myself and maybe a medical student all evaluate the patient. And they learn from the experience of evaluating and coming up with a treatment plan.

Q Okay. Now in addition to your clinical and academic work -- and in this case, you're doing a -- sort of a forensic kind of work. If you would explain to the jury the difference between those two I guess engagements.

A Well, as a forensic expert, I would not be treating the individual. In other words, I wouldn't be seeing them on a day-to-day basis or a week to month basis, or performing any injections or any workup on them, but evaluating what had been done and what kind of treatment has been involved and whether or not that's appropriate, related to the events that may have occurred.

Q Okay. As a treating medical provider, are there things that you are, I guess, less interested in than you are when you're a forensic expert?

A Well, I don't know if I'd be less interested in. I mean I'm interested in the whole aspect around them. I think the expert component is taking a person from an injury to what kind of treatment was involved. The -- usually, as a treating physician, you're really not as concerned with the causation of that injury in terms of what caused it, but you may just want to make sure that the person seems to be progressing in their therapies and improving. As an expert person who's

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reading records, there's really no way of allowing that person or influencing that person to have any improvement in their therapies, because you really have no say in their therapies.

Q Okay. Let me phrase the question this way. When you're a treating provider and you're treating a patient who comes to you for any given complaint, do you do what you did in this case, as a forensic examiner, and investigate all the records surrounding the treatment from start to finish?

A Well, sometimes I don't have the luxury of having all those records. In a case like this, there's a lot of records that I'm given. And usually, when you're coming in for an evaluation, I may not have a lot of those components of the records surrounding that issue.

Q Okay. When were you first contacted and retained to be an expert in this case?

A February 2008 -- 2009.

Q Okay. So two to three years ago?

A Yes, about.

Q How much do you charge per hour for your work in this case?

A Seven hundred dollars per hour.

Q When you're working at UCLA, do you make more or less than that?

A Well, it depends on what I'm doing. But you're billing a lot more than 700 an hour.

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Q Okay. And we've discussed with the jury that every expert who comes in is being paid for the time off. And you, of course, flew in from Los Angeles to appear today for them. And how much is your charge for the day?

A Today's charge is $12,000 for the day.

Q Okay. And is that -- all that money going to you?

A Well, it becomes inclusion with the overall salary at UCLA. So it goes to the department and then it's a part of my salary.

Q So are you being paid anything extra today than you would have earned otherwise if you weren't in this courtroom?

A No. I'm probably taking somewhat of a pay cut, because I'm not seeing patients. I'm not evaluating them. My residents and fellows are -- they have nowhere to go for today. And I'm not generating income for the hospital or the department today. So --

Q Okay. Well, naturally, the question is then why are you doing that?

A Well, I think it's an important aspect of -- as a clinician, what you do on a day-to-day basis. And it's evaluating how patients are being brought from point A to point B and what their therapy is, and how the community at large, say, versus an academic center, may approach these patients. So there's somewhat of a puzzle factor within it. And understanding the whole components and putting them

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together is something that I think a physician does on a day-to-day basis. But having the opportunity to have a plethora of records and looking at a big component of a case is a unique thing that you do on a day-to-day basis. And so, I think it's important to have that aspect. And on top of it, looking at the components of how individuals are treated, bringing it back to the residents and the trainees on the component of what they're learning on a day-to-day basis and how other people may handle a case.

Q Now how did you approach your forensic review in this case? You've mentioned the records. What else have you done?

A I had the opportunity to meet Mr. Simao for about 45 minutes or so and examine him and discuss with him the events that had taken place, as well as the treatments. And then based on the -- on that discussion and a direct examination of Mr. Simao, as well as looking at the records and the images and looking at the treatment that had been conferred upon him, came up with opinions.

Q And what did you do to prepare for trial today?

A I tried to re-review my records, my own records and my summaries, relook at the imaging studies to make sure that I understood what they conveyed to me, reevaluated the records that were given as well as reevaluating my examination of him.

Q All right.

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MR. ROGERS: Your Honor, at this time, we offer Dr. Fish as an expert in physical medicine, rehabilitation, pain management, and diagnostics.

THE COURT: Would counsel approach, please?

[Bench Conference Begins]

MR. EGLET: I want to address at the bench there's no electro diagnostic studies in this case. He didn't perform any electro diagnostic studies on our client when he examined him.

MR. ROGERS: No, there is an EMG and there is a conduction study done after the surgery.

MR. EGLET: Okay. Well, he didn't present any opinions on that in his reports, on the electro diagnostic study. He did not present any opinions in his reports, and he didn't do it in his deposition. So I would object to him offering any opinions on electro diagnostic studies. It wasn't disclosed. He may very well have expertise in that area. I'm not doubting that. But it wasn't disclosed. It's not in his reports, and it's not in his deposition.

MR. ROGERS: I think what was discussed was that -- like Dr. McNulty [phonetic] mentioned yesterday, that an EMG and nerve conduction study is done that show positive findings for carpal tunnel. And I believe that was brought up by Dr. Fish, and not in the report, in the deposition. I don't have the record right in front of me, but I'm fairly confident that

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issue has come up, because it's been a running issue in the case.

MR. EGLET: I've read his reports. He has four or five of them. It's not in any of his reports. I can tell you that. And I don't believe it's in his deposition either.

THE COURT: Let's defer any questions until we can confirm that.

MR. EGLET: We think that's something to wait till the end, till he's done.

THE COURT: Yeah, I think it's an issue we'll have to discuss later.

MR. ROGERS: Okay. Well, I may address it, not as the jury question, but my own.

[Bench Conference Ends]

THE COURT: Any objection to counsel's motion?

MR. EGLET: With the qualifying on the electro diagnostics, that that's not included, Your Honor.

THE COURT: Other than that, any objection?

MR. EGLET: No.

THE COURT: Other than that, the motion is granted.

BY MR. ROGERS:

Q Doctor, I want to go back to the things that you have reviewed to prepare for this case. A question has been posed about what other records you have seen. Are there any other records of treatment that the Plaintiff has undergone,

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and as presented in this case, that you have not seen?

A I think I've seen all the records that have been made available to me.

Q And we'll be walking through these records as we go through the examination today. But including the diagnostic films and the treatment records, but it is your understanding that every record the Plaintiff has produced in this case, every medical record, you've seen?

A I believe so.

Q Okay. Now I want to start with your medical opinions, and then we will get into the specifics of them as we go. First, did this car accident of April 15, 2005 cause a traumatic cervical disc injury?

A No, it did not.

Q Was the Plaintiff, Mr. Simao injured in a car accident?

A He complained of neck pain and head pain initially. But as -- when you have these gaps in care, if you look at the record component, he did not really complain much of neck pain and didn't really seek care consistently for the next couple of months, and then there was another gap in care. So it's hard for me to say that he was truly injured in this accident.

Q Okay. And of the care that he has undergone since the car accident, what care might be related to the accident?

A Well, initially, he presented to the Urgent Care

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Clinic, and he was having a headache and some neck pain. And I think they evaluated him at the time and felt that the workup that was done was appropriate. But then when no other treatment was rendered and there was no further follow-up, anything into May -- or the end of May, anything after that didn't seem to be related to the accident.

Q Okay. As I said, we'll get into the details on that. An issue that's been brought up today is -- and through this trial is occipital pain or occipital headaches. Is occipital pain the same as neck pain?

A No, it's different.

Q Okay. If you would describe the difference?

A When you talk about occipital pain, it's basically the back of the hand.

Q You can stand up and show the jurors.

A And show them the back of my head. The back of the head as opposed to the neck, which is more of the component below the head. There is a distinct difference between the two.

Q Okay. And can a person have occipital headaches without having neck pain?

A Yes.

Q Now are there things other than the cervical spine that can cause occipital pain?

A Well, you have the muscles that are going to attach

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to the head, which is a main component. Plus you have nerves in the back of the skull. You have the skull itself as well as the skin layers. So there may be many components that can cause that type of pain.

Q Okay. Are there other kinds of headaches that can also be experienced in the occipital region?

A Sure. You can have what's called a tension headache or a migraine headache or a chronic daily headache. There's various types of headache components that can give you occipital region pain.

Q All right. The focus of the Plaintiff's injury claim is that the car accident cause disc disruption at C3/4 and C4/5. Would a traumatic injury at C3/4 or C4/5 cause occipital headaches?

A No, because the occipital nerve comes off of the C2/3, or the third occipital nerve. And so, that's above the level of where the C3/4 and 4/5 nerve comes out.

Q If you then sustained a traumatic injury at C3/4 and C4/5 -- and I'll have you come down in a minute and then show this to the jury in a little bit. But if you did sustain a traumatic injury at those levels, would it be head pain or neck pain that you would most likely experience?

A You'd probably get more neck pain and trapezius pain, possibly a little bit of the shoulder in terms of the pain region.

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Q Okay. Now there's been some suggestion here in this proceeding, the gate theory [phonetic] explain, a delay in onset of neck symptoms, that there is -- could be a headache complaint, and a neck injury might not be felt at C3/4 and C4/5. Is that an accurate account of what happened here?

A So when you say gate theory, is it the typical Melzack and Walls gate theory of pain or is this a -- I'm not sure I understand what gate theory that is being discussed.

Q You're already over my head. So --

A So let me try to clarify. The gate theory is what, in the 50s, Melzack and Walls were the two scientists who kind of came up with this idea of pain. And if you had people wearing different color shirts, let's say a red shirt, blue, or green shirt, and they're all trying to get through a gate to the other side, if you had people all wearing blue, and there's only a few of them, they're going to get through to the other side, no problem. But if you flood it with red, orange, yellow, and blue, and then shove them all through the gate, you're not going to get that blue going through at one time. You're going to get other colors. And so, it's going to confuse the information on the other side. So when you talk about pain and how it distributes to an area, if multiple stimuli is coming in at one point, the individual may not feel a component of that pain. It's -- the signals are scrambled if you will.

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Q Okay. Can that scrambling of signals occur then in a case as the Plaintiff has described, which is an immediate onset of occipital pain and a five to six-month gap in onset of neck pain?

A No, huh-uh. If you're going to have a disc problem, and it's going to happen right there, you're going to feel it right then and there. If someone got hit in the head with a baseball or hit in the shoulder, you're going to know you got hit in that shoulder. It's not going to spread to your knee or other areas. Yes, they're close, because you have the occiput in the neck, but it's going to be distinct. People are going to know that there's a problem with the disc.

Q There has been some discussion with the two doctors who testified so far, Doctors McNulty and Rosler, that there could be a delayed onset of neck pain with traumatic disc injuries, with a traumatic disc injury at C3/4 and C4/5. Now you -- as you've touched on and reviewed these records, can there be a delay in onset such as the Plaintiff experienced?

A Usually within 48 to 72 hours is probably the latest I've seen. But anybody that has an immediate disc injury is going to feel the pain right then and there. And it's going to be obvious, completely obvious. Even if it's mild, you still would have that pain component.

Q Now let's combine these two theories that have been proposed, the gate theory and this delay in onset theory. Can

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this explain the gap in symptoms for the Plaintiff from the date of the incident up until roughly October, five or six months after the incident?

A I don't think that explains it.

Q Why not?

A You would expect pain right away. This delay is just inconsistent with anything I've seen in the emergency room, in the military M*A*S*H units that I was in in Bosnia, in the care that I get from pati- -- or the people that come in to see me on a day-to-day basis. It's just you're not going to have a delay like that. It's just not going to happen.

Q And do you work at a trauma center?

A We're a level one trauma center.

Q So you see people involved in car accidents --

A Yes.

Q -- as well as other type patients.

A We get all the patients who have major car accidents get flown to our center from all over the area and southern California.

Q I want to turn to the medical records. We'll start with the date of the incident, which I believe is Exhibit 18. Doctor, there's a monitor up there next to you.

[Counsel Confer]

MR. ROGERS: Okay. Now if you can pull out the

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assessment. Okay, or the reason for visit will do.

BY MR. ROGERS:

Q Some hours following the incident, the Plaintiff complained of left elbow pain, tenderness in the back of his head. And the assessment shows that he was assessed with neck pain. We don't see the neck complaint right here, but he was assessed with a neck sprain. Now is that a common assessment following a car accident?

A Yes.

Q Okay. Dr. McNulty discussed yesterday that a neck sprain, in many instances, is sort of a catch all. It's not a really complete diagnosis. It's just a way of describing neck pain.

A Right. It's -- it can encompass a lot of different factors. You've got the muscle, the ligaments, the joints, anything can really encompass a sprain if you will. So it's a catch all term in some respects.

Q All right. And then we see that in this business, the plan --

[Counsel Confer]

BY MR. ROGERS:

Q Now the plan was the Plaintiff should seek primary care follow-up if not improving in the next week to 10 days. If a patient has sustained a traumatic injury at C3/4 or C4/5 and doesn't follow up within seven to 10 days, what will

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happen?

A Well, if the injury is significant enough, you would have progression of the symptoms. You could have weakness in the shoulder, weakness in the components of the upper part of the neck and area here. The -- you may get some numbness, burning sensation in the arms. You may get some bowel and bladder insufficiency if there was enough trauma to the spinal cord itself, because you have the cord right underneath that area of the disk. You may experience ongoing symptoms that are just not getting better with just simple rest, if you will.

Q Okay. Now as you learned from your records review, the Plaintiff did not return during that seven to 10 days. He returned three weeks later, on May 4, 2005.

[Counsel Confer]

BY MR. ROGERS:

Q All right. Now --

[Counsel Confer]

MR. ROGERS: While we're waiting, what I can do to speed this up, Your Honor, can I take the trial folder up to --

THE COURT: Sure.

MR. ROGERS: Well, if we have it, we'll just go ahead with it.

BY MR. ROGERS:

Q Okay. Now when the Plaintiff presents on May 4, he

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complained about what, Doctor?

A Can you pull up the ---

[Counsel Confer]

THE WITNESS: It says -- I think it says checkup on headaches, MVA, 4/22/05.

BY MR. ROGERS:

Q All right. And if there were no neck complaints at this visit, what would that --

A That the neck is not a problem. It's not bothering him.

Q Okay. Now there's a physical exam also in this visit --

[Counsel Confer]

BY MR. ROGERS:

Q -- that includes an examination of the neck.

MR. EGLET: Would that be the assessment?

MR. ROGERS: It might the following page. There it is. Okay.

BY MR. ROGERS:

Q Okay. Now are there any abnormal findings on this physical exam of the neck?

A Well, there's positive tenderness to palpation over the occiput scalp, which is the back of the head here, scalp. And there are no palpable masses or palpable defects that can be felt over the skull or scalp. The pupil are equal round,

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reactive to light in accommodation. So the eyes look good. There's no facial trauma in any area. The throat looks good. The neck shows no issues. Neurological exam shows the nerves are intact. And the musculoskeletal exam, there's a notation of full range of motion in the extremities with strength as five over five and the reflexes are normal.

Q Okay. Do these findings suggest or refuse a traumatic injury at C3/4 and C4/5?

A I would have expected some kind of examination component for, specifically, the neck. But, you know, with full range of motion of the extremities, being able to move the entire arms, it's hard to say that there was a nerve damage or there was a specific shoulder injury or a joint injury based on this.

Q Okay. Now I want you to explain to the jury where the occipital scalp is -- I believe I have it as --

[Counsel Confer]

BY MR. ROGERS:

Q Okay. If you would come down.

A Sure.

Q If you'll just --

A Okay. Obviously, the ears. This line right here, pretty much the line right along this top here. So the occiput is going to be his upper part here or the part right up here, as opposed to the neck region. And you can see that

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C3 is down here, and the occiput region is up here. Well, it's a little bit lower. It's probably down in this area here.

Q Okay. And you said there was some tenderness at the occiput but not the neck.

A Right. So the -- you have the big musculature -- the trapezius muscle is going to come up to this point and it's going to attach at the lower part of the head. But the palpating area here is not tender, and the area of the pain is in the upper part right here, much higher.

Q Okay. And if you would, explain to the jury how it is that the C2/3 is what might innervate or cause headaches from the occipital region but not C3/4 and 4/5?

A So if this is the C3, this area right here, 2/3, you can see these nerves right here coming at -- I'm sorry. 2/3. 3/4 is just a little bit lower. So the C2/3 area nerve comes up around this area here, but the C3/4 is down below, and that's going to cover more of the shoulder area here.

Q Okay. And what of C4/5?

A C4/5 is going to be even lower, and that's going to be the lower part down in the shoulder area that you can't quite see further down.

Q Now with the findings that they had on the objective exam three weeks after the accident, do you see that they refer the Plaintiff out for a CT scan?

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A Of the head.

Q Right. And was that an appropriate recommendation given his complaints on that day?

A Yeah, absolutely. I mean if you think someone has had a head bump or a head hit, you want to make sure that there's no, especially weeks out, there's a small bleed in the brain. So it would be appropriate to get that test.

Q And on this day, May 4, 2005, was there any suggestion or need of a [indiscernible] in the neck?

A No, there wasn't really any suggestion for that, because there really wasn't pain in that area.

Q Okay, good. You can take your seat again. Now I asked you earlier about the difference between occipital tension, migraine, and then I think you mentioned another kind of headache or two. And I want to get into that at this point. Can a person have the same headache presentation that the Plaintiff had on May 4, three weeks after the accident, if it's a tension type headache?

A Sure, he could definitely have that.

Q Okay. And what about migraines?

A Well, migraines you -- sometimes people have nausea, facial numbness, pain behind the eyes. They call it photophobia, where the light really bothers you, or pressure deep inside the front part of the side of your head. It's maybe a little bit different, but it could still be that, but

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it's -- you know, it's hard to say.

Q All right. What do you know about the Plaintiff Mr. Simao's headaches before the car accident?

A He was treated for a left side headache problem. I think he was first evaluated at the Southwest Medical Associates in 2002. So he was having pain on the left side and actually some facial numbness as well. So it was a left sided headache component.

Q And what kind of headache does that consist of?

A Well, it can vary. It can be a tension. It can be a migraine. I think they called it a migraine. That's kind of what he was treated for and even seeing a neurologist to evaluate it as well. And they tried him on different migraine abortive medications to see if that would help.

Q On the date of the incident, when he presented to Southwest Medical Associates, if I recall right, he reported that he was taking Butalbital.

A Correct.

Q Is that a medication for migraines or for a different --

A Right. It's a migrainous type of medications, an opiate with a caffeine component to it to try to help stop some of the migraine components.

Q Okay. Then after he has this CT scan of the head, which comes back normal, he reports again to Southwest Medical

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Associates the following week, and he complains of something you just mentioned a moment ago, and that was facial pain and numbness.

A Correct.

Q Do you recall that May 12 --

[Counsel Confer]

BY MR. ROGERS:

Q Okay. Now is -- are the symptoms with which he's presenting on this day -- here we are nearly a month out now from the car accident -- similar to the symptoms that he presented with before the car accident?

A It says headache, numbness in the upper lip. And can you blow up the -- numbness in the upper lip and nose, status post-MVA. Persistent pressure/sensation in the occipital head after being involved in MVCA. Pressure in the scalp, radiating at time.

Q Okay. That describes --

A He doesn't have new onset of blurred vision with facial field defects. So there's no pain behind the eyes component. So it's possible.

Q Okay. It's -- I'm not --

A It's possible that it could be similar to the pain complaints and the headache symptoms that --

MR. EGLET: Your Honor, I'm going to object on the foundation grounds. Possibilities are not the basis for

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expert testimony.

THE COURT: Let's ask for some clarification.

MR. ROGERS: Yes, very good.

BY MR. ROGERS:

Q Okay. Now you have somewhat similar symptom presentation and you say this -- that appears to be a possibility.

MR. EGLET: Objection, leading.

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

MR. ROGERS: Okay.

BY MR. ROGERS:

Q It is possible that it's the same. Is it possible that it's not? And if so, if you would explain that to the jury.

A Well, you know, if you've been --

MR. EGLET: Your Honor, I'm going to object on possibilities.

THE COURT: The Court already sustained that objection. Ask you to rephrase, please.

MR. ROGERS: Okay.

BY MR. ROGERS:

Q What I'm trying to get, Doctor, is the Plaintiff presented with the headaches you described from before the car accident.

MR. EGLET: Objection, leading.

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MR. ROGERS: This is foundational, Your Honor.

MR. EGLET: It's leading.

THE COURT: Overruled.

BY MR. ROGERS:

Q And then he presented again after the accident with the headaches that you see before, roughly a month after this. And the question is is there a different kind of headache going on?

A It seems the same.

Q Now on this visit, were there any neck complaints?

A No, there were no neck complaints.

Q And what was the diagnosis?

A Can you blow up AP.

Q Sure.

A Headache, tension type.

Q Okay. Was any testing ordered on the neck?

A Well, the -- they reviewed the CT scan, which was negative. So there was no bleed. There wasn't an inner cranial problem. And since the -- it was negative, there was a referral for an MRI of the brain.

Q Okay. Let's pull up the findings on that MRI to see what the result was.

[Counsel Confer]

BY MR. ROGERS:

Q Do you recall, Doctor, while you're waiting on that

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what the findings were?

A Yeah, I believe it was normal. It was unremarkable and normal. There was no evidence of an inner cranial lesion. There was no evidence of any component that would explain a headache or a brain type problem.

Q Okay. Was there any evidence form the CT scan or the MRI that a head injury occurred at this accident?

A No, there was not.

Q All right. The Plaintiff then was next seen on May 26th, again, at Southwest Medical. At that visit --

MR. ROGERS: This is actually page 20.

BY MR. ROGERS:

Q Were there any signs or symptoms of neck problems at that time?

A I was there to review the results. And if you bring up the bottom part, it says A, assessment. Has a history of migraine headaches. Did experience a change in the headache intensity and character after a motor vehicle accident. The workup of the x-rays of the cervical spine, the CT of the head were normal. And the results were explained and there was no neck issue really discussed or complained of.

Q All right. And is there any note of any opinion or prescription pain medication?

A There was none given.

Q What was the plan with this visit?

A Follow up in six months.

Q All right. Now of all the records that we've reviewed up until now, is there any evidence of a traumatic cervical spine injury?

A No.

Q If there's been a traumatic cervical spine injury, what difference would you expect to see?

A Pain at the neck, pain radiating down to the arm, possibly bowel and bladder problems if it's a significant enough injury, sensory change, weakness in the arm, depending on the distribution of those nerves.

Q And would the gate theory or this potential delay in onset explain the lack of neck symptoms here now, a month-and-a-half after the accident?

A No, it wouldn't.

Q Now let's assume, hypothetically, that there will come testimony that the Plaintiff was complaining of neck pain, only not to his doctors at this time. If that were true, would that change your position?

A No.

Q Why not?

A Well, he was -- his job is very active. And so, given what he was doing at the time when I discussed with him on my exam in February of 2009, it's possible these are just aches and pains from his work.

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MR. EGLET: Your Honor, I object, possible. That calls for speculation. Move to strike.

THE COURT: Sustain the objection.

Jury will disregard the witness' statement.

Ask you to clarify, Mr. Rogers.

MR. ROGERS: Okay.

BY MR. ROGERS:

Q I believe what the Court is looking for, so limit the answer to the question, which is if there is, hypothetically, any suggestion or testimony that, you know what, I was experiencing neck problems, I just wasn't telling my doctors, the question is would that change your opinion?

A If it's a significant enough neck problem, you're going to tell your doctors, especially if there's a concern.

MR. EGLET: Your Honor, I'm going to object. That's speculation. He's asking him to speculate what Mr. Simao's had.

THE COURT: Sustain the objection.

Jury will disregard the witness' last statement.

Ask you to rephrase the question.

BY MR. ROGERS:

Q In the patients who you treat -- at UCLA and at the Veterans Center, for those who do sustain a traumatically induced disc injury in the cervical spine, do you see no complaints for a month-and-a-half?

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A No.

MR. EGLET: Objection, vague and ambiguous. What's the extent of the disc injury? He's described significant disc injuries where you have bowel and bladder --

THE COURT: Counsel, approach, please. Counsel, approach, please. Off the record.

[Bench Conference Begins]

THE COURT: I thought we agreed on no speaking objections.

MR. EGLET: I apologize, Your Honor.

THE COURT: All right. Go --

MR. EGLET: The point is it's vague and ambiguous and overbroad, because with this witness he is talking about -- in all of these questions, when he asked him well, what kind of symptoms would you expect, well, bowel and bladder loss, you know, significant paresthesia, and stuff like that. I mean there's a range of disc injuries, okay. Everybody here knows that, especially this doctor. So for him to suggest if you're going to have any disc injury at all in the neck, you're going to have bowel and bladder loss, and all these significant symptoms, it's ridiculous and it's improper. So I'd ask that the question be narrowed. It's way too broad of a scope. He needs to narrow it to a specific type of injury, because we're not talking about somebody who has a cord compression. Nobody has said that, and that's essentially what he's talking about

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is a major cord compression, a major nerve compression. Nobody suggested that, but it was that kind of -- that amount of an injury. But when he's talking about the symptoms, here's what he's talking about.

So when he asks you, you know, [indiscernible] significant [indiscernible] bowel -- loss of bowel [indiscernible] start to see yeah, somewhat [indiscernible] traumatic injury to the disc [indiscernible] mention that [indiscernible].

THE COURT: Go ahead, Mr. Rogers.

MR. ROGERS: Yes. My answer is that [indiscernible] cross-examination [indiscernible] is not proper on direct, because the question is limited to cervical traumatic injuries to cervical [indiscernible] bring up all the different kinds there may be. But in this case, everybody knows that we're talking about a claim of traumatic injuries internal disc disruption.

MR. EGLET: Well, you have a history of it.

MR. ROGERS: Yeah, but he's listening to the jury -- we're not talking about somebody who has such a traumatic disc injury that [indiscernible] compression or a such an impinging on a major nerve that you're going to have significant numbness, you know, immediately from the accident or even shortly after. That's what this witness is implying, Your Honor. This has got to -- the scope of the question has to be

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narrow. Otherwise, it's just painting a picture that is a fantasy. It has nothing to do with this case. Nobody is claiming there's any type of injury like this.

THE COURT: We'll, here's the thing. The Court is inclined to sustained the objection. The way that you posed the question I think it is pretty vague and overbroad. And frankly, the way you first posed the question with respect to his [indiscernible] UCLA didn't really have anything to do with this particular Plaintiff. That was -- it looked like the approach that you were taking. So the Court is sustaining the objection.

But here's the other thing. This witness is giving a lot of answers that offer possibilities and speculation, and the jury is not to consider that. So I hope we can proceed accordingly. I hope I don't have to keep striking his testimony, because he offers lots of possibilities.

MR. EGLET: Thank you, Your Honor.

MR. ROGERS: Okay.

[Bench Conference Ends]

THE COURT: Sustain the objection for the record.

BY MR. ROGERS:

Q Okay. Now given the patients that you have examined outside of a forensic exam, who have been involved in an incident in which they sustained what the Plaintiff alleges in this case, C3/4, C4/5 traumatically induced internal disc

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disruption, have you ever seen a delay in onset of a month-and-a-half?

A No.

Q All right. That moves us then to this point where the Plaintiff stops treatment, from May 26th up until October 26th, roughly four-and-a-half. And it's your understanding that the Plaintiff wasn't treating with anyone during that time?

A That's my understanding he wasn't being treated by any providers or getting therapy or taking medications that were new other than what he has been taking before.

Q Okay. Did -- was he undergoing any exercise there, physical therapy, or chiropractics, or anything like that during that time?

A Not a formal program. It was prescribed. He wasn't seeing a therapist on a day -- a weekly basis, a physical therapist.

Q And again, up to this point, we're now roughly six months after the accident. Is there any medical evidence of a traumatic injury that the Plaintiff alleges in this case?

A I don't see any.

Q Okay. Now the Plaintiff returned to treatment --

MR. ROGERS: And this is pages 21 and we may go to 22 as well.

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BY MR. ROGERS:

Q He returned to treatment in October.

MR. ROGERS: I want to pull that record up. And if you can show the reason for visit.

BY MR. ROGERS:

Q The question is did the Plaintiff complain of neck [audio skips] --

A It says checkup neck, shoulder pain.

Q And to your knowledge, is this the first time the Plaintiff complained of neck pain since April 15, six months earlier?

A Complained to his provider [audio skips at 2:40:44] Medical Associates. It's also the first time of shoulder pain.

Q Okay. Did the accident cause a [audio skips at 2:40:56]?

A There's no evidence of that.

Q [Audio skips at 2:41:00] treated for on this day?

A Can you go to the assessment?

[Counsel Confer]

THE WITNESS: This -- no. Oh, yeah, that's fine.

[Counsel Confer]

THE WITNESS: Tension type headache and migraine [audio skips at 2:41:20].

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BY MR. ROGERS:

Q All right. Would you agree that something changed in the symptoms on this day?

MR. EGLET: Objection, leading.

THE COURT: Sustained.

BY MR. ROGERS:

Q Is there anything different in the assessment on the visit compared to the assessment in the April visit?

A No.

Q And on the April visit, we don't see an entry of shoulder sprain.

A Correct.

Q Okay. That's the difference I'm asking about.

A Oh. I guess because it's crossed off, I'm not sure if that was what the intent of the notation was here. But if you go down to the next section, the assessment section I guess.

Q Okay.

A The summary. History of migraine started to become worse in the last few months, more frequently, nausea, vomiting. These are all kind of migraine components. Tightness in the left shoulder and then radiating up to the neck. So it's like from the shoulder up to the neck. It's not the neck. And later on, will develop a migraine headache with this. So it's really talking about the migraine, and

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they're suggesting that he goes to neurology for an evaluation and a CT scan. So I think the provider thought there was some kind of change, but --

MR. EGLET: Your Honor, I'm going to object to what he thinks the provider thought. That's speculation.

THE COURT: Sustained.

MR. ROGERS: Okay.

BY MR. ROGERS:

Q Go ahead, Doctor, with what the provider recommended.

A Provider recommended a CT scan to rule out causes for the headaches. No neck issues.

Q Okay. There was also a recommendation there for a shoulder x-ray.

A That must be on the next page.

MR. ROGERS: Okay. If you would, Dan.

THE WITNESS: Actually, go to A. Migraine headache with a muscle contracture component, indicating a tension type headache with a migraine. And --

BY MR. ROGERS:

Q I think we're on the wrong date. I'm looking -- I was talking about October 12, where the x-ray is ordered. Do you have that?

MR. EGLET: Page number?

MR. ROGERS: It would be the next one in order. We were

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just on October 6th.

THE WITNESS: This is October 12.

BY MR. ROGERS:

Q Yes.

A The assessment is nicotine dependence. I don't -- I'm not sure where you're pointing to the shoulder component.

Q I'm being terribly clumsy with this demonstration. So I'll move it along. If there's a traumatic disc injury, would it be shown on an x-ray?

A No. The x-ray is only going to show bone structure. It's not going to show soft tissues like an MRI.

Q Okay. Now the Plaintiff returns to treatment a couple months later. And at this point, in December -- I believe this is pages 28 in Exhibit 18. Let's make sure I've got it right this time.

A December --

MR. ROGERS: Pull up the -- it looks like the date is cut off. It's right under tobacco -- is 42 -- good.

BY MR. ROGERS:

Q Okay. And here, he's complaining of what?

A Neck and shoulder pain for the past several months. It's gotten worse in the past couple weeks. Not tried any medications for it, although has some in the past, which made him sleepy.

Q Now is there anything in this record suggesting a

traumatic injury at C3/4 and C4/5?

A No.

Q Now again, do traumatic injuries go -- to C3/4 and 4/5 go months without any comment?

A No.

Q Now I want to turn to some testimony by Dr. McNulty. The Plaintiff went to see him a few months after this visit. And Dr. McNulty talked about an MRI that he ordered, that was taken in April 2006. If, hypothetically, Dr. McNulty told the jury that MRIs are not very reliable for determining a traumatic injury to the cervical spine, would you agree or disagree?

A I don't know how he can say that, because in our spine center we have neurosurgeons and orthopedic spine surgeons --

MR. EGLET: Your Honor, I'm going to object to this question. He's commenting on a spine surgeon's opinion here.

THE COURT: Sustain the objection.

MR. ROGERS: Okay.

BY MR. ROGERS:

Q Then the question is can an MRI be used to see a traumatic cervical disc injury?

A Yes.

Q And is it something you use at UCLA?

A Yes. All of the patients that come through that

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have neck issues, back issues, any kind of spine issues, the standard for us is to get an MRI of the spine.

Q Okay. I'm sorry.

A No, go ahead.

Q Now you've reviewed the actual films, right?

A Yes.

Q Is there any evidence of a traumatic cervical disc injury on this March 2006 cervical MRI?

A No.

Q Are there any abnormalities at all?

A Well, he has a large facet. If you have it, we can look at it.

Q Yeah.

[Counsel Confer]

MR. EGLET: Which date?

MR. ROGERS: March 22, 2006.

BY MR. ROGERS:

Q If you would --

A Yeah. Can you go to the next one? So what we're going to do is go through what -- the process for me to evaluate an MRI. Okay. This is like a middle picture down the middle of your nose, and you're looking sideways, kind of a sideways view. Okay. You can see the jaw right here. You can see the brain. You can see the spinal cord through here. You can see some nice pictures of the discs in between the

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In the Supreme Court of Nevada

Case Nos. 58504, 59208 and 59423

JENNY RISH,

Appellant,

vs.

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

Respondents.

APPEAL

from the Eighth Judicial District Court, Clark County
The Honorable JESSIE WALSH, District Judge
District Court Case No. A539455

APPELLANT'S APPENDIX
VOLUME 8
PAGES 1678-1928

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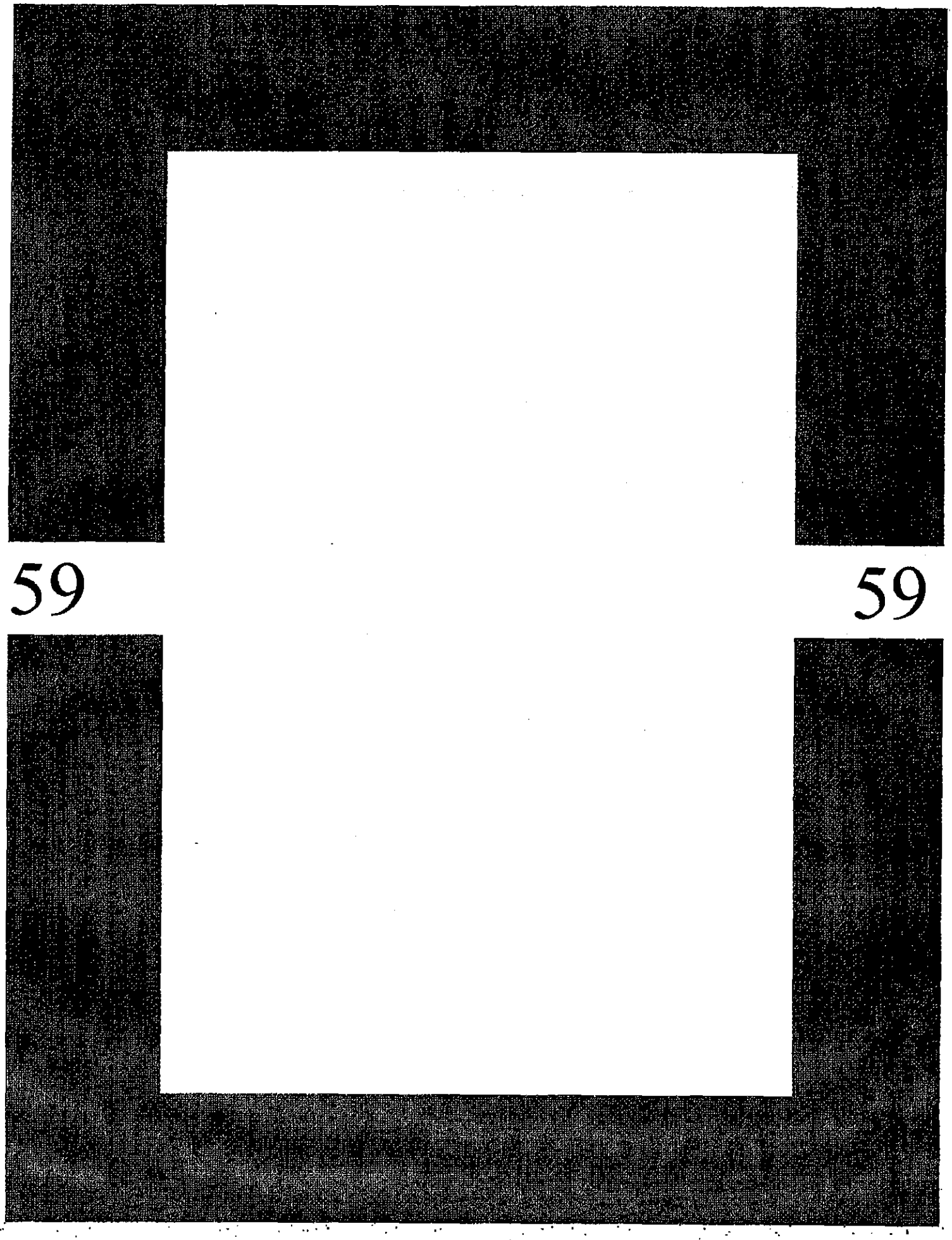
TABLE OF CONTENTS TO APPENDIX



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DISTRICT COURT
CLARK COUNTY, NEVADA

WILLIAM JAY SIMAO, individually and CHERYL ANN SIMAO, individually, and as husband and wife, Plaintiffs, v. JENNY RISH; JAMES RISH; LINDA RISH; DOES I through V; and ROE CORPORATIONS 1 through V, inclusive, Defendants.	CASE NO.: A539455 DEPT. NO.: X **RECEIPT OF COPY OF PLAINTIFFS' OPPOSITION TO DEFENDANT'S TRIAL BRIEF IN SUPPORT OF ORAL MOTION FOR MISTRIAL**

RECEIPT OF COPY

RECEIPT OF A COPY OF the foregoing **PLAINTIFFS' O PPOSITION TO DEFENDANT'S TRIAL BRIEF IN SUPPORT OF ORAL MOTION FOR MISTRIAL** in the matter of **SIMAO v. RISH; et al**, is hereby acknowledged:

Date: 3/18/11 Time: 11am

Stephen H. Rogers, Esq.
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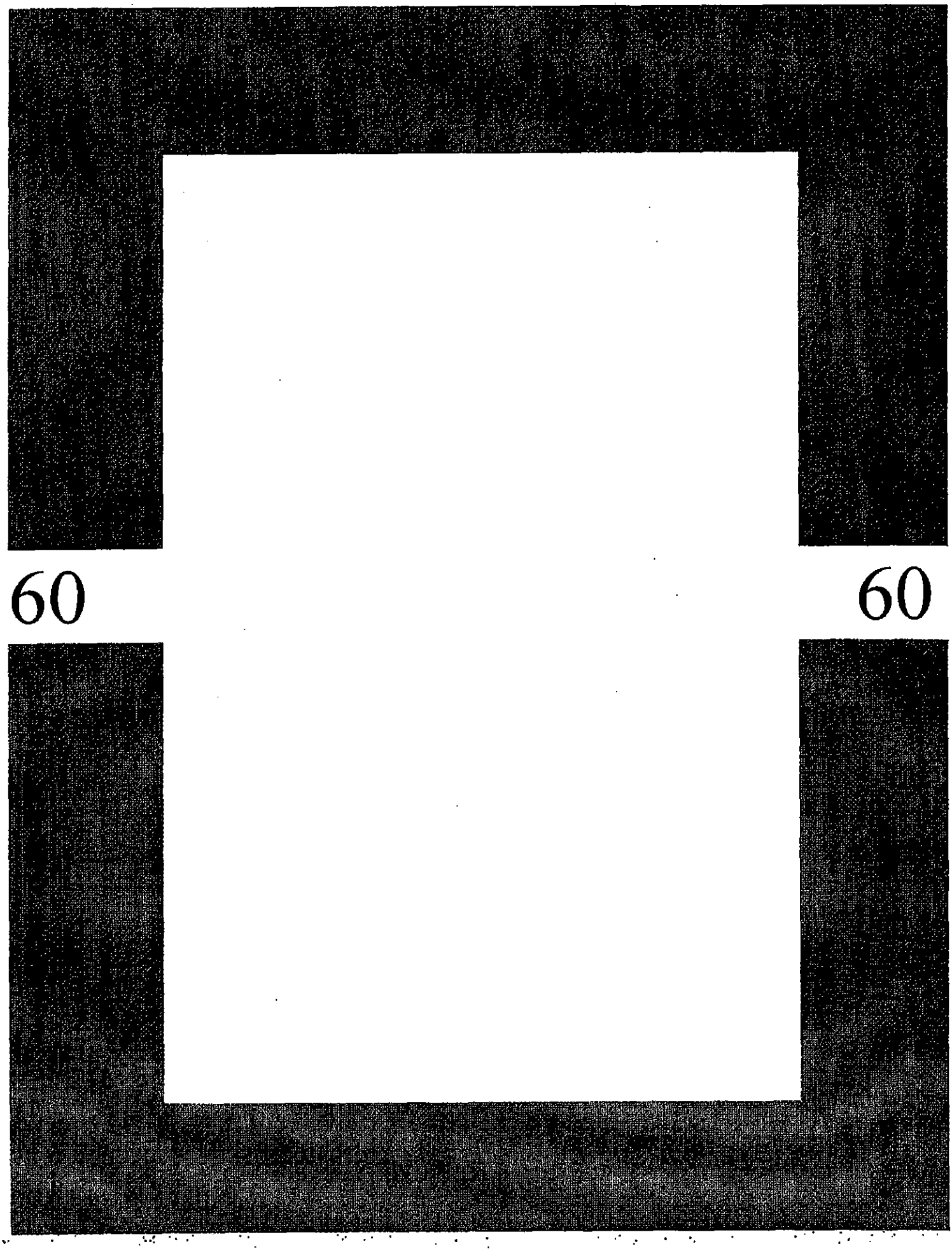

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DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiff,

v.

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

Defendants.

CASE NO. A539455
DEPT. NO X

ORDER GRANTING MOTION TO EXCLUDE TRAFFIC ACCIDENT REPORT AND INVESTIGATING OFFICER'S CONCLUSIONS

This matter having come on regularly for hearing before the Court on February 15, 2011, Stephen H. Rogers, Esq. of the law firm of Rogers, Mastrangelo, Carvalho & Mitchell appearing on behalf of Defendant Jenny Rish; and David T. Wall, Esq.. of the law firm of Mainor Eglet appearing on behalf of Plaintiffs; and the Court having entertained the respective arguments of counsel as well as being fully apprised of all the papers and pleadings on file with respect Jenny Rish's Motion to Exclude Traffic Accident Report and Investigating Officer's Conclusions, and good cause appearing:

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IT IS HEREBY ORDERED, ADJUDGED AND DECREED that:

1. Defendant Jenny Rish's Motion to Exclude Traffic Accident Report and Investigating Officer's Conclusions is GRANTED.

IT IS SO ORDERED.

Dated: 16 Mar 2011

The Honorable Jessie Walsh
District Court Judge

Submitted by:

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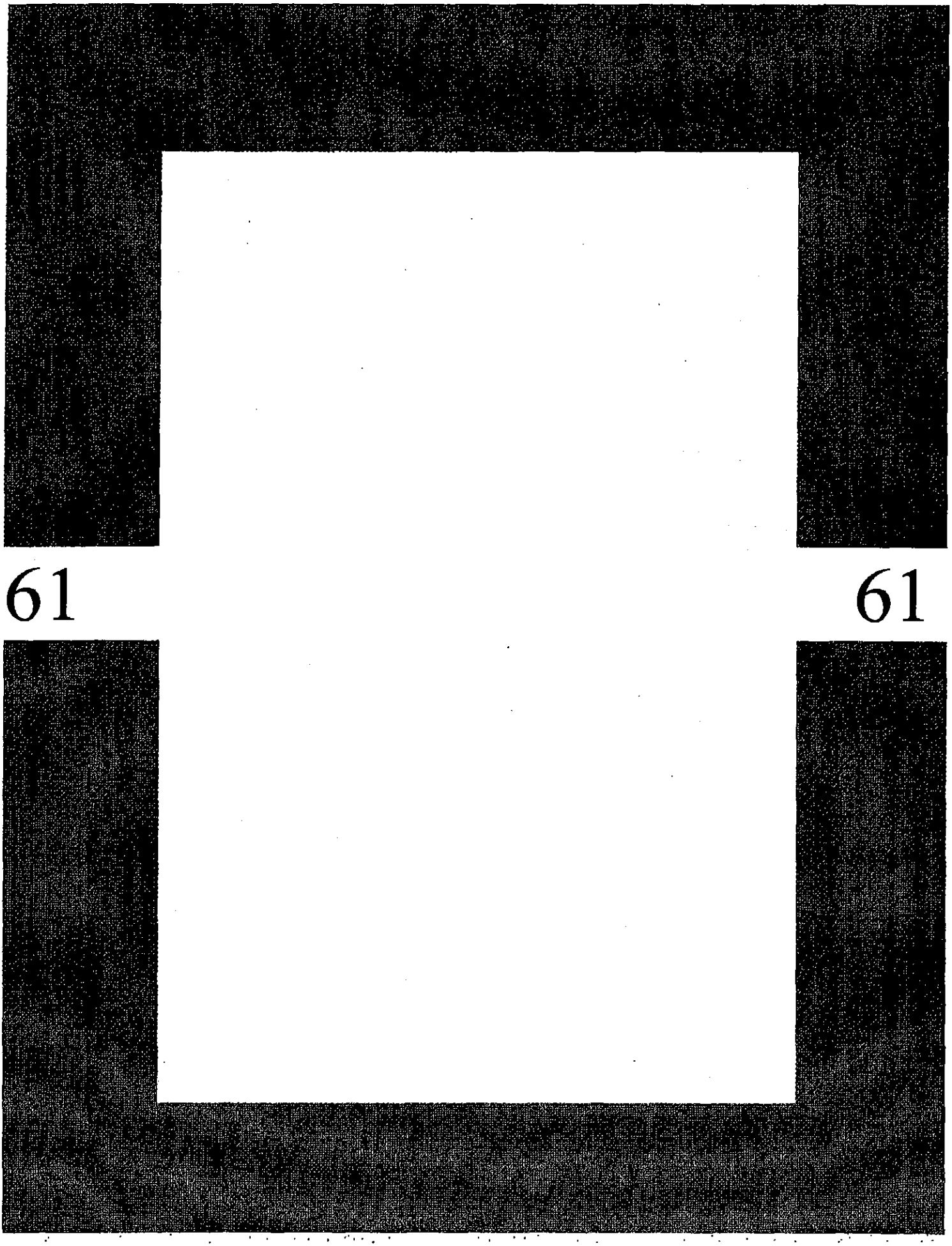

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DISTRICT COURT

CLARK COUNTY, NEVADA

WILLIAM JAY SIMAO, individually and CHERYL ANN SIMAO, individually, and as husband and wife, Plaintiffs, v. JENNY RISH; JAMES RISH; LINDA RISH; DOES I through V; and ROE CORPORATIONS I through V, inclusive, Defendants.	CASE NO.: A539455 DEPT. NO.: X **ORDER REGARDING PLAINTIFFS' SECOND OMNIBUS MOTION IN LIMINE**

This Honorable Court, having read the pleadings and papers on file herein regarding the

Plaintiffs' Second Omnibus Motion in Limine, the parties appearing before the Court on March 8, 2011 for hearing, and good cause appearing therefore, the Court rules upon the Plaintiffs' Motion as follows:

IT IS HEREBY ORDERED that Plaintiffs' request to exclude Plaintiffs' prior and subsequent unrelated accidents, injuries and medical conditions and prior and subsequent claims or lawsuits is hereby **GRANTED in part and DENIED in part.** Any and all evidence relating to Plaintiffs' lawsuit concerning their home is excluded. However, William's diagnosis of a non-cancerous tumor may be admitted for the limited purpose to show emotional distress.

IT IS FURTHER ORDERED that Plaintiffs' request to exclude hypothetical medical conditions is hereby **GRANTED** as written.

IT IS FURTHER ORDERED that Plaintiffs' request to exclude evidence of the absence of medical records for any period of time prior to the accident is hereby **GRANTED.**

IT IS FURTHER ORDERED that Plaintiffs' request to exclude any reference to an alleged federal grand jury investigation into doctors and lawyers in Las Vegas is hereby **GRANTED.**

IT IS FURTHER ORDERED that Plaintiffs' request to exclude reference to attorney advertising is hereby **GRANTED.** However, if during voir dire members of the venire volunteer information on the subject of attorney advertising based upon questions in the Jury

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Questionnaire, the subject of attorney advertising may be inquired into during voir dire.

DATED this 22 day of March, 2011.

DISTRICT COURT JUDGE

Respectfully submitted by:

MAINOR EGLET

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Attorney for Plaintiffs

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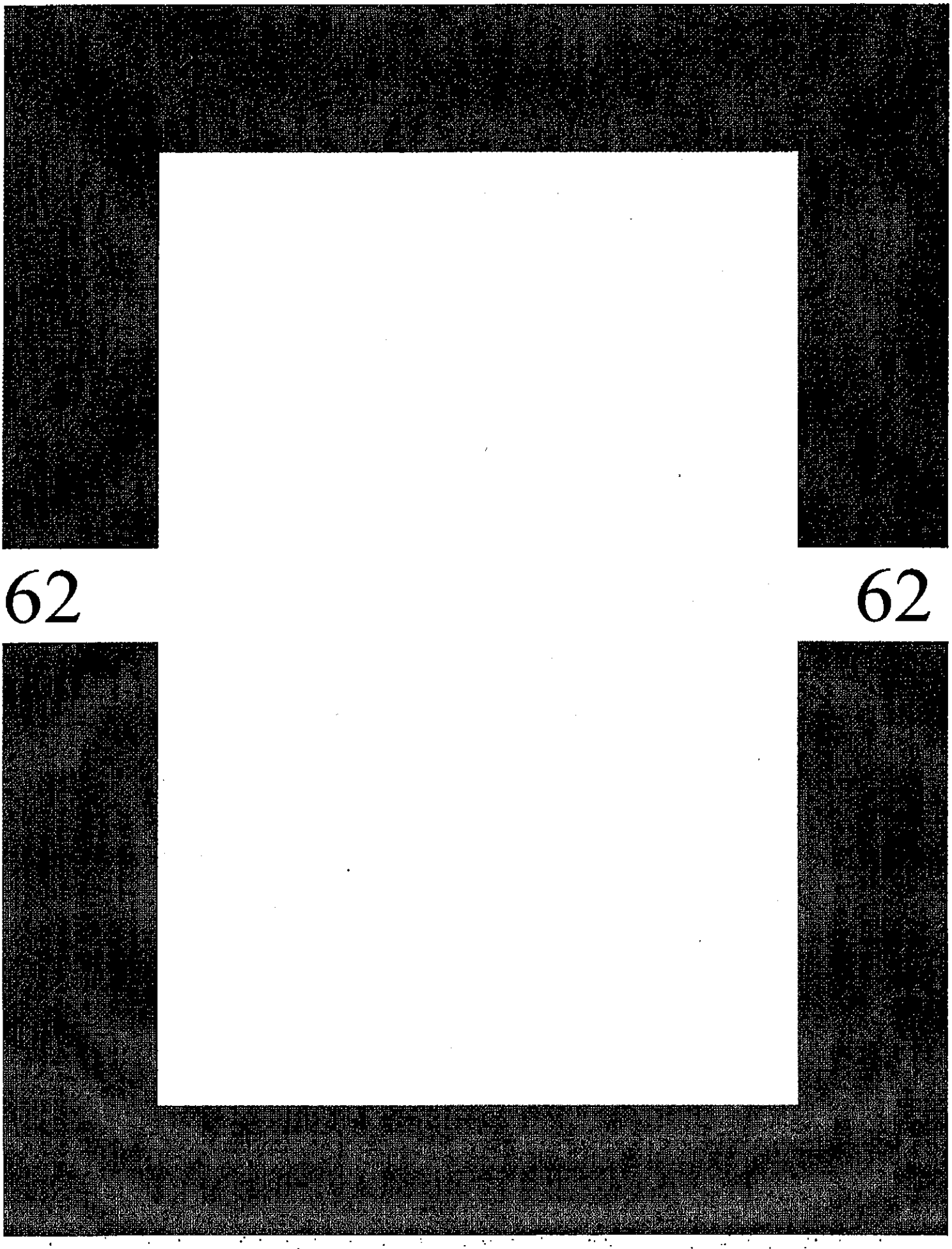

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DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiff,

v.

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

Defendants.

CASE NO. A539455
DEPT. NO X

ORDER GRANTING MOTION TO EXCLUDE LIFE CARE EXPERT, KATHLEEN HARTMANN, R.N.

This matter having come on regularly for hearing before the Court on February 15, 2011, Stephen H. Rogers, Esq. of the law firm of Rogers, Mastrangelo, Carvalho & Mitchell appearing on behalf of Defendant Jenny Rish; and David T. Wall, Esq.. of the law firm of Mainor Eglet appearing on behalf of Plaintiffs; and the Court having entertained the respective arguments of counsel as well as being fully apprised of all the papers and pleadings on file with respect Jenny Rish's Motion to Exclude Life Care Expert, Kathleen Hartmann, R.N., and good cause appearing:

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IT IS HEREBY ORDERED, ADJUDGED AND DECREED that:

1. Defendant Jenny Rish's Motion to Exclude Life Care Expert, Kathleen Hartman, R.N. is DENIED, but the Plaintiff must provide foundation before Ms. Hartmann will be permitted to offer expert testimony

IT IS SO ORDERED.

Dated: 21 Mar 2011

The Honorable Jessie Walsh
District Court Judge

Submitted by:

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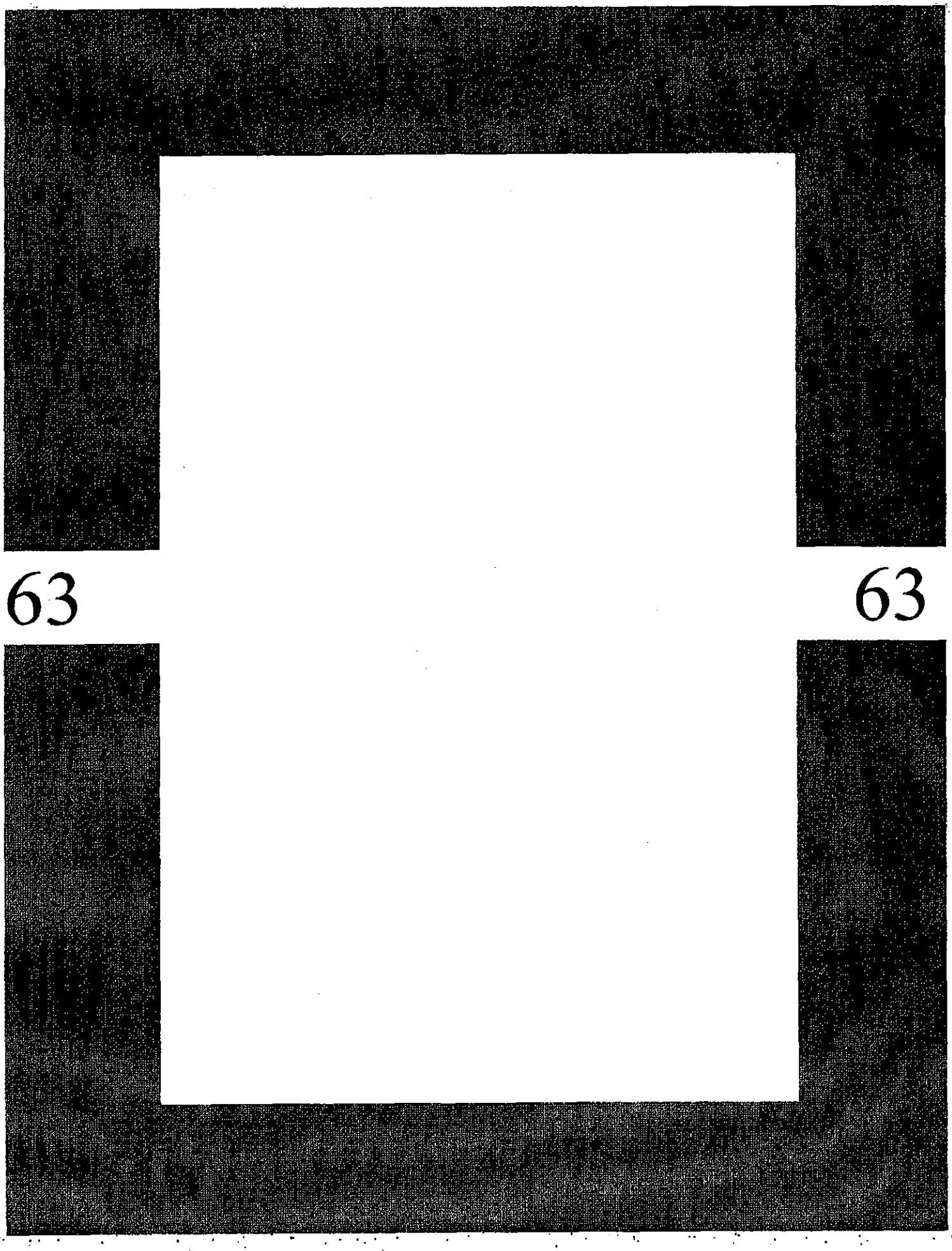

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DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiff,

v.

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

Defendants.

CASE NO. A539455
DEPT. NO X

ORDER GRANTING MOTION TO EXCLUDE WITNESSES FROM TESTIFYING REGARDING THE CREDIBILITY OR VERACITY OF OTHER WITNESSES

This matter having come on regularly for hearing before the Court on February 15, 2011, Stephen H. Rogers, Esq. of the law firm of Rogers, Mastrangelo, Carvalho & Mitchell appearing on behalf of Defendant Jenny Rish; and David T. Wall, Esq.. of the law firm of Mainor Eglet appearing on behalf of Plaintiffs; and the Court having entertained the respective arguments of counsel as well as being fully apprised of all the papers and pleadings on file with respect Jenny Rish's Motion to Exclude Witnesses from Testifying Regarding the Credibility or Veracity of Other Witnesses, and good cause appearing:

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IT IS HEREBY ORDERED, ADJUDGED AND DECREED that:

1. Defendant Jenny Rish's Motion to Exclude Witnesses from Testifying Regarding the Credibility or Veracity of Other Witnesses is GRANTED.

IT IS SO ORDERED.

Dated: Mar 21, 2011

The Honorable Jessie Walsh
District Court Judge

Submitted by:

ROGERS, MASTRANGELO, CARVALHO & MITCHELL

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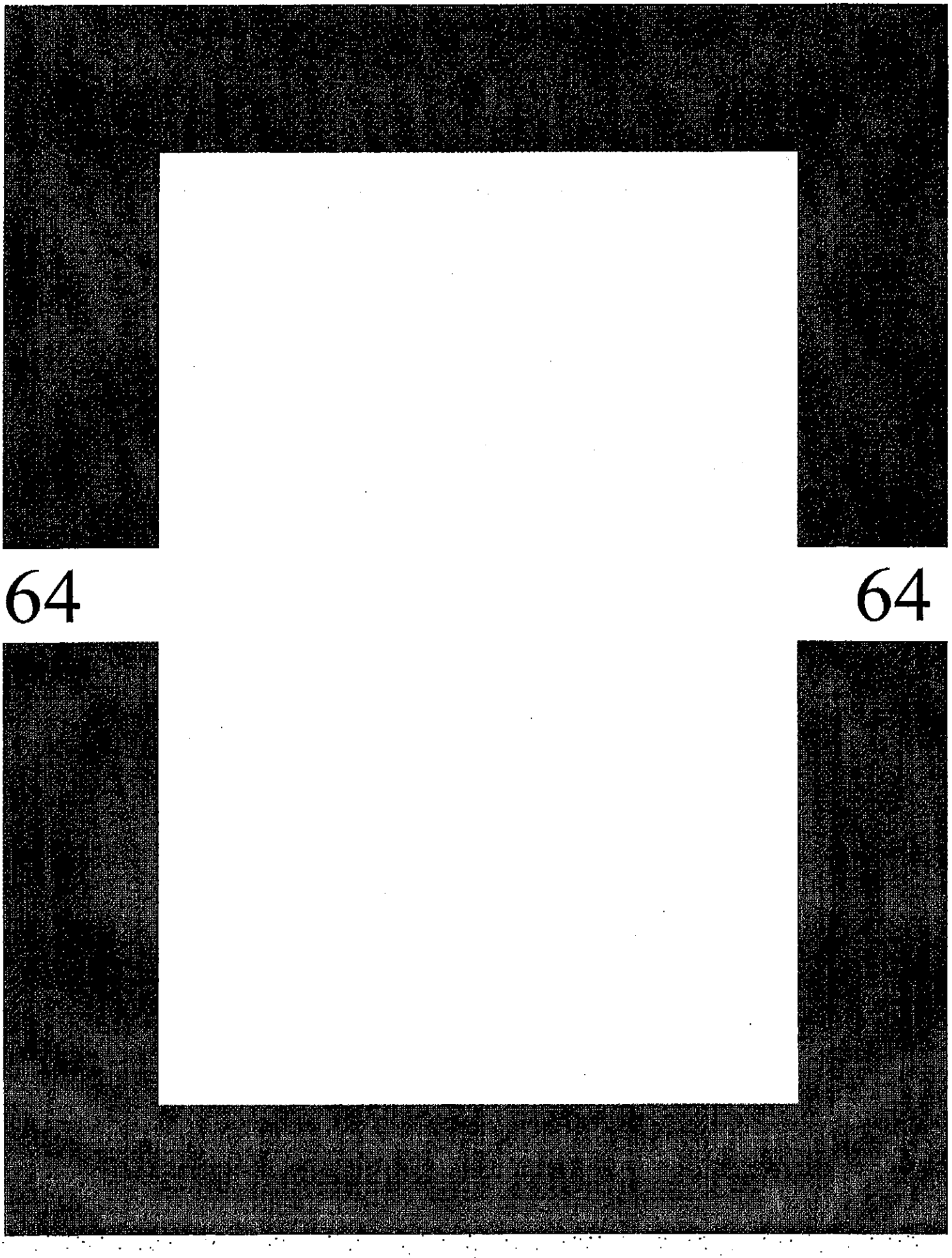

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DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiff,

v.

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

Defendants.

CASE NO. A539455
DEPT. NO X

ORDER GRANTING MOTION TO EXCLUDE GRAPHIC AND LURID VIDEO OF SURGERY

This matter having come on regularly for hearing before the Court on February 15, 2011, Stephen H. Rogers, Esq. of the law firm of Rogers, Mastrangelo, Carvalho & Mitchell appearing on behalf of Defendant Jenny Rish; and David T. Wall, Esq.. of the law firm of Mainor Eglet appearing on behalf of Plaintiffs; and the Court having entertained the respective arguments of counsel as well as being fully apprised of all the papers and pleadings on file with respect Jenny Rish's Motion to Exclude Graphic and Lurid Video of Surgery, and good cause appearing:

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IT IS HEREBY ORDERED, ADJUDGED AND DECREED that:

1. Defendant Jenny Rish's Motion to Exclude Graphic and Lurid Video of Surgery is GRANTED "as to blood," but DENIED "as to non-bloody photos or animation."

IT IS SO ORDERED.

Dated: 22 Mar 2011

The Honorable Jessie Walsh
District Court Judge

Submitted by:

ROGERS, MASTRANGELO, CARVALHO & MITCHELL

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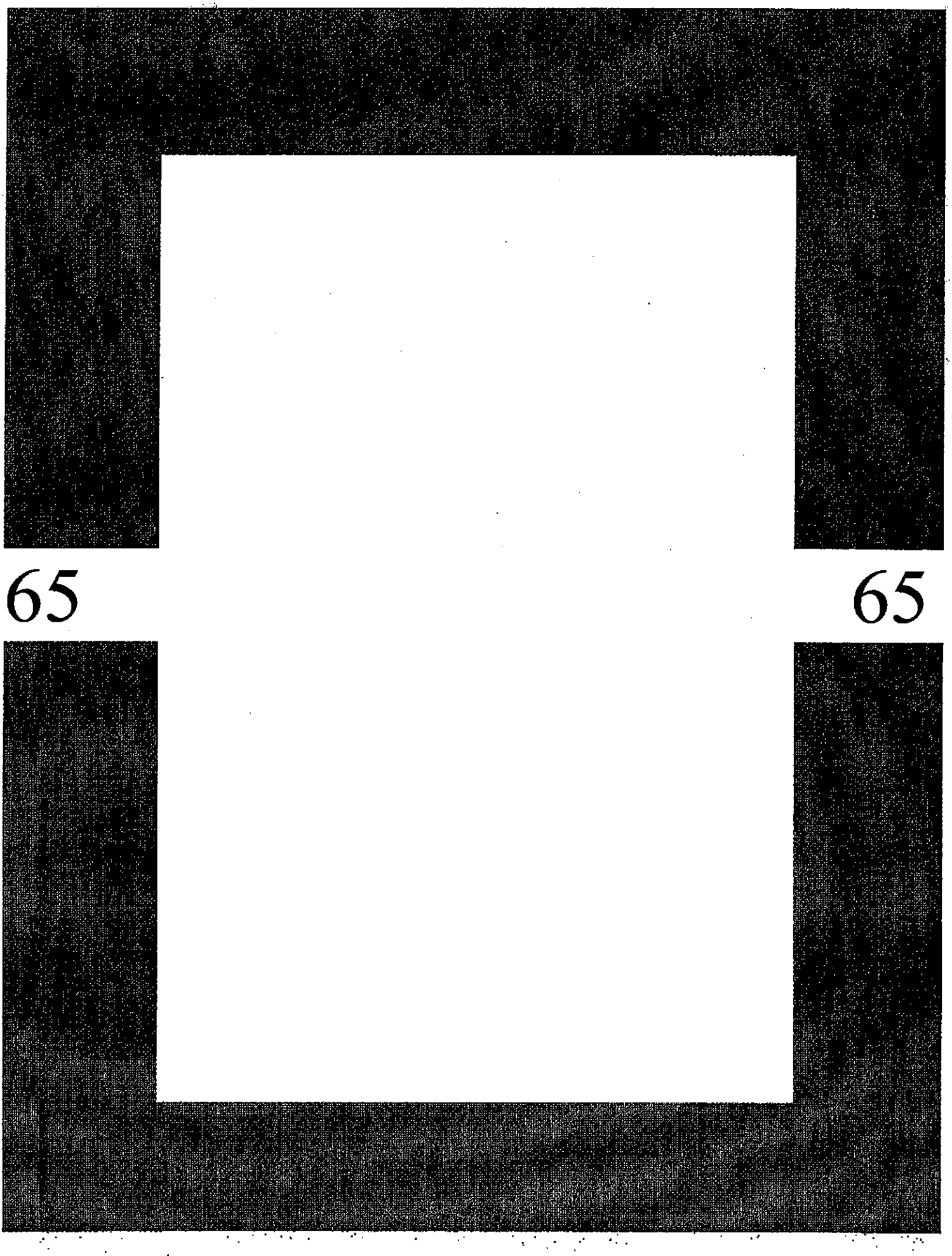

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CLERK OF THE COURT

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DISTRICT COURT

CLARK COUNTY, NEVADA

WILLIAM JAY SIMAO, individually and CHERYL ANN SIMAO, individually, and as husband and wife, Plaintiff, v. JENNY RISH; JAMES RISH; LINDA RISH; DOES I - V; and ROE CORPORATIONS I - V, inclusive, Defendants.	CASE NO. A539455 DEPT. NO X

ORDER GRANTING MOTION TO EXCLUDE DUPLICATIVE AND CUMULATIVE TESTIMONY

This matter having come on regularly for hearing before the Court on February 15, 2011, Stephen H. Rogers, Esq. of the law firm of Rogers, Mastrangelo, Carvalho & Mitchell appearing on behalf of Defendant Jenny Rish; and David T. Wall, Esq.. of the law firm of Mainor Eglet appearing on behalf of Plaintiffs; and the Court having entertained the respective arguments of counsel as well as being fully apprised of all the papers and pleadings on file with respect Jenny Rish's Motion to Exclude Duplicative and Cumulative Testimony, and good cause appearing:

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IT IS HEREBY ORDERED, ADJUDGED AND DECREED that:

1. Defendant Jenny Rish's Motion to Exclude Duplicative and Cumulative Testimony is DENIED "as Written," but the defense may object if the testimony becomes duplicative or cumulative.

IT IS SO ORDERED.

Dated: 22 Mar 2011

The Honorable Jessie Walsh
District Court Judge

Submitted by:

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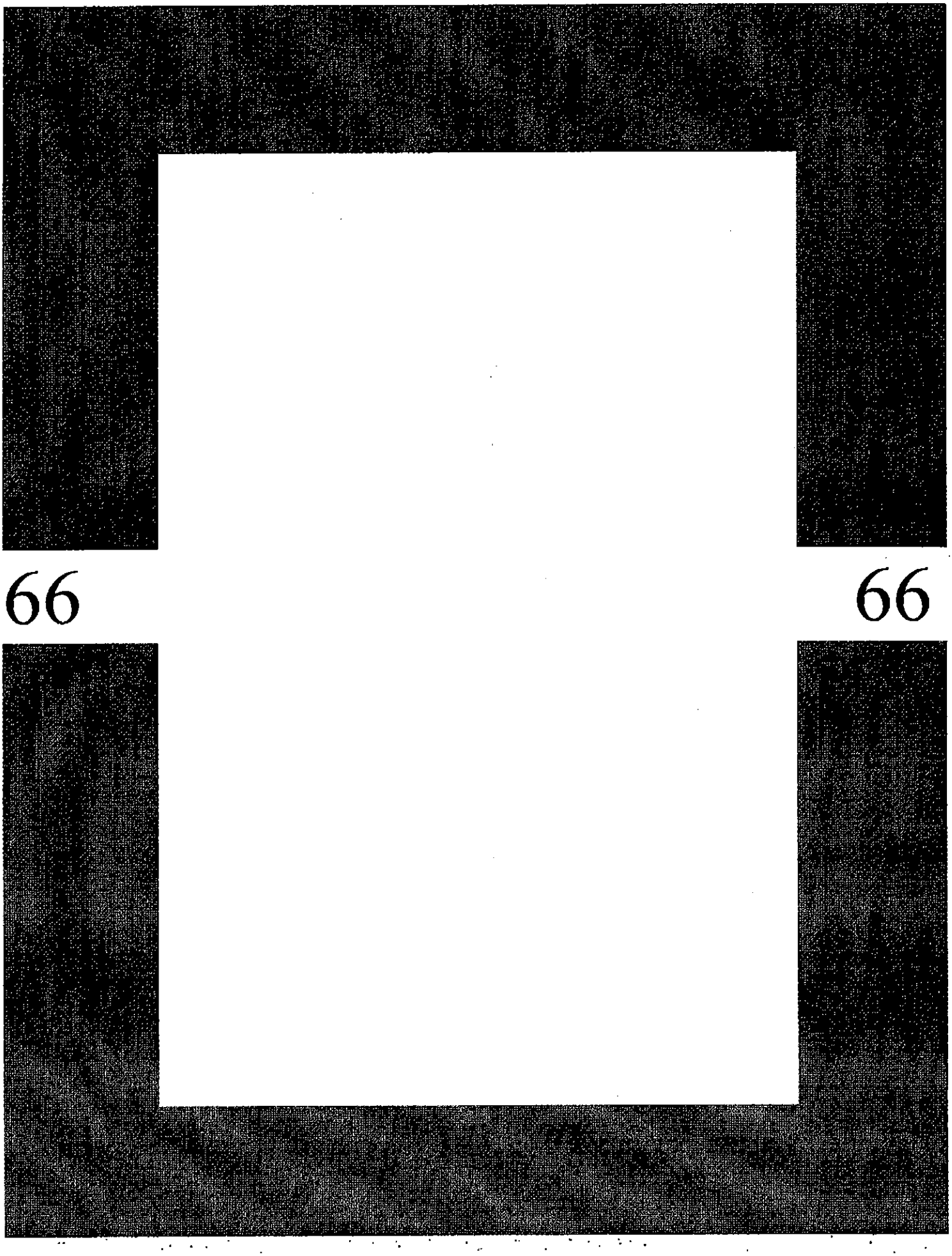

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DISTRICT COURT

CLARK COUNTY, NEVADA

WILLIAM JAY SIMAO, individually and CHERYL ANN SIMAO, individually, and as husband and wife, Plaintiff, v. JENNY RISH; JAMES RISH; LINDA RISH; DOES I - V; and ROE CORPORATIONS I - V, inclusive, Defendants.	CASE NO. A539455 DEPT. NO X

ORDER GRANTING MOTION TO EXCLUDE PLAINTIFF'S ACCIDENT RECONSTRUCTIONIST/BIOMECHANICAL EXPERT DAVID INGEBRETSEN

This matter having come on regularly for hearing before the Court on February 15, 2011, Stephen H. Rogers, Esq. of the law firm of Rogers, Mastrangelo, Carvalho & Mitchell appearing on behalf of Defendant Jenny Rish; and David T. Wall, Esq.. of the law firm of Mainor Eglet appearing on behalf of Plaintiffs; and the Court having entertained the respective arguments of counsel as well as being fully apprised of all the papers and pleadings on file with respect Jenny Rish's Motion to Exclude Plaintiff's Accident Reconstructionist/Biomechanical Expert David Ingebretsen, and good cause appearing:

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IT IS HEREBY ORDERED, ADJUDGED AND DECREED that:

1. Defendant Jenny Rish's Motion to Exclude Exclude Plaintiff's Accident Reconstructionist/Biomechanical Expert David Ingebretsen is DENIED.

The defense is granted leave to conduct voir dire of the witness before he offers expert opinion testimony.

IT IS SO ORDERED.

Dated: 22 Mar 2011

Jessie Walsh

The Honorable Jessie Walsh
District Court Judge

Submitted by:

ROGERS, MASTRANGELO, CARVALHO & MITCHELL

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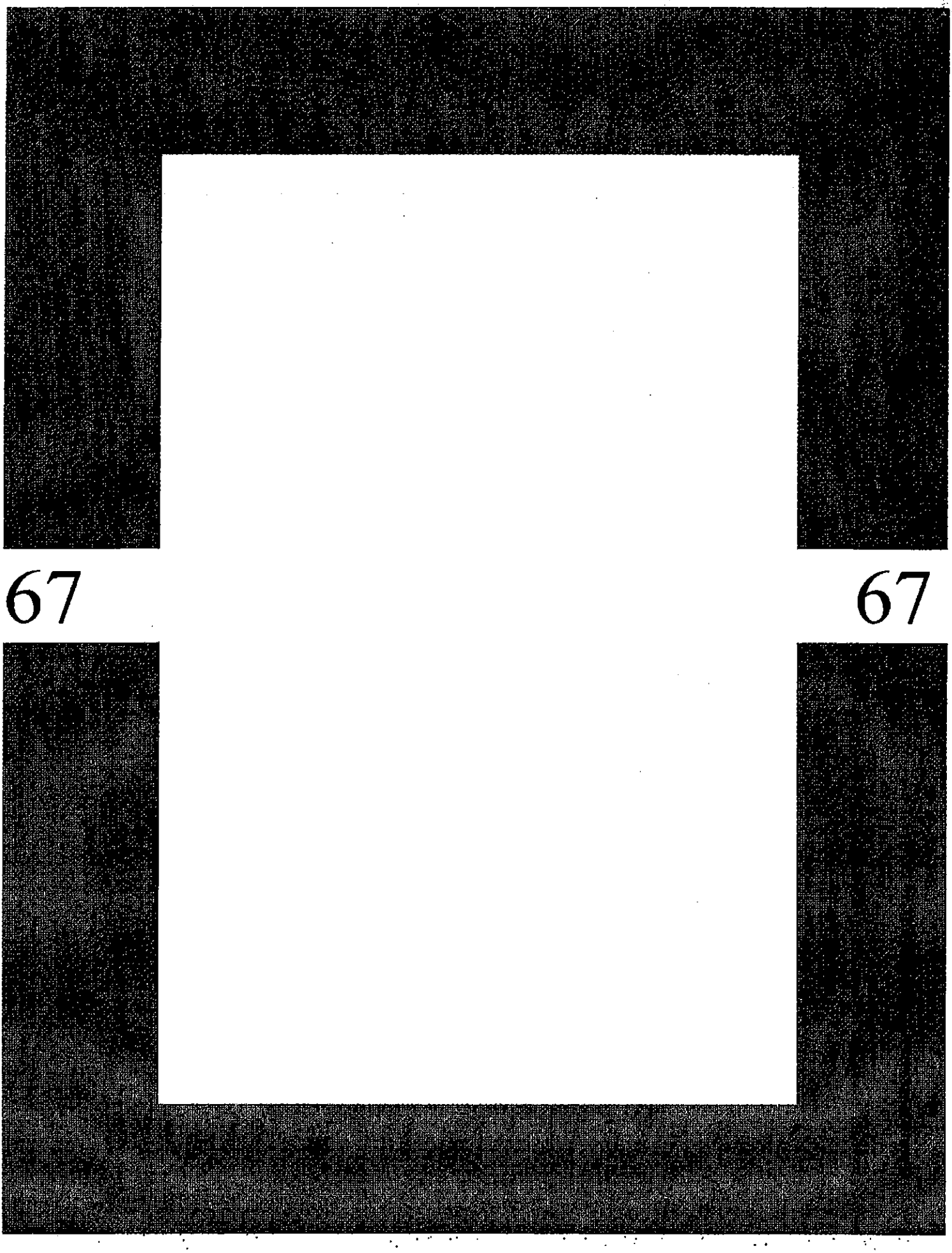

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CLERK OF THE COURT

ORDR
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DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiff,

v.

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

Defendants.

CASE NO. A539455
DEPT. NO X

ORDER GRANTING MOTION TO EXCLUDE ARGUMENT OF CASE DURING VOIR DIRE

This matter having come on regularly for hearing before the Court on February 15, 2011, Stephen H. Rogers, Esq. of the law firm of Rogers, Mastrangelo, Carvalho & Mitchell appearing on behalf of Defendant Jenny Rish; and David T. Wall, Esq.. of the law firm of Mainor Eglet appearing on behalf of Plaintiffs; and the Court having entertained the respective arguments of counsel as well as being fully apprised of all the papers and pleadings on file with respect Jenny Rish's Motion to Exclude Argument of Case during Voir Dire, and good cause appearing:

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IT IS HEREBY ORDERED, ADJUDGED AND DECREED that:

1. Defendant Jenny Rish's Motion to Exclude Motion to Exclude Argument of Case during Voir Dire is GRANTED;

IT IS SO ORDERED.

Dated: 22 Mar 2011

Jessie Walsh

The Honorable Jessie Walsh
District Court Judge

Submitted by:

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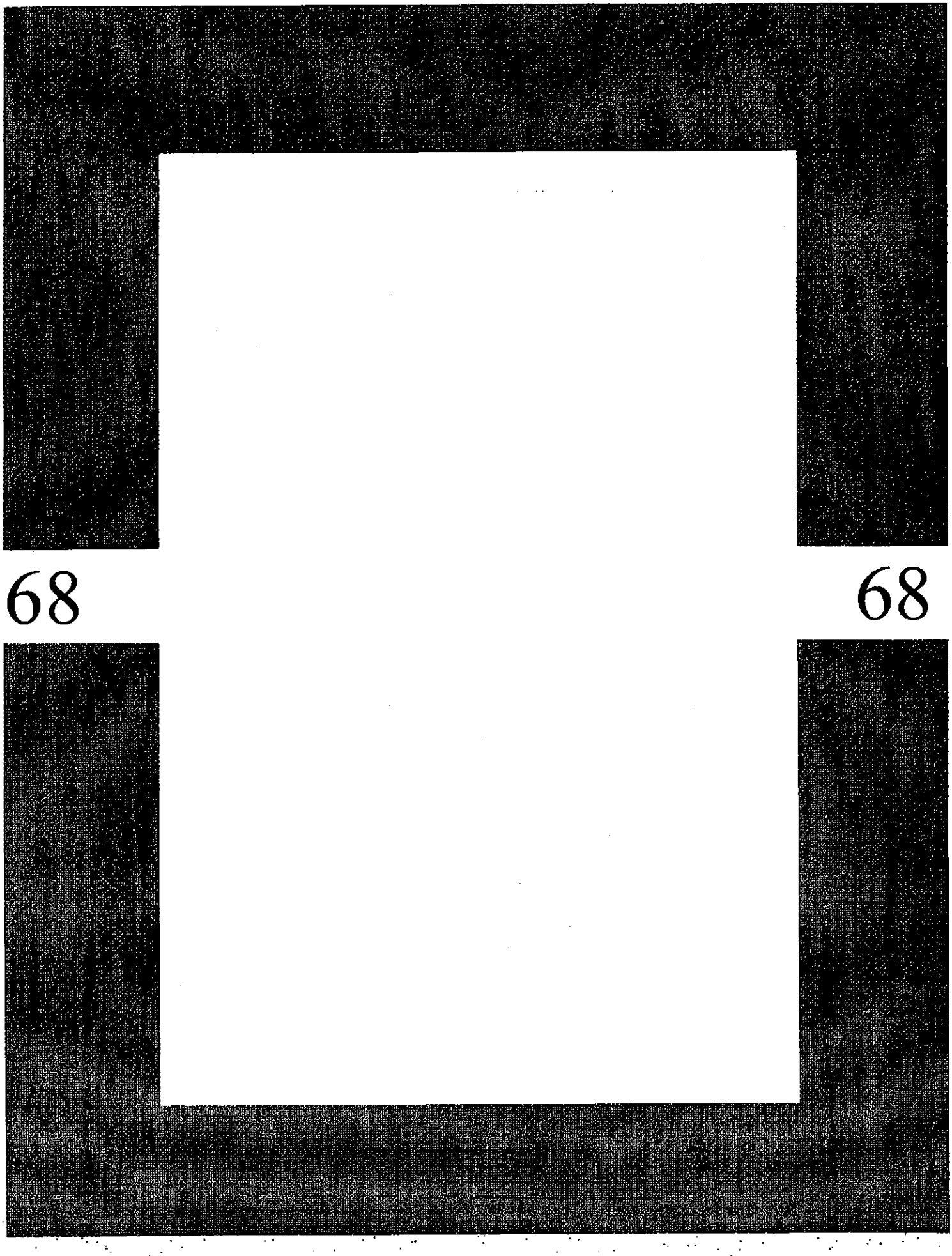

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CLERK OF THE COURT

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Attorneys for Defendant Jenny Rish

DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiff,

v.

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

Defendants.

CASE NO. A539455
DEPT. NO X

ORDER GRANTING MOTION TO EXCLUDE PLAINTIFF'S ECONOMIST, STAN SMITH, FOR LACK OF FOUNDATION TO OFFER EXPERT ECONOMIST OPINION TESTIMONY

This matter having come on regularly for hearing before the Court on February 15, 2011, Stephen H. Rogers, Esq. of the law firm of Rogers, Mastrangelo, Carvalho & Mitchell appearing on behalf of Defendant Jenny Rish; and David T. Wall, Esq.. of the law firm of Mainor Eglet appearing on behalf of Plaintiffs; and the Court having entertained the respective arguments of counsel as well as being fully apprised of all the papers and pleadings on file with respect Jenny Rish's Motion to Exclude Plaintiff's Economist, Stan Smith, for Lack of Foundation to Offer Expert Economic Opinion Testimony, and good cause appearing:

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IT IS HEREBY ORDERED, ADJUDGED AND DECREED that:

1. Defendant Jenny Rish's Motion to Exclude Plaintiff's Economist, Stan Smith, for Lack of Foundation to Offer Expert Economic Opinion Testimony is GRANTED in part; and Plaintiff's economist offers opinion testimony in five (5) categories:

A. Loss of business earnings

Motion granted

B. Household services

Motion denied, but Plaintiff must lay the foundation.

C. Loss of Enjoyment

Motion denied, but Plaintiff must lay the foundation.

D. Loss of Society and Relation

Motion denied, but Plaintiff must lay the foundation.

E. Present Value of Future Life Care Plan

The ruling will be made after the hearing on the motion to exclude the life care plan.

IT IS SO ORDERED.

Dated: 22 Mar 2011

The Honorable Jessie Walsh
District Court Judge

Submitted by:

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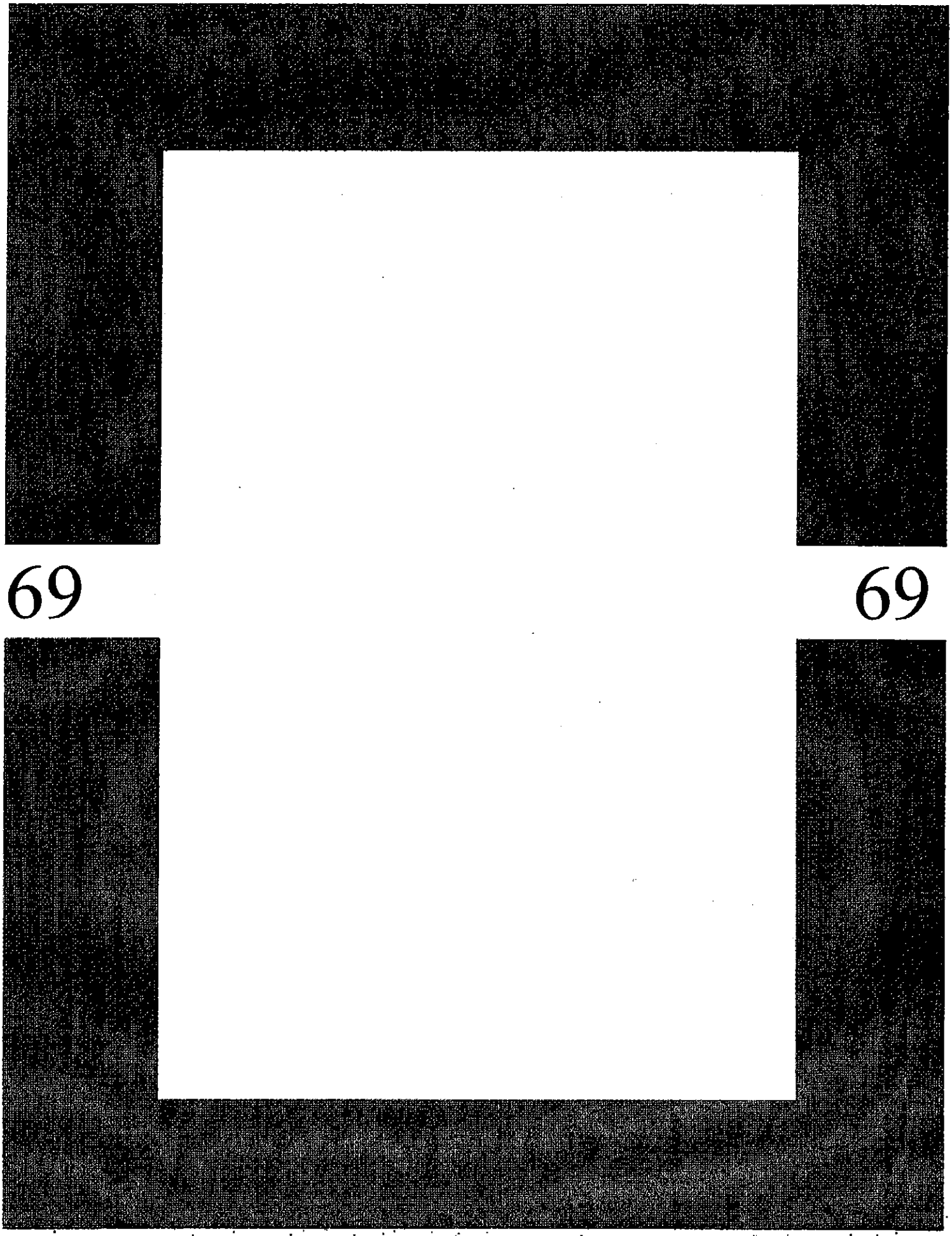

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DISTRICT COURT

CLARK COUNTY, NEVADA

CLERK OF THE COURT

CHERYL A. SIMAO and WILLIAM J. SIMAO, Plaintiffs,	CASE NO. A-539455
v.	DEPT. X
JAMES RISH, LINDA RISH and JENNY RISH, Defendants.	

BEFORE THE HONORABLE JESSIE WALSH, DISTRICT COURT JUDGE

WEDNESDAY, MARCH 23, 2011

REPORTER'S TRANSCRIPT
TRIAL TO THE JURY
DAY 3 - 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. CHARLES A. MICHALEK, ESQ. Hutchison & Steffen, LLC

RECORDED BY: VICTORIA BOYD, COURT RECORDER

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TABLE OF CONTENTS

001711

001711

001711

EXHIBITS

001712

001712

001712

WEDNESDAY, MARCH 23, 2011 AT 1:00 P.M.

THE COURT: Please be seated. I understand there's something outside of the presence of the jury, Mr. Rogers.

MR. MICHALEK: I want to discuss sort of the objections that went on yesterday and sort of the mis-citation in the record and what happened.

MR. EGLET: Your Honor, if I could --

MR. MICHALEK: There was a motion in limine --

MR. EGLET: Before Mr. Michalek begins, if I could interrupt. I've got a doctor waiting out in the hall. I have got to get him --

MR. MICHALEK: He's right behind you.

MR. EGLET: Actually, he's here. I've got to get him finished today. Mr. Michalek wants to make a record and do some offers of proof regarding yesterday's witness. That can be done during a break or at the end of the day. Can we -- can get this started? It has nothing to do with this witness.

THE COURT: I agree. Yes.

MR. EGLET: Thank you.

MR. MICHALEK: Your Honor, it does have something to do with this witness. Mr. Eglet is incorrect. What I'm discussing affects the questions that Mr. Rogers will ask this witness. I'm going to be very brief, but I need to go through the ground --

THE COURT: Well, specifically, what does it have to do

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with this witness?

MR. MICHALEK: Okay. The veracity of witnesses and experts, we had a motion in limine which was filed, and I'll read to you the relief that we asked for. We said, "Defendant asks this Court to enter an order precluding any witness, including expert or medical witnesses, from vouching for the veracity of credibility of another witness." Now, yesterday, that's exactly what Dr. Rosler [phonetic] did. Dr. Rosler commented upon the veracity of his patient. He vouched for it, he said that he was trained to tell if patients are exaggerating or lying, and he gave his opinion upon questioning from Mr. Eglet that his patient was telling essentially the truth. He vouched for that credibility. If that's going to happen again with the other medical doctors, I think it's important the fact that the Court granted this motion in limine without objection. And I can show you in the -- I got a copy of the transcript --

THE COURT: If that --

MR. MICHALEK: -- of hearing --

THE COURT: If that's the subject of your wanting to make a record as to this witness, then it can wait, frankly, because what I heard was not an expert witness or a -- or a treating physician vouch for the credibility of his -- of his patient. That's not what I heard. So let's move on. Let's bring our jury in and --

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MR. MICHALEK: All right.

THE COURT: -- let's get going.

Can we have the witness come forward to the witness box. Save a little time.

[Jury In]

THE COURT: Please be seated, ladies and gentlemen.

Counsel, stipulate to the presence of the jury.

MR. ROGERS: Yes, Your Honor.

MR. EGLET: Yes, Your Honor.

THE COURT: Okay. I ask the witness to raise his right hand to be sworn by Madam clerk.

PATRICK SHAWN MCNULTY, PLAINTIFFS' WITNESS, SWORN

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

THE WITNESS: Patrick Shawn McNulty. Patrick, P-a-t-r-i-c-k, Shawn, S-h-a-w-n, McNulty, M-c-N-u-l-t-y.

THE COURT: Whenever you're ready, Mr. Eglet.

MR. EGLET: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. EGLET:

Q Good afternoon, Dr. McNulty.

A Good afternoon.

Q Doctor, would you please tell the jury the specialty in medicine you practice.

A I'm a board certified orthopedic surgeon who

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subspecializes in spine surgery.

Q And can you please tell us where you attended medical school.

A University of Miami.

Q And what year did you graduate?

A 1988.

Q And where did you do your internship and residency training?

A U.T. Southwestern and Dallas, Texas, essentially Parkland.

Q And you did your orthopedic surgery residency there as well?

A Yes.

Q Okay. And did you go on to do a spine fellowship?

A Yes.

Q And what years did you do your spine fellowship?

A 1993 through 1994.

Q Where did you do your spine fellowship?

A Johns Hopkins.

Q Are you board certified?

A Yes.

Q And what does it mean to be board certified?

A Board certified is simply a process by which an independent national entity vouches for your credentials and qualifications to practice a specific specialty of medication.

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I've got board certification by the orth- -- American Board of Orthopedic Surgery as well as the American Board of Spine Surgery.

Q And do you belong to any professional memberships?

A Yes.

Q What memberships?

A Scoliosis Research Society, North American Spine Society, the American Academy of Orthopedic Surgeons, also members of various engineering societies because I was an engineer before.

Q And could you detail for us the scope of your practice as an orthopedic spine surgeon.

A Essentially my practice is focused on spine problems. Occasionally I do some general orthopedics in the sense it's -- a good example would be shoulders can be sometimes presenting as neck problems and vice-versa since I evaluate patients and then decide in a general sense what's appropriate treatment. And I myself as -- primarily I'm a spine surgeon.

Q And do you have hospital privileges?

A Yes.

Q At what hospitals do you have privileges?

A I have several. I primarily practice at University Medical Center, but I also will practice at Valley Hospital, Mountain View, Sunrise, Southern Hills. The facilities in the

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Valley for which I choose not to have privileges is primarily North Vista and St. Rose Delima.

Q And have you ever worked at a military hospital?

A Yes.

Q What military hospital?

A I was active duty in the military. During the course of my training in medical school I was at Oakland Nava Hospital, Bethesda Naval Hospital, San Diego Naval Hospital, as well as when I was active duty doing spine surgery, teaching residents I was at Port Smith Naval Hospital.

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

A Yes.

MR. EGLET: Your Honor, we would offer Dr. McNulty as an expert in orthopedic surgery and orthopedic spine surgery?

THE COURT: Any objection?

MR. ROGERS: No objection.

THE COURT: So ordered.

BY MR. EGLET:

Q Doctor, would you please describe for us the scope -- strike that.

Now Doctor, are you one of William Simao's treating orthopedic spine surgeons?

A Yes.

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Q And who referred Mr. Simao to you for orthopedic spine evaluation?

MR. EGLET: Would you put up Exhibit 22, page 2, please.

THE WITNESS: I would confirm by referring to my notes, but I believe it was a Southwest Medical primary care provider.

BY MR. EGLET:

Q Okay. And was it a physician assistant, Brent Hill [phonetic], at Southwest Medical?

A I can confirm that simply with my first chart note. Yes, Brent Hill, physician assistant.

Q Okay. And what date did you first see Mr. Simao?

A It was 4/18/2006.

Q Okay.

MR. EGLET: Page 3, please, Brendan [phonetic].

BY MR. EGLET:

Q Did Mr. Simao complete a pain diagram before being seen by you on April 18, 2006?

A Yes.

Q Would you review for us this pain diagram and describe the location, character and severity of his pain.

A Is it possible for me to manipulate this image, or do you know?

Q What -- you mean draw on it?

A No, just move it around if you want me to refer to

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it.

Q Tell us where you want it to move and Brendan can do that for you.

A Okay. So what was your question, please?

Q Well, the question is can you review this diagram with us and describe the location, character and severity of his pain.

A Sure. So essentially this is a front-back figure which the patient will ideally shade in the painful areas and further describe whether or not it's -- in his case he checked off ache, pins and needles, numbness, stabbing, pressure. So you can see he's basically drawn in the back of the neck extending up to the back of the head going out onto the trapezius or the trapezial regions down into the upper back and in between the central portion of the upper back, what we call the periscapular region. There's also some extension onto the front of the left chest and down the left arm.

Q Okay.

MR. EGLET: Page 5, please, Brendan.

BY MR. EGLET:

Q What history did you obtain from Mr. Simao at the time of your initial evaluation of him?

A Is it -- can we go to the first page of the diagram -- or the questionnaire as well.

Let me go find that.

The symbol-- my history that's written in the chart note reflects both reviewing the questionnaire as well as asking questions, so -- that's hard for you. It'd just be simpler to pull that up. Are you able to get that on or no?

Okay.

I can simply start with reading the chart note then or --

BY MR. EGLET:

Q That's fine.

A So he presents to me for the first time April 18th, 2006, stating that he has a one-year history of pain basically as drawn on his pain diagram, where he divides his pain 75 percent axial, which means it's basically the head, neck, central portion of his spine, and 25 percent arm, stating it's worse 10 out of 10, meaning the worst pain he can experience, and currently 6.5 out of 10. States it's worse with movement, better with massage and pressure. Does not relate any significant limitations with sitting, standing, riding in a car or walking, and describes his symptoms as aching, pins and needles, numbness, stabbing and pressure. He states he's had physical therapy, he's had medications. And the symptoms started after a motor vehicle accident. Also stated -- went over medications. No known drug allergies. Smokes a half pack of cigarettes a day, rare alcohol. Working in flooring sales. No surgeries. Past medical history of high blood pressure, high cholesterol. And no fever, chills or weight

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loss.

MR. EGLET: MR. EGLET: Now go to page 5, please, Brendan.

BY MR. EGLET:

Q What treatment at Mr. Simao undergone before being seen by you, Doctor?

A Stated he's had medications and physical therapy.

Q Okay. And when did Mr. Simao's symptoms start?

A He simply stated after a motor vehicle accident. But if you can find that first page --

Q Is that on the screen?

A Is that the date of -- yes. Can you zoom out a little bit so I can see. I'm having a little trouble with the left margin.

MR. EGLET: Move back.

THE WITNESS: Okay. If you can go to the top. So here he states it's been going on approximately a year. Stated it was a car accident. Doesn't give a specific, but I would assume April of '05.

BY MR. EGLET:

Q All right. Now, Why did you not detail the nature of Mr. Simao's motor vehicle accident in your initial evaluation of him?

A Well, the details -- from a practical sense as far as treating him, he was simply in an accident. He's had

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conservative measures. So as far as additional details, I would -- assuming like details of the accident, preexisting history -- at that point in time I specifically stated he had, quote, unquote, no significant medical legal issues, and that's simply because I see patients occasionally who do have accidents and there are entities involved who want to know details so they can sort out legal issues. So at that point in time I was not aware of any. Otherwise, there would have been an additional line of questioning to more specifically clarify any significant prior problems, when did the symptoms start, did they stay consistent, did they go away, did they come back, and that line of questioning is pointed to helping legal parties figure out the issues they'd like to figure out.

Q Okay. Now, have you had your deposition taken in this case by a defense attorney?

A Yes.

Q And you had it taken once in December 2008 and then again in June 2009?

A I assume so. I know there was two separate days.

Q During the course of those two depositions were you asked by Mr. Rogers about Mr. Simao's previous medical history?

A I would assume so. Do you want to -- do you want me to look at the depositions to confirm?

Q No. Just do you recall being --

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A Yes.
Q -- asked about -- okay.
A Yes.
Q And Did Mr. Rogers also ask you about the details of the motor vehicle wreck that was -- that has brought you here today?
A I assume so.
Q Were you also asked by Mr. Rogers to review the treatment that Mr. Simao reviewed -- received by other medical providers during your depositions?
A Yes.
Q Okay. So while your primary focus during your evaluation of Mr. Simao was to clinically evaluate and treat his chronic pain, did you also review additional medical records and documents as a result of the depositions that were taken of you in this matter?
A During the course of the deposition, yes.
Q What do you recall about the motor vehicle wreck Mr. Simao was involved in on April 15th, 2005?
A Quite honestly, I have no direct recollection.
Q Okay. Do you -- do you recall reading other medical records which documented the nature of the motor vehicle accident, in other words, whether it was a rear-end or versus a --
A I don't have independent recollection.

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Q All right. Fair enough. As a result of the injuries Mr. Simao sustained in the April 15th, 2005 motor vehicle accident, what clinical diagnosis was given to Mr. Simao by his treating medical providers at Southwest Medical Associates regarding his neck after his evaluation there on April 15th, 2005?

A Well, I mean I recall them having concerns. Initially they said he had a cervical sprain. It mentions some occipital pain. And I think there was more focus concern about issues of headaches, alteration of vision, that initiated a workup that was basically focused on making sure there wasn't any significant intercranial or brain problems.

Q Can a traumatic injury to the neck resulting in a sprain or strain injury to the neck also result in disc or facet injuries to the cervical spine at the same time?

A Well, I would make the general comment that the term "sprain" by definition means a muscle is overstretched and injured. The term "strain" means a ligament, a perfect example would be an ankle ligament, is overstretched, ruptured and injured. So those terms get used frequently when people come in with neck complaints with a traumatic mechanism as a history, but the reality is they're really not doing anything to confirm in a general sense whether or not it's muscle strain, a ligament strain, a disc injury, a facet injury. So I personally prefer the term "cervical syndrome" which

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basically says yes, there's complaints in regards to the neck, the cervical spine, but it's really not pragmatic at that initial onset to really state a more defined structural cause unless someone's obviously presenting with a more extreme case of a fracture, paralysis. In that case, you've got other more severe presenting complaints findings. But in general, the more -- the less severe complaints I use cervical syndrome, and I don't think you can really appropriately in the strict definition of the words apply sprain and strain. I think they're, in a practical sense, just used to recognize the patient's having complaints of neck pain.

Q In your practice when you see patients -- patients ultimately referred to you after a traumatic event, let's say in the neck, and you -- and you go on to ultimately diagnose them with a disc injury of some type, is it common that the initial medical providers, whether it's emergency room police or primary care providers or physical therapist of chiropractors will -- the initial working diagnosis will be sprain/strain to the cervical spine?

A Yes.

Q Okay. Can the symptoms of a neck sprain or strain be similar to those of a traumatic cervical disc or facet injury?

A Yes.

Q Okay. In patients who have sustained traumatic cervical disc or facet injuries -- strike that.

Now, how do you clinically distinguish the diagnosis of a neck sprain or strain from a cervical disc or facet injury?

MR. ROGERS: Well, I --

THE WITNESS: I'm sorry.

MR. ROGERS: I'm just going to object because it's compound. We're talking ligaments, muscles, facets and discs.

THE COURT: Ask you to rephrase, please.

BY MR. EGLET:

Q How do you clinically distinguish the diagnosis of, one the one hand, the soft tissue, muscular or ligament sprain/strain type injuries we talked about, versus a disc injury or a facet injury?

A Well, the answer is, for the most part, pragmatic. When you see someone initially you assess the severity of the mechanism, and then once you've ruled out serious injuries like significant instability or ligament disrupture to the point the vertebra aren't reliably staying together, or fractures, then the prognosis overall is very good. I would say that in general 85 to 90 percent of people during the course of the next six to twelve weeks are going to improve. So at that point, just being relatively pragmatic, you reassure the patient that there is not a majority structural injury, and you follow them clinically, encourage them to be active. Personally, if I were following them from the initial

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onset, which typically as a spine surgeon I am not, if they're not getting better by four weeks I would potentially initiate physical therapy. But the simple answer to the question is you let time tell you over the course of the ensuing six to twelve weeks whether or not they're going to improve. Then at that point, after three to four months, if they're not improving, then you can initiate a more defined, potentially invasive workup that would more clearly define the ongoing structural issues that are causing the pain, and that's simply because at that point if you're not better, chances are relatively low, less than 10 to 15 percent, that you're going to improve if you've had a reasonable course of conservative measures. So you're trying to be optimistic -- appropriately optimistic, but at the same time if you're reaching a fork in the road where you're not improving, you don't want to unnecessarily drag things out because that -- that starts a whole other slew of problems and then you start getting into the issues of chronic pain.

Q Okay. If someone were to stand in front of this jury and tell them that a cervical disc injury is immediately described symptomatically by the patient and/or diagnosed immediately by the patient's treating physicians following a traumatic event, would that be an accurate statement?

MR. ROGERS: Objection, Your Honor, that's compound as

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well.

THE COURT: Overruled. You may answer --

THE WITNESS: Well --

THE COURT: -- the question.

THE WITNESS: -- there are extreme severe traumatic episodes, but this is more along the line of someone who's had a severe injury where literally their spine has been ripped apart, and in that particular, very unique case, sure. The patient comes in with severe pain, their neck is diffusely tender, they get an x-ray where there is some shifting of the vertebra. You get a confirmatory MRI because you're worried about a significant ligament injury where literally all the ligaments that are keeping the vertebra together are potentially ripped, in that particular case you could have a quote, unquote, disc injury defined by diagnostic studies, but that's a severe injury in which all the surrounding structures of a disc -- the disc vastly is held by tough ligamentous rim -- and all that's ripped. And that is not the classic more common scenario we typically talk about in these cases.

BY MR. EGLET:

Q Do you believe that the fact that there is no documentation of neck pain in Mr. Simao's medical records from May 2005 until October 2005 means that he was not having neck pain during that time?

MR. ROGERS: Objection, calls for speculation.

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THE COURT: Overruled.

THE WITNESS: I reviewed those records, and again, it was my opinion that the focus appeared to be mainly his complaints of headache, altered vision. It appeared that they were more concerned about a serious problem with his head or his brain that overshadowed or diverted the attention to a potentially more serious problem. So I would agree the notes themselves did not reflect any complaints of neck pain, but at the same time if I was treating him and someone had come in with trauma and was having complaints of altered vision and headaches, you know, I would be focusing my attention on the brain/head problem as well.

BY MR. EGLET:

Q And do you have any reason to believe that Mr. Simao was not truthful with you during your treatment of him?

MR. ROGERS: Objection, Your Honor. We raised this same objection yesterday. If you'd like, we can approach. Otherwise, it's as --

THE COURT: I don't know --

MR. ROGERS: -- stated.

THE COURT: I don't know that it's necessary. Noted for the record. Overruled. You may answer the question.

THE WITNESS: I don't have any recollection either through the charts or independently, of him not being forthright and truthful to me.

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BY MR. EGLET:

Q Now, let's return now to your initial --

MR. EGLET: If we could go -- is this page 5, Brendan?

BY MR. EGLET:

Q Let's return now to your initial evaluation of Mr. Simao. Did you document his history of migraine headache syndrome?

A Well, I can tell you just by the simple fact he takes Fiorinal, even though it's not clearly listed, Fiorinal is typically for migraine headaches.

Q Did the fact that Mr. Simao had a history of chronic migraine headaches at any -- strike -- at the time of his presentation to you impact your clinical evaluation or assessment of his chronic neck pain?

A No.

Q Why not?

A Well, in the simple sense, headaches -- migraine headaches are typically headaches. The pain diagram obviously shows a lot of other areas of his body that Mr. Simao was complaining about that would not be related to headaches -- or migraine headaches. Excuse me.

Q Could you please review for us your document physical examination of Mr. Simao on April 18th, 2006.

A Briefly, I stated that he was alert, oriented, appropriately responding, healthy. His vital signs appeared

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to be stable. Had a -- basically a lean, healthy body build, and says that he wasn't excessively overweight at all, 6 foot 6, 275 pounds. I stated there was no significant difference C5 to T1 dermatomes and myotomes. Specifically what that's stating is while a patient is sitting there I will test various muscle groups and actions side to side at the same time to appreciate any subtle imbalance or asymmetry. And at that point in time he really didn't have any discernible significant weakness or numbness that would be classically associated with any specific spinal nerves coming out of the neck. Also stated he has no clonus or Babinski or Hoffman's. Those are specifically exam maneuvers to elicit or see if there's any problems with the function of the spinal cord. Also, there was not any abnormal reflexes or increased reflexes in the arms or legs.

Also had at that point in time a negative elbow flexion test and negative Phalen's. Those are specifically tests to see if there's any associated irritations of the ulnar nerves at the elbow. The ulnar nerves are the layman's funny bone. If you hit it, that's when you get the zinger going down to your hand. Because occasionally you can have pinched nerves that can present with similar symptoms as problems with ulnar nerves at the elbows or the ulnar nerves at the wrist or the median nerves at the wrist, and that's called carpal tunnel. So that's important to also note that

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at that point in time there was really no clinical findings to suggest he had any problems with the ulnar or median nerves as they travel through his arm.

Q What diagnostic testing did you review at the time of your initial evaluation of Mr. Simao?

A An MRI of the cervical spine.

Q And would you please --

MR. EGLET: Could you put up Exhibit 19, page 11 and 12, please, Brendan.

BY MR. EGLET:

Q Please show and review for us the diagnostic findings on this March 22nd, 2006 cervical MRI.

A Well, let make the first -- the qualifying statement. My diagnostic testing basically reflects me looking at the report, as well as reviewing the films and making a summary. So, for instance, if I'm missing a report or missing the films, I make such a qualifying statement. So having said this, this reflects both looking at the report as well as looking at the films. So I basically said that there was some mild narrowing of the left C3-4 neuroforamen. That's basically where the nerve is exiting from the spinal canal between the third and the fourth vertebral levels on the left side. And stated also there may be some contact with the left C4 nerve, and looking at the report there's really no significant discrepancy there. They mention facet

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hypertrophy. Facet hypertrophy is basically the small joint in the back of the spine. At each level you have a disc and two facet joints, and sometimes those facet joints can enlarge. As they enlarge they can pinch the exiting nerves going out of that nerve exit hole. And then also mentioned that he had a small central protrusion, which is basically the disc with a small bulge in the middle back towards the spinal cord at C4-5. And no significant other abnormalities. So it doesn't appear like there's anything I stated there that wasn't stated in the report.

MR. EGLET: Brendan, could you put up Exhibit 39, please.

BY MR. EGLET:

Q Doctor --

MR. EGLET: Your Honor, may I have the doctor come out of the box?

THE COURT: Yes.

BY MR. EGLET:

Q Could you come back out of the box here, and I'm going to ask you to discuss your findings -- your findings. Just tell Brendan -- I think this is page 1 of 4 -- you can tell him to go to the next page or point to what --

THE WITNESS: Next page. Next page. Are we able to blow this up and enlarge?

MR. EGLET: Well, tell -- point what you want to blow it up.

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THE WITNESS: Okay. So this is starting at the top. So basically this is our map. So if we pull the model here. What an MRI does is basically it takes your spine and it cuts it up so you can see it. So you've got pictures that are looking from the side, sometimes pictures look from the front, and then pictures that look down the two like cutting a piece of hotdog into little round slices.

So these cuts are starting at the C3 vertebra which is above the C3-4 disc.

Now, let's -- are you able to go down square by square?

UNIDENTIFIED MALE: Yeah.

THE WITNESS: Okay. So let's start here, please. So -- can we go to the next one down.

Okay. So this is a good picture to start. So this is the C3-4 level. So this is basically the level -- this is the whole spine, but obviously we're concentrating here. So this is the level starting at this disc which is between the third and fourth cervical vertebra. So this is the right nerve exit hole here, okay. You see how wide open that is. Now, just so you know, nature gave you plenty of room, so for the most part we've all got a three-car garage to get our one car out. So as we get older we've got extra room to get old, so -- but you can see going to the left you've got this extra prominence. This is the facet joint which is narrowing this

nerve exit hole. So you can obviously see where you can appreciate that this left -- left is over here -- the C3-4 neuroforamen or nerve exit hole is narrowed.

If we go to the next cut down.

So that is definitely there and potentially it's something to keep in mind as we go on.

So we keep going down. We'll go down to the next level. Keep going. So let's see. Go back one. Can't see on that. Go back one. Okay. Keep going now back the other way. Keep going. Keep going.

So we're basically coming down the spinal canal here.

Go back to the bigger -- the overall views. All the squares. Just want to easily march down these. Okay. So here, this is the square you want. Next one down.

And here's the C4-5 level where there is a small little bulge or extra slight prominence of this disc. But there's really no significant neurologic compromise or pinching of that.

BY MR. EGLET:

Q Now, are the findings that you described for us on this March 22nd, 2006 cervical -- thank you -- MRI caused by the motor vehicle crash that Mr. Simao was involved in on April 25th --

MR. ROGERS: Objection, foundation.

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Q -- 2005?

THE COURT: Counsel approach, please.

[Bench Conference Not Transcribed]

BY MR. EGLET:

Q The question, doctor, was are the findings that you just described for us as shown to us on the March 22, 2006 cervical MRI caused by the motor vehicle crash Mr. Simao was involved in in April of 2005?

A Well, the answer isn't simple. The answer could be yes. The answer could be no. The simple reality is this MRI is a year after. So then you have to start paying attention to the patient's history and when the symptoms began. But this MRI and an otherwise asymptomatic person with no complaints could also simply be age-related changes. But this MRI, in the context of a person who's presenting with ongoing complaints, hypothetically, since the motor vehicle accident with no significant problems to it -- or prior to it could also be structurally associated to the motor vehicle accident.

Q Let's assume for a minute that they weren't structurally caused by this motor vehicle accident. What is the cause of the changes that -- that you -- what would be the cause of the changes you've described for us in CV4 and C4-5?

A I would say simply age-related changes; meaning, as we get older we all potentially have a whole plethora of findings that can show up on x-rays, CT scans, MRIs, but

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they're okay.

Q And are age-related changes sometimes referred to as degenerative changes?

A I would say they're more commonly referred to as degenerate, yes.

Q Okay. Can patients with the changes you've just described for us in Mr. Simao's C3-4 and C4-5 cervical discs be asymptomatic without complaints of neck pain or upper extremity symptoms?

A Yes.

Q Okay. Before his April 15th, 2005 motor vehicle crash, was Mr. Simao symptomatic with neck pain or upper extremity symptoms as a result of the age-appropriate changes documented on this cervical MRI?

A No.

MR. ROGERS: Objection. I don't think any foundation has been laid about his understanding of the Plaintiff -- or of the Plaintiff's pre-accident. He's --

MR. EGLET: Your Honor, first of all, I object to this speaking objection, okay? May we approach?

THE COURT: Counsel approach, please.

[Bench Conference Not Transcribed]

MR. EGLET: Objection is overruled, Your Honor?

THE COURT: Yes.

MR. EGLET: Thank you.

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BY MR. EGLET:

Q Okay. The question, doctor, is before the April 15th, 2005 motor vehicle crash, assuming -- I think for this question that we should assume that these structural changes you've described on the MRI pre-existed the motor vehicle accident, that they were these age-related changes we discussed, okay?

A Yes.

Q Before his April 15th, 2005 motor vehicle crash, was Mr. Simao symptomatic with neck pain or upper extremity symptoms as a result of the age-related changes documented in this MRI?

A According to his history, no.

Q Now by way of obtaining a history from Mr. Simao and reviewing the medical records and documents provided -- documents provided you in this case, does Mr. Simao have any history of cervical spine problems or symptoms that required medical evaluation and treatment before April 15th, 2005?

A No.

Q Are patients with age-related changes of their cervical spine more susceptible to traumatic injury to their cervical spine than patients without degenerative or age-related changes in their cervical spine?

A I would say there's a spectrum there, but in general in I would say, hypothetically with this, I would say no.

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Q Why not?

A Well, in this case the age-related changes are relatively mild. An extreme example of a, quote, unquote, age-related change is where someone has had degenerative changes; they're more advanced, and there's actually a slippage of a vertebra forward reference the vertebra below. And that's a scenario where someone potentially could be more susceptible to problems from a known traumatic event.

Q Whether the age-related changes make them more susceptible or not, can the asymptomatic age-related changes be caused to become symptomatic by a traumatic event such as a motor vehicle crash?

A Yes.

Q Okay. Did Mr. Simao develop neck pain immediately after his April 15th, 2005 motor vehicle crash?

A Well, by history, he says it started after the crash.

Q Okay. Was he seen at the Southern -- at -- strike.

Was he seen at Southwest Medical Associates approximately three hours after the motor vehicle crash complaining of neck pain and diagnosed with neck sprain?

A Yes.

Q Okay. What was your --

MR. EGLET: Put up page 5, please, line 22.

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BY MR. EGLET:

Q What was your clinical assessment of Mr. Simao following your initial evaluation?

A I stated that he primarily had axial cervical pain; meaning, basically, his neck hurt, which also included his upper back, his head. I specifically addressed the MRI finding of narrowing of that C3-4 nerve exit hole which would classically affect the C4 nerve root; classically that is a pattern of numbness, paresthesias tingling that goes on to the front of your chest. I stated he did not have that classic pattern.

But it was also in the context that he was complaining of an entire left arm numbness, tingling, parasthesias, and I felt it was important to make out the clear distinction that that would not be explained by this narrowing of the nerve exit hole in and of itself.

Q And is that because the narrowing of the nerve exit hole would imply more of an impingement on a specific nerve that would follow the classic pattern you talked about?

A Again, classically this would affect the C4 nerve, and classically the C4 was here. Anything that goes down the arm, classically below the elbow, potentially would be C6, C7, C8, T1.

Q All right. And what is axial cervical pain?

A Axial means basically the middle. So when I say

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"axial", it's the middle of your body; your head, your neck, thoracic spine, your low back.

Q And what is a dermatome?

A A dermatome is the pattern of innervation that is classically assigned to a specific nerve.

Q Okay. And so what is the clinical significance of the fact that Mr. Simao's dermatomal pattern of C4 did not fit his clinical symptoms of left-upper extremity paresthesia?

A Well, the significant [sic] is, someone comes in with a numb arm, that's part of their complaints, obviously you're -- you are going to try to explain that, and potentially do what you need to do to make it better. So, basically, that was simply to establish as a point of fact for further diagnosis, potential treatment; that to simply go in and do something about that C4 nerve really wouldn't do anything for the patient in the sense of, you know, relieving upper parasthesias.

Q Okay. What is a sclerotome?

A The two terms that are classically used are dermatome, which we just discussed, and sclerotome. So sclerotome actually refers to the embryo, which is a fetus as it's initially growing. You've got these -- sclerotomes are basically the fine segments of the body coming from the head, going down to the sacrum or the bottom. So what a sclerotome is, is from individual sclerotomes you'll have structures that

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are formed. Like the heart comes from a specific sclerotome.

So that sclerotome pain is important because, a perfect example -- or a good example would be, someone who's having chest pain from heart problems, it's because of that sclerotomal origin that they have pain into the arm, pain into the jaw, pain into the ear. But obviously the heart technically doesn't have a neurologic structure that goes to the arm, per se; but because they have similar sclerotomal origins, that's why chest pain or heart problems can give you arm symptoms.

Another classic example is someone who has gallbladder problems, which is here, they'll get pain going to their shoulder blade. So basically what it is, is when -- structurally when common sclerotomal structures are irritated, they will referred pain from that same scleratome origin.

Q Did Mr. Simao have a scleratomal pain when he initially presented to you in April, 2006?

A Well, when I examine him and I go through the discussion, specifically I don't think I actually discussed scleratome. But the simple concept is, is that if you have a known problem, let's say a disc problem hypothetically at C3-4; well, if that disc is causing a pinched nerve and it's pinching the C4 nerve, you'll get classically symptoms that come here. Okay? And that would be dermatomal because it's causing a pinched nerve.

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But if you're getting a different kind of pain pattern where you're getting more trapezial pain, or shoulder blade pain, or pain to your neck, pain to the back of your head, that would be sclerotomal; meaning it's coming because the disc itself is causing pain, and causing nerve receptors to send pain impulses. That's what the patient perceives, and that perception is a pattern that is sclerotomal, not dermatomal, making that distinction between a classic pinched-nerve pain or this common, more sclerotomal pain.

Q And Mr. Simao had the sclerotomal --

A Yes.

Q -- presentation?

A As we go on, that's basically the distinction we make.

Q And was the sclerotomal pain that Mr. Simao presented with coming from his cervical spine?

A As we go on it appears such, as we go through the follow-up charts.

Q Was Mr. Simao's documentation of his symptoms, occipital pressure or pain radiating to the sides, in May of 2005 consistent with the sclerotomal pattern of radiation of pain from his cervical spine?

A Yes.

Q Okay. Are there any other explanations for the occipital pain other than sclerotomal radiation from Mr.

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Simao's cervical spine?

A Yes. You can have a problem with the occipital nerve itself. The occipital nerve is a nerve that comes from the upper levels of the cervical spine, and they go through the various muscle levels on the back of your head and neck, and innervate the back of your head. So those nerves potentially can be susceptible either to a direct blow or they can be susceptible to chronic irritation when patients are having a lot of chronic spasm of the muscle layers, the various layers, that can cause relative sheering of the nerve as it's coming through the muscle layers and cause irritation.

Q What options did you discuss with Mr. Simao at the time of your initial evaluation of him?

A Well, at that point in time we stated that -- at that -- Mr. Simao did not feel surgery was something he was ready to consider simply because he did not feel his pain was bad enough, usually. Then -- but at the same time he also wanted to better define his pain so he'd know what his options are would be to potentially fix it.

So we discussed that injections would be helpful in the sense of defining the structural cause of the pain, but probably not helpful in decreasing long-term pain. That's simply driven by the fact it's already been a year.

So with that in mind, Mr. Simao wanted to get a better idea of what was going on so at least he knew where he

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stood, and potentially knew better options to consider. We went on to, well, recommend getting some injections at the C3-4 and C4-5 facets, as well as the corresponding C4 and C5 nerves that exited those levels.

Q Do -- was that the recommendation for the C4 and C5 selective nerve root blocks?

A Right. Basically I wanted to inject the facet joints, which is the small joints in the back of the spine, C3-4, two levels, or two, one on each side; and C4-5, another two; and then also the corresponding nerves that are exiting at that level.

Q Okay. What was your clinical rationale for making those recommendations?

A Well, the simple goal was to at least, by level, define where the pain was coming from. So the intention was, the patient would get those injection, and as I stated in my chart wrote, "would have the immediate post-injection pain relief documented."

Because technically, the whole, simple idea is that you've got this scenario where you know things can just show up in an asymptomatic fashion due to age-related, slash, degenerative processes, yet patients are doing fine. And at the same time you can have a patient whose not doing fine. So you need to add another layer of confirmation or validity to the process.

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So the whole idea is, if I think you're knee hurts, as a perfect example, sometimes knee pain can come from your hip. So if I want to make sure it's your knee and not your hip, I would simple put an anesthetic in your knee, numb it, and then I would have you keep track of what happens to your pain over the next four to eight hours. I say four to eight hours because I personally use Marcaine, which last anywhere from four to 12 hours.

Then that gives you chance to actually go home, do the things you would normally find aggravated. I like to use the analogy, gives you chance to test drive the car before you put in your order. I think that's a very good way to evaluate these suspect structural issues, and put them in perspective, and clearly confirm whether or not they're players in the pain.

So because of the facet changes at C3-4 and the small disc bulge at C4-5, I thought that it would be reasonable to evaluate those and their pain-generating status; hence, the reason to order those injections.

Q Now at that time did you refer Mr. Simao to Dr. Seebel [phonetic] -- or is it Seibel?

A Seibel.

Q -- Seibel at the Pain Management Center of Southwestern Medical Associates for the cervical spine injections you recommended?

A Yes.

MR. EGLET: Could you put up page 9, please, Brennan.

BY MR. EGLET:

Q Now after you referred Mr. Simao to the pain management center at Southwest Medical, when did he return to see you for follow-up evaluation?

A Well, I have my chart. Well, it appears 9-6-07.

Q And what interval history did you obtain from Mr. Simao at that time?

A Let's see. At this point, what was it, about almost a year-and-a-half. So he's back essentially saying he has a new problem, but the same problem. I think he filled out a new -- did he fill out a new pain diagram? Let me see here.

Briefly stated that when he was seen by myself 4-18-06, "Patient went to pain management. Pain management took him on a course of various injections in order to avoid surgery." And I stated that I didn't have any definitive diagnostic information as clearly defining his pain. Stated, "The patient has failed injections as well as pulse-radio frequency. Pain has persisted."

Essentially it's been a year-and-a-half since his MRI. I wanted to repeat the MRI to make sure there was no significant changes, and then also "do injections at C3-4 and" C4-5 -- that's a typographic error. It should be "C4-5", not "L4-5". -- to define whether or not the previous suspect

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levels at C3-4 and C4-5 were significant pain generators.

And the patient was to come back for the injections and the new MRI.

Q Now was it reasonable for Mr. Simao to undertake this prolonged course of pain management evaluation and treatment in order to try to avoid surgery to his neck?

A Well, the simple answer is, it's basically whatever's right for that patient. I would say in general, Mr. Simao, well, he tended to be a tough guy in the sense that he obviously was -- he didn't come back for almost a year-and-a-half. So I'm sure that pain management offered him injections, and he considered it, and did what he thought was reasonable. But in the end it didn't work so he came back to see me.

Q What conclusions did you reach at the time of your follow-up evaluation of Mr. Simao?

A On 9-6-07?

MR. EGLET: Go to page 9, please, Brennan.

BY MR. EGLET:

Q Was your conclusion that he had failed a course of injection therapy as well as pulse-radio frequency with persistent pain?

A Yes.

Q And so what did you recommend for Mr. Simao at that time? And I think you indicated to repeat MRIs and the C3-4

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and C4-5 transforaminal epidural steroid injections?

A Yes.

Q Okay. How do transforaminal epidural steroid injections define symptomatic motion segments in the cervical spine?

A Well, the anatomy of the cervical spine is such that each level is fairly well independently and autonomously innervated by the exiting nerves. So you can reliable numb up those exiting nerves at each level, and that essentially numbs up the motions segment; primarily discogentic pain, or pain from the disc, as well as potentially facet pain. But in a simple sense, it just simply tells you on a segment-by-segment level where the pain is coming from.

Also, if someone was having corresponding nerve irritation pain, that would also confirm that. So you've got the motion-segment pain, which is basically the spine itself, at each level you have a disc in the front, two facets in the back; and the potentially you've got the other pain, which is the dermatomal pain from the pinched nerve. Mr. Simao, because he had primarily axial pain, the main issue is sorting that out, or it would scleratomal pain.

So it turns out that the anatomy of the cervical spine is fairly level by level independent and autonomous. So you do those injections to specifically numb up each motion segment, and then as long as you use a good technique, you're

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not putting in too much medicine so it doesn't go all over the place, then you can selectively numb up each level and reliably confirm the pain-generating component of each level.

MR. EGLET: Now page 14, please, Brennan.

BY MR. EGLET:

Q When you saw Mr. Simao in your office again on November 13th, 2007, did you review the results of his updated MRI with him?

A Yes.

Q Okay. And what did you review of this diagnostic imaging study?

A Well, essentially it was the same. It showed a central disc herniation at C4-5, and foraminal narrowing on the left at C3-4.

Q And how did the radiologist, Dr. Momii, interpret this September 24th, 2007 cervical spine MRI?

MR. EGLET: Page 17, please, Brennan.

THE WITNESS: Looks like he said negative.

BY MR. EGLET:

Q Okay. And how do you explain the difference between your interpretation and the radiologist interpretation of Mr. Simao's September 24th, 2007 cervical MRI?

A That can vary. I would say that most of the time, usually I will get them on the phone, ask them to read it again, and we agree. So in this particular case, it -- it

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didn't seem important enough in the sense that we weren't talking about cancer or anything. I would just simply state, I can't explain why he said something other than I.

I mean, we could actually pull up those films and maybe I could point out where they're obviously not normal. That's really the only way to resolve it, I would say.

What was the date on that, again?

Q September 24th, 2007.

A I would have to guess for some reason or another I didn't have the report at that point in time, because usually I'm pretty dogmatic about getting that radiologist on the phone.

Q We're going to bring this up, doctor, and maybe you can point out the area of your finding.

A Okay.

Q We've got four different --

A Because I wouldn't expect that narrowing of the nerve foramina to go away, for sure.

Q If you could come back down out of the box, Brennan is --

A Other general comments, sometimes you can have a different techniques that show different types.

Q Tell us which sheets you want to look at, and which images.

A I'll start with this one here. Have you got the

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date confirmed?

Q Yes.

MR. EGLET: And it's Exhibit 40, Your Honor.

THE COURT: Thank you.

THE WITNESS: All right. I think the jury can hear. I appreciate this. So let's blowup this one right here.

So here it is, this is -- you can see where that left one is narrow; the right one's wide open. So for some reason the radiologist chose not to mention that.

BY MR. EGLET:

Q Okay.

A Let's go back to the composite with all the different numbers, and let's blowup this right here. And you can see that this is a bulging. So I would say -- I can't explain why the radiologist didn't see that.

Q Okay. Thank you.

Now, Dr. McNulty, what are the risks of cervical transforaminal epidural injections?

A On general it's very safe for people who know what they're doing. But it is potentially something that can have problems. In general, what I tell my patients, it's a very first simple statement, is anything can happen and no guarantees. And then the few details I would mention to them would be allergic reaction, infection, blood clot, nerve damage, spinal fluid leak; but I also add the term paralysis

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here, and specifically since paralysis has been associated with a specific type of steroid use, which I don't use.

So having said that, knock on wood, I haven't had an issue.

MR. EGLET: Page 18, please Brennan.

BY MR. EGLET:

Q And, doctor, when did you perform a left-sided C3-4 and a C4-5 transforaminal epidural injections on Mr. Simao?

A It looks like you have that up. It looks like 11-16-2007.

Q Okay. And, doctor, if you could come back down out of the box.

A Sure.

Q And if you could use the spine model here, and you could demonstrate and explain to the jury exactly what you did in performing this procedure.

A Okay. Well, just to clarify a couple details: Initially I said bilateral, but when I talked to the patient he said his symptoms were only on the left side. So I said, fine, we'll just do the injections on the left. No sense to do both sides.

So when we do this, the patient is actually lying on his back, and we're coming in on the left side. So typical, I have Mr. Simao turn his head to the right, extend his neck, and then we're coming in basically here.

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So basically this is how the patient is. So if he's -- assuming he's lying right here; he's turned his head away; we're coming on the patient's left side. So what we're doing is carefully, I'm bringing the needles in. This is under live x-ray or fluoroscopy, and I'm carefully monitoring. These are very small needles where they're technically going behind the nerve, and I carefully advance that needle tip so it's actually just inside the spinal canal. And that's a very important distinction, because you're trying to use this injection to define axial pain.

So it turns out the small subcategory of nerves that are going off, and going to the disc [audio skips at 2:03:28], a lot of those nerves inside the spinal canal, so it's a very important technique. Some doctors, when they try to do this, they get the nerve -- tip of the needle close, but not get it into the spinal canal. So when you're using it for this purpose, to clearly confirm cause of the axial pain or neck pain, it's a very important technical issue that you have to pay attention to.

So once I get that needle in, I'm -- the patient's awake because I want to make sure he's telling me, "Look, I'm not having any trouble with zingers going down my arm," because you want to do these awake because it adds another level of [audio skips at 2:04:06].

And then what I do is I inject a small amount of dye

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to confirm that the needle position, the dye spreads around [audio skips at 2:04:15], and that it's not going into an artery. And then once I do that, I think, specifically, I said I injected a 1/2 cc.

Can you scroll down a little bit on the procedure note?

So you can see here where I'm talking about [Audio skips at 2:04:33] at all. I'm getting just the [audio skips at 2:04:37] neural space, which is the spinal canal, and then I inject a 1/2 cc of Marcaine with a little bit of steroid, make sure that we're not really injecting anything into the bloodstream.

So the amounts very important, because you only want it to spread at that level. If -- 1/2 cc is a very [audio skips at 2:04:58]. If I put in 3 ccs, it could easily spread up and down maybe four or five levels. We're trying to use this as a very specific confirmation process; so we say, okay, the pain's coming from here or it's not coming from here. So we did that at C3-4 and C4-5.

Q Okay. Thank you.

MR. EGLET: And go to page 19, please, Brennan.

BY MR. EGLET:

Q Doctor, can you tell us what were the immediate post-procedural -- procedure results of this cervical injection you performed on Mr. Simao?

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A Well, what I do, my routine is, I like the patient to go home. I get their phone number and call them later that day. Because, again, I try to say, "Look, I want you to go home, do the stuff that you would normally find aggravating, and be able to tell me percentage improvement: Is it nothing; is it 100 percent; is it 50 percent?"

So that portion of the procedure, now, basically reflects me calling him later and asking him how he's doing, and him telling me how much pain relief he got.

Q In the recovery room, did Bill note that his typical symptomology was at least 80-percent improved during the anesthetic phase of the injection?

A Yes.

Q Okay. What is the clinical significance of that response?

A Well, that would reliably confirm that those two levels, C3-4 and C4-5, were the primary structural causes of his pain.

Q Okay.

MR. EGLET: Page 19, please, Brennan.

BY MR. EGLET:

Q What did you discuss with Mr. Simao when you re-evaluated him on December 6th, 2007, about it?

A Let's see. He had significant pain relief. Again, this is confirming what he told me, and this is a typographic

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error. It's "C3-4 and C4-5".

Q Not "L3-4 and L4-5"?

A No. No.

Q All right.

A And, again, just simply stating, "The patient's failed reasonable concern measures as a disc herniation foraminal narrowing," and the plan was to proceed with a two-level anterior or front cervical reconstruction.

Q Did Mr. Simao proceed with the anterior cervical fusion surgery you recommended for him at that time?

A It appears that he did not, and the next time I saw him was November of 2008.

Q And do you know why he didn't proceed with the surgery at that time?

A Not precisely. I think he got a second opinion, or --

Q Subsequently you found out he wanted to get a second opinion?

A Subsequently.

Q Okay.

MR. EGLET: And go to page 27, please, Brennan.

BY MR. EGLET:

Q When did you next have the opportunity to evaluate Mr. Simao?

A I saw him again on November 4th, 2008.

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Q And what was his clinical status at that time?

A His pain has increased. It is posterior neck pain, trapezial radiation, mainly left-sided. And, again, because of a approximately a year change, I want to get an updated MRI to see if there had been any change.

MR. EGLET: And page 22, please, Brennan.

BY MR. EGLET:

Q What were the results of the November 6th, 2008 repeat cervical MRI you ordered for Mr. Simao?

A Mr. Simao followed up on the 25th of November with the MRI as we ordered, and I stated that there didn't appear to be any significant changes compared to the MRI done 9-24-2007. Stated the mild issue of potential left C3-4 foraminal narrowing; stated that he'd been seen by Dr. Rosler and Dr. Grover; also mentioned that the results of a discogram are -- not in the sense that -- I didn't mention the whole report, but stated that he had a discogram; and at C3-4, C4-5, and C5-6, there are abnormalities at all three levels.

And at that point in time I did not have the complete information from the discogram, so I needed that information. So I was to get Dr. Rosler's and Dr. Grover's notes, and see the patient back.

Q So at that time you were informed that he, in fact, had seen a -- gotten a second opinion and gone to Dr. Grover, who is also an orthopedic spine surgeon; is that correct?

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A Yes.

Q And Dr. Grover had sent him to Dr Rosler, a pain management physician?

A Yes.

Q Who had done some other injection diagnostic studies, including a discogram?

A Yes.

Q Okay. And what was your assessment and recommendation for Mr. Simao at that time?

A "Patient follows up on 1-6-2009. Patient's pain has changed. He has posterior cervical thoracic pain, left-sided component." I need to confirm the status of the pain generators, and there had been a significant amount of time. So I wanted to repeat the foraminal epidural injections at C3-4, C4-5. I stated that the discograms were provocative discograms in the sense that they showed painful concordant pain, which means - briefly, the discogram is where you put a small needle in the disc, and you're trying to stimulate that disc by injecting dye. And that stimulating response, if it causes pain, you want to know if it's concordant, which means the patient is experiencing pain that's very similar or exactly his typical pain; or non-painful, which means it doesn't hurt, or discordant. That means it's painful but it's not the typical pain he's complaining about.

So specifically for Mr. Simao's discograms, he had

positive concordant at C3-4, C4-5; meaning that they were painful and the pain was his typical pain. And he had leakage of the dye at C5-6, but it was non-painful; therefore, C5-6, the dye leaked out of the disc, but it wasn't painful. And a simple common about that -- when you do a discogram in a cervical disc, technically the cervical disc isn't surrounded and enclosed by this annulus.

So it's not like a tight balloon. The sides, there's certain little joints called uncovertebral joints, and those joints can actually, in a normal state, actually leak dye. So I would say in a cervical discogram, the fact that the dye is, quote, unquote, leaking isn't as -- isn't as much of an issue at all in a similar situation when you do a lumbar or a low-back.

Q So did you consider the C5-6 and the discogram a control level?

A I would consider it a control level. At the same time, I also felt it was important to confirm with an analgesic block.

Q You -- I think you mentioned that there was a change in Bill -- in William's pain to posterior cervical thoracic pain with a left-sided component. Recall that?

A I did, and the change may have been it got worse. In a similar -- in a very simple sense, it's very similar. I mean the true nature of pain day-to-day is it can vary.

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Q So with this note -- pain change you noted, the fact that you now have the provocative discogram results performed by Dr. Rosler showing concordant pain at the C3-4, C4-5 level, and the control level at C5-6, what did you recommend for him at this time?

A Well, my simple practice principles are that I think I'm doing a better job of selecting patients for surgery if I can do a confirmatory analgesic or numbing injection. I think that does a better job of both confirming the pain generator status, but also selecting a patient who has a better chance of doing well with appropriate surgery. So I simply wanted to repeat the foraminal epidural injections and again document the pain relieving effect of those injections before definitely embarking upon surgery.

Q Okay. And what is the difference between a provocative study and an analgesic study when performing injections in the spine to determine a pain generating site?

A Well, the simple concept is if you want to know if something hurts -- let's say if I want to know your knee hurts. I can take your knee and move it and try to grind it and manipulate it and that motion makes it hurt. Okay. But at the same time, again referring to the hip, that same manipulative maneuvers may also move the hip or stimulate the hip.

So another way to clearly confirm a structure's

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painful is to simply, in a specific controlled fashion, numb up that structure. And then if the pain goes away for the same provocative maneuvers then you can reliably say that structure's causing the pain. So a provocative disc -- unfortunately, the spine is very difficult to examine. If I want to make a distinction between wrist pain and elbow pain there's enough physical distance to manipulate your wrist and not really do anything to your elbow. But as you can see by that model, the distance between C3-4 and C4-5 isn't that much.

So I can't reliably shuck [audio skips at 2:15:30] back and forth and then go down and shuck C4-5 back and forth without having some effect. So that's why we have to depend on these injections in order to more selectively confirm various levels. So a provocative discogram is essentially trying to stimulate the disc so the patient can tell whether or not it's painful and what that pain is.

There's an analgesic discogram, which we didn't do here, because we can essentially get the same effect by selectively just numbing up that corresponding nerve; would confirm the pain by taking the pain away.

Q Now hypothetically, if a physician hired by the defense in this case were to criticize you as a spine surgeon for performing your own diagnostic spine injections, how would you respond to that?

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A Well, I would be open to criticism in general. But in this specific case I'm not doing provocative testing, meaning I'm not sitting there while I'm injecting and the patient's telling me oh yeah, that's it. This is -- there's a layer of transparency here in the sense that I'm putting the analgesic or the anesthetic where I want it, but it's the patient telling me, you know, later that day, after four to eight hours, whether or not they feel any significant change in their pain.

So -- and the other reason I think there's really not an issue with that is that it also allows the patient to have direct recall of that. A lot of times with these provocative discograms patients are given sedatives that make them amnestic, so they don't even remember the procedure. This way, the patient can independently recall and say yeah, I remember that afternoon. It felt great. So I, you know, I don't think it really -- there's a problem with that in that sense.

And also in general orthopedics we do that all the time. Another common scenario, someone has impingement, which is irritation of the rotator cuff, we do it all the time where we do a injection in there under -- around the rotator cuff. We use that as another predictor to tell us whether or not surgery's appropriate and whether or not they'd do well. So again, I think the patient telling you, I really don't think

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that's an issue.

Q [Audio skips at 2:18:10] an injection for Mr. Simao when you previously performed only left-sided [audio skips at 2:18:23] and his symptoms were --

A [Audio skips at 2:18:25] the pain diagram. More reliably [audio skips at 2:18:35] do we have the procedure note?

Q Page --

A So if it's central portion, then you're going to have confirming [audio skips at 2:19:12] the status of that level by doing injections from both sides.

Q Okay. Now when did you perform the bilateral C3-4 and C4-5 transforaminal epidural injections?

A This appears to be 2/13/2009.

Q When you spoke to Mr. Simao after this procedure, what was the anesthetic response to his cervical injections?

A Can we go to the end of the procedure note? "Patient was later called and noted that during the anesthetic phase, or the period that it was numb, he had 65 to 70 percent relief of his typical chronic pain, confirming those as significant pain generators at C3-4 and C4-5."

Q Okay. Now at this point in time, am I correct in stating that there had been a previous selective nerve root block -- a transforaminal selective nerve root block performed by you which confirmed that the C3-4 and C4-5 discs were pain

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generators; there had been selective nerve root blocks performed by Dr. Rosler, who had confirmed the C3-4 and C4-5 discs were pain generators; there had been discogram -- discography performed --

MR. ROGERS: Objection, Your Honor; leading.

THE COURT: It's pretty compound, Mr. Eglet.

MR. EGLET: I'm asking him an entire question. I'm laying a foundation for the question, Your Honor, if I can have some leeway.

THE COURT: All right.

MR. EGLET: His testimony has already occurred, so I'm just laying the foundation for it.

BY MR. EGLET:

Q Dr. Rosler had performed a discogram, discography, which confirmed that C3-4, C4-5 were pain generators, and now you had performed an analgesic selective nerve root blocks which had confirmed that the C3-4, C4-5 were pain generators in this case. Is that all correct?

A The only slight technical point is I don't have independent recollection of Dr. Rosler's selective nerve root blocks.

Q Okay.

A With the exception of that little point, yes.

Q All right.

MR. EGLET: Can you give us page 43 please, Brendon, of

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Exhibit 22.

BY MR. EGLET:

Q Doctor, could you discuss with us the difficulty that you documented in sorting out the immediate post procedure pain relief when you re-evaluated Mr. Simao on February 24th, 2009?

A Well, I simply stated "The patient had some difficulty sorting out the post procedure pain relief immediately after the procedure because he had some pain associated placing the needle, as well as some pain removing the adhesive stereo -- sterile drapes or barriers." There's a typo there. Obviously Mr. Simao's a he, not a she. But he was able to make that distinction about his chronic pain, so he was able to separate those two issues and state clearly that his chronic typical pain was 65 to 70 percent better.

The term this conflicts is not correct. That again is a type -- it doesn't conflict. It basically confirms --

Q Where are you talking about in there?

A On the same chart note, third line from the bottom of the first paragraph. Says "This conflicts."

Q This conflicts?

A Yeah, that's a typographic. Doesn't conflict, it's basically consistent with the previous discograms which showed painful discogenic responses at C3-4 and C4-5, as well as pain relief with previous injections at those levels. So I stated

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that because he had pain relief with the analgesic blocks in the context of a confirmatory or consistent provocative discograms, that I stated that he had painful segments at C3-4 and C4-5, primarily discogenic.

Q Discogenic pain?

A Yes.

Q Okay. And page 40 -- I guess we're still on page 43. What did you recommend for Mr. Simao at that time, Doctor?

A Anterior cervical reconstruction fusion, C3 to C5.

Q Could you please discuss for us all the clinical information that you used and your thought process in determining that Mr. Simao had painful motion segments at C3-4 and C4-5 that were primarily discogenic, for which surgical reconstruction could be beneficial?

A Well, the simple answer is everything we've previously discussed. The brief summary is the patient stating that his symptoms have persisted. He's gone through reasonable conservative measures which would be time, medications, physical therapy. He's failed other measures such as pulse radio frequency, various injections. The MRI in and of itself does not definitively tell you that this is the problem, but it does raise the potential structural pain generators. Then we used the injections we discussed, both the provocative or pain inducing discograms, as well as the

confirmatory analgesic blocks that are specifically targeting those levels.

But in the end, it's simply the statement that the patient feels that their pain is significant enough on a day-to-day basis, a functional status, that they're ready to do something to make it better.

Q Now hypothetically, if someone stood in front of this jury and told this jury that the C3-4 and C4-5 cervical segments were not pain generators, would that be an accurate statement?

A Well, I'm always open to different opinions. I'd want to know why they say such. Is there any hypothetical justification for their opinion?

Q Well, it's a lawyer.

A Oh well, okay. I would say it'd be my opinion that I would disagree and I would say that I think they are painful motion segments for all the reasons we've just stated.

Q And hypothetically, if someone stood in front of this jury and told this jury that Mr. Simao did not have a cervical disc injury because cervical x-rays and MRIs did not show a disc injury, would that be an accurate statement?

A Again, as I answered previously, with the exception of the severe injury where literally the spine is being ripped apart, I would state that x-rays, CAT scans, MRIs by themselves, without some type of injection process, with the

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exception of that severe injury where the disc is literally ripped apart, do not reliably confirm or eliminate discogenic pain.

MR. EGLET: And could you go to page 52 please, Brendan.

BY MR. EGLET:

Q Doctor, what was the purpose for your re-evaluation of Mr. Simao on March 24, 2009?

A That point, we were -- it's what I call our final procedure consideration visit. That's where we simply have our final check off before doing surgery, make sure there hasn't been any significant changes, go over pertinent issues of past medical history exam, make sure the patient understands the plan, review the studies. It's basically just a final confirmation before embarking upon surgery.

Q What are the risks of anterior cervical decompression, fusion, and instrumentation?

A Well, I can briefly just tell you the speech that I give the patient.

Q Okay.

A The simple statement I state is that there's no guarantees. Anything can happen. Give me permission to change the plan at my discretion. If I am there and I feel something else needs to be done or changed, I do it. I'll mention specifics such as heart attack, stroke, pneumonia, allergic reaction, infection, blood clot, death. I also

mention specifics such as weakness, numbness, paralysis, spinal fluid leak, altered bile and bladder function, sexual function. When we do the surgery I put in cages that are filled with a synthetic bone putty to fuse or glue the vertebrae together, take out the disc, replace it with a structural cage, and fill the -- excuse me, the inside portion with a synthetic bone putty to provide a calm or conduit to help the vertebrae bone to bone and then secure it internally so it doesn't move with a low profile plate. It has two screws that go into each vertebra. It's like gluing two pieces of wood together, put the glue, put them together, and then ideally put a clamp on there to hold it until it's solid. So I tell them about the potential of that breaking, not healing, moving, going somewhere I don't want it to go. I also specifically mention typically the issues of potential swallowing difficulties, hoarseness, which usually are simply related to the retraction you do to get things out of the way to see and then get better.

Q Now before proceeding to anterior cervical decompression and fusion, did you send Mr. Simao to Southwest Medical for preoperative clearance?

A To be quite honest, I don't know. Selectively, if someone's relatively healthy, I'll just get all the stuff myself. And if there's anything that pops up, I'll send them back to their primary. Or if it's -- usually it's a matter of

convenience with how the flow is going with patients to get back to their primary. If it's relatively easy for them to get back, then I'll let them handle it. But ultimately it's me looking at the stuff and agreeing that it looks okay.

Q Assuming you did that, is it your understanding that Mr. Simao was cleared for surgical procedure you recommended to him by the medical personnel at Southwest Medical?

A Yes. And then one little caveat is ultimately the anesthesiologist who sees the patient the day of surgery has final say.

MR. EGLET: Page 88 please, Brendan.

BY MR. EGLET:

Q In your dictated preoperative history and physical at University Medical Center, what did you document regarding Mr. Simao's employment history?

A Do you have that up? Okay, perfect. Let's see, works in flooring sales.

Q Okay. Hypothetically, if someone told this jury that Mr. Simao did not have a -- or could not have had a cervical spine injury because he returned to work after the April 2005 motor vehicle crash, would that be accurate?

A I would disagree. I'd say no.

Q And why?

A I would say it's my opinion, generally Mr. Simao's a tough guy who doesn't let things slow him down.

MR. EGLET: Page 90 please, Brendan.

BY MR. EGLET:

Q Doctor, what procedure did you perform on Mr. Simao on March 25th, 2009 at University Medical Center?

A Well, briefly I've already talked about what we do, but I --

Q Well, if you could come out of the box using the spine and demonstrate for the jury with the spine model the procedure you did, the surgery you did that time.

A So the goal of the surgery is to eliminate these disks that are potentially contributing to the pain. But also when you do that you're fusing the vertebra together. So hypothetically, if there is any component of facet pain, which are the small joints in the back, you would be addressing that because it would stop moving. In the old days before we had hip replacements, the treatment for hip arthritis was fusion. So essentially it's applying old school technology and principles to the cervical spine. And also -- and again, my simple goal with surgery is to do as much as I can to take care of any potential problem.

So we have Mr. Simao lying down again, he was on his back. We slightly extend his neck, rotate his head to the right, and we come in from the left side, classically make an incision that's cosmetic and transverse here. And when we just scoot the voice box and the swallowing tube over to get

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to the front of the spine and put retractors in that are gently holding things out of the way. We also go right next to the carotid artery, expose the spine.

Typically I'll put pins into the actual vertebra to confirm we're at the right level, we'll take an x-ray, say okay, everything looks good. First thing I like to do that because that way if you are not at the correct level you're not putting a needle in the disc per se. So you wouldn't want to ideally stick a needle in a disc that doesn't need the surgery. Then what we do is we use those pins to spread apart the vertebra.

We take out the disc, I go ahead and make sure that there's no pressure into the front of the spinal canal. And also the process of taking out the disc, what you do is you, when you -- you have to fill that space up with something. After you take out the disc you make sure the bone is good and what we call raw, meaning it's nice and exposed and it's got some bleeding to it so that way it's going to heal to other bone. So you put in these structural cages. These cages specifically are made of the plastic called PEEK, which stands for polyether ether ketone.

And in the center portion of these cages we put a synthetic bone putty, so that way avoids the pain. In the old days we used to take bone off their hip, cut it to size and put it in there, but there's a certain incidence of pain from

that procedure. And in the process of jacking open the disc space, also would theoretically evaluate the potential, if there is any component of this nerve at C3-4 exit hole, that process also relieves that. Okay?

So again, the idea is if I'm going to do this, I'm going to try to maximize every potential benefit to it. So if he's got -- if we think he's got discogenic pain, but maybe he's also got facet pain, the fusion should take care of that. If you think he mainly has discogenic pain but he may actually have some component of this nerve getting pinched, jacking up on that disc and fusion, it should take care of that too. So from a general perspective, I thought this would be the best thing to potentially take care of the major players in Mr. Simao's problem.

So we do that and then we put a low profile plate, and it has screws that go into each vertebra to lock it all down. The other important thing while we're doing this, we have spinal cord monitoring, which is a separate technician who's looking at a laptop. We have various needles and pads that are constantly monitoring the traveling electrical impulses up and down through the spinal cord. So that way if anything's going on that's starting to affect it, we get a early warning and we can intervene and do whatever we can. So that's helpful for spinal cord. And that's good, but the technology really doesn't protect or tell you anything about

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the nerves themselves, but the spinal cord does. He had no problems with that, but that's just a standard precaution that we do.

After that we go ahead and make every -- make sure everything looks good with an x-ray, and then I'll close him up cosmetically, put a small drain in. Then typically they're in the hospital for a day or two depending how long it takes for them to get their swallowing back to a reasonable degree where at least they can swallow liquids, their pills, and have good pain control.

Q Were there any complications of the surgical procedure you performed on Mr. Simao?

A No.

Q Okay. You can sit back --

[Pause]

MR. EGLET: And page 92 please, Brendan.

BY MR. EGLET:

Q When was Mr. Simao discharged to home from University Medical Center?

A Looks like we had surgery on the 25th of March, and then he was discharged two days later on the 27th.

Q Okay.

MR. EGLET: Page 56 please, Brendan.

BY MR. EGLET:

Q What was Mr. Simao's clinical status when you

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evaluated him for his first postoperative visit on April 14th, 2009?

A Let's see. At that point, typically I'll see my patients two weeks or a little over two weeks. Generally he was doing well, already noticing significant improvement. X-rays taken showed good maintenance of the reconstruction and plan was to follow up in six weeks.

Q Did you obtain postoperative cervical spine x-rays at that time?

A I did. They showed everything looked good.

MR. EGLET: Could you put up both images from Exhibit 61 please, Brendan.

BY MR. EGLET:

Q And could you please review this, study with us these x-rays and tell us what they show?

A Okay. So this basically shows where -- this is the cage we put. So this is normal disc, so these are the discs we've operated on. So the discs are removed. These are plastic cages that are placed in the space. These are little localizer titanium bars so we know where the plastic is; it doesn't show up on x-ray. These are little clips we use. That space between the voice box and the carotid artery there's crossing blood vessels you have to snip and clip. And then this is the plate that's on the front with the screws going into the vertebra locking everything down. So

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everything looks good.

Q Okay, thank you.

MR. EGLET: Now page 58 please, Brendan.

BY MR. EGLET:

Q What was Mr. Simao's clinical status when you evaluated him two months postoperatively on May 26th, 2009?

A Two months.

"Doing well. X-rays showed good maintenance of reconstruction. Plan: discontinue collar, start physical therapy, may resume work as tolerated, come back in four months."

MR. EGLET: Page 61 please, Brendan.

BY MR. EGLET:

Q What was Mr. Simao's clinical status when you saw him on July 14, 2009, approximately three and a half months postoperatively?

A "Has had left upper extremity paresthesias and pain down to the hand for approximately a week. A neurological exam shows no significant weakness or numbness in the arms or hand. C5 to T1 dermatomes and monotones. X-rays again taken, show good maintenance of reconstruction. Make a note, please note prior to surgery upper extremities did not go distal, which means past or below the elbow. Concern for potential C6 radiculopathy. Plan: MRI

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cervical spine and CT cervical spine, see patient back after above."

Q Why were you concerned about a possible C6 radiculopathy at that time?

A Well, in general when you have problems present like this, there's always a chance that a disc above or below is causing problems. So there's typically more stress or typically the disc that may be more suspect would be the disc below the fusion. So that would be C5-6, lastly C5-6 would affect the C6 nerve root.

Q So you ordered an MRI with -- of the cervical spine with contrast and a CT of the cervical spine?

A Yes.

Q Why did you recommend those two diagnostic studies at that time?

A Well, in general, the MRI does a good job of assessing whether or not there's any disc herniation or bone spur, pinching a nerve or a spinal cord. And the CAT scan does a good job of telling me what the status is of the bony elements, the fusion, the hardware, where the screws are, how the fusion looks.

MR. EGLET: And page 31 please, Brendan.

BY MR. EGLET:

Q What were the results of the MRI of Mr. Simao's spine that you ordered and was performed on August 11, 2009?

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