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

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

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

MR. WALL: Yes, Your Honor.

MR. ROGERS: Yes, Your Honor.

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

PATRICK SHAWN MCNULTY, PLAINTIFF'S WITNESS, SWORN

THE CLERK: Thank you. Please be seated and 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: Very well. Mr. Rogers?

MR. ROGERS: Yes.

THE COURT: Are you ready?

CROSS-EXAMINATION CONTINUED

BY MR. ROGERS:

Q Good afternoon, Doctor.

A Good afternoon.

Q All right. The neck condition that you diagnosed

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

A Yes.

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

A Yes.

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

A I cannot tell you when they actually occurred.

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

A Yes.

Q -- in April of '06?

A Yes.

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

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

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

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

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

MR. EGLET: Objection; relevance.

002047
002047
002047

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

MR. ROGERS: Well --

MR. EGLET: May we approach, Your Honor?

THE COURT: Yes.

[Begin Bench Conference]

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

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

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

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

MR. EGLET: Yeah, the fact --

MR. WALL: Whether Jenny Rish received --

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

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

THE COURT: Sustain the objection.

[End Bench Conference]

///

002048

002048

002048

BY MR. ROGERS:

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

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

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

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

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

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

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

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

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

002049
002049
002049

A That and others, yes.

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

A Yes.

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

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

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

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

Q Yes.

A analgesic?

Q Yes.

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

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

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

structure than a provocative block.

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

A I would not.

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

A The simple answer is no.

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

A Yes, he chose not to at that time.

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

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

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

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

002051

002051

002051

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

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

A I had no conversation with Britt Hill.

Q Okay.

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

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

A Okay. I'm ready.

Q Do you have the records in front of you?

A I've got my copy as well.

Q Okay. You may refer to either one.

A Okay. I'm ready.

Q Okay. Is that correct?

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

002052
002052
002052

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

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

A Yes.

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

A Yes.

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

A I -- I know there was --

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

A Correct, yes.

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

A Yes.

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

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

002053

002053

002053

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

A Yes.

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

A Before my epidural?

Q Yes.

A I wasn't aware of that, no.

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

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

Q Yes.

A Okay.

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

A Well, let's see. Yes.

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

002054

002054

002054

A Yes.

Q Okay.

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

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

A Okay.

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

A Yes.

Q All right. Not traumatic, but degenerative?

A Correct.

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

A Yes.

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

A Yes.

002055
002055
002055

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

A Yes.

Q And this surgery was an elective procedure, correct?

A Yes.

Q There were no complications in the surgery?

A No.

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

A Yes.

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

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

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

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

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

A Uh-huh.

Q These arm symptoms --

A Yes.

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

002056
002056
002056

that right?

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

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

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

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

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

Q Okay.

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

Q Okay. Like arthritis?

002057

002057

002057

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

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

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

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

A I'm sorry?

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

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

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

A That was me actually.

Q Okay.

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

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

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

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

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

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

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

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

002059

002059

002059

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

A Yes.

Q Yes, that's correct?

A Yes, that's correct.

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

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

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

A Yes.

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

A Yes.

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

002060

002060

002060

A Yes.

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

THE COURT: Very well.

[Begin Bench Conference]

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

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

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

002061

002061

002061

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

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

THE COURT: Did --

MR. ROGERS: He didn't --

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

MR. ROGERS: No.

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

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

THE COURT: -- during the discovery process?

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

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

There are no psychological issues in this case.

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

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

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

MR. EGLET: Thank you, Your Honor.

[End Bench Conference]

BY MR. ROGERS:

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

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

Q Things like ruling out potential unrelated causes

002063
002063
002063

and all that stuff.

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

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

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

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

MR. ROGERS: Sure.

BY MR. ROGERS:

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

A Correct. Yes.

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

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

MR. EGLET: May we approach, Your Honor?

THE COURT: Sure.

THE WITNESS: So I'm to wait?

THE COURT: Yes, please.

[Begin Bench Conference]

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

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

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

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

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

002065

002065

002065

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

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

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

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

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

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

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

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

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

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

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

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

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

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

002067
002067
002067

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

MR. EGLET: Correct.

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

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

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

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

MR. ROGERS: Notice, because --

THE COURT: There's no notice?

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

002068
002068
002068

McNulty attached his testimony history to his deposition.

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

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

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

THE COURT: Sustain the objection.

[End Bench Conference]

BY MR. ROGERS:

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

A I think it's 1250.

Q Meaning 1,250?

A $1,250 per hour.

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

002069

002069

002069

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

THE COURT: Okay. Redirect?

MR. EGLET: Thank you, Your Honor.

REDIRECT EXAMINATION

BY MR. EGLET:

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

A Yes.

Q What other things is it based upon?

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

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

A Yes.

Q -- is that a fair statement?

A Yes.

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

002070

002070

002070

A Yes.
Q There are cases where it is appropriate?
A Yes.
Q Okay. Did you find any fault in -- or -- in Dr. Grover ordering and Dr. Rosler performing a cervical discography in this particular case?
A No.
Q Okay. Did you review the discography report?
A Yes.
Q Did it appear from the report that the discography was performed properly?
A Yes.
Q Did it appear from the report that there was any complications from the discography?
A No.
Q Okay. Did it appear from the report that the discography was positive at -- for disc disruption at C-3/4 and C-4/5?
A I would simply answer that, it was positive for concordant pain at C-3/4 and C-4/5.
Q Which is a positive discography, correct?
A Correct.
MR. ROGERS: Your Honor, this is leading.
THE COURT: It is. Sustained.
///

002071
002071
002071

BY MR. EGLET:

Q Is that a positive discography?

A Yes.

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

A Yes.

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

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

A Yes.

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

A Yes.

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

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

002072
002072
002072

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

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

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

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

A No.

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

A No.

Q Okay.

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

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

BY MR. EGLET:

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

002073
002073
002073

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

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

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

A Correct.

Q What about C-4/5?

A No.

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

A No.

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

A Yes.

Q And what are those other things?

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

Q Okay. And that can cause radiculitis?

002074
002074
002074

A Yes.

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

A Yes.

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

A Yes.

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

A It can be more variable.

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

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

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

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

A Yeah.

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

A Yes.

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

A Yes.

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

A I use the term radiculopathy versus radiculitis.

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

A Yes.

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

is that right?

A Yes.

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

A Yes.

Q What does that mean to wax and wane?

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

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

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

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

002077
002077
002077

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

A Yes.

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

A Yes.

Q Where the patient doesn't get better?

A Yes.

Q Continues to have pain?

A Yes.

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

A No.

Q Why?

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

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

002078
002078
002078

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

A Right.

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

A Yes.

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

MR. EGLET: I'll --

THE COURT: Sustained.

MR. EGLET: I'll rephrase.

BY MR. EGLET:

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

A No.

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

A Yes.

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

002079
002079
002079

A Yes.

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

A Yes.

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

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

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

A Yes.

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

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

002080

002080

002080

percent.

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

A Correct.

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

MR. ROGERS: Objection, foundation, Your Honor.

THE COURT: Overruled.

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

BY MR. EGLET:

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

MR. ROGERS: Leading again, Your Honor.

THE COURT: Sustained.

BY MR. EGLET:

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

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

A Yes.

Q And that was when?

A After his accident in April of 2005.

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

A Yes.

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

A Yes.

Q Who is that?

A Daniel Lee.

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

A Yes.

Q And has been seeing Mr. Simao?

A Yes.

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

MR. ROGERS: Your Honor --

THE COURT: Counsel, approach please.

002082

002082

002082

[Begin Bench Conference]

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

THE COURT: I'm sorry?

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

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

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

MR. EGLET: Yeah.

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

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

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

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

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

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

THE COURT: Huh?

MR. WALL: Seventeen on it.

MR. EGLET: Looks like February 24th.

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

002083
002083
002083

[End Bench Conference]

BY MR. EGLET:

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

MR. EGLET: Bring that up.

BY MR. EGLET:

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

A 2/24/2011.

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

A Yes.

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

A Yes.

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

A Yes.

Q -- it's a pain management device?

A Yes.

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

002084

002084

002084

Simao will benefit from a spinal cord stimulator?

A Yes.

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

A Yes.

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

MR. EGLET: You can take that down now.

BY MR. EGLET:

Q -- in his testimony yesterday.

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

A What's his -- is he --

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

A Is he rehab, physiatry, anesthesia --

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

A Physiatrist.

Q -- and also pain management.

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

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

002085

002085

002085

Do you agree with that?

A No.

Q Why not?

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

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

A No.

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

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

MR. ROGERS: -- Your Honor.

THE COURT: Counsel, approach please.

[Begin Bench Conference]

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

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

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

002086
002086
002086

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

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

THE COURT: Dr. Fish said you mean?

MR. EGLET: Dr. Fish said it.

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

MR. ROGERS: I --

THE COURT: You don't recall that?

MR. ROGERS: I don't.

THE COURT: Yeah, he did.

[End Bench Conference]

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

[Court Admonishes Jury]

[Jury Out]

[Recess]

[Begin Bench Conference]

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

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

MR. ROGERS: It's possible for me

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

THE COURT: It is possible for me.

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

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

THE COURT: On Fridays.

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

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

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

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

MR. EGLET: Okay.

MR. ROGERS: Your call.

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

THE COURT: All right. Thank you.

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

THE COURT: Tomorrow?

MR. ROGERS: Monday.

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

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

002088

002088

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

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

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

MR. ROGERS: Yong is Tuesday.

MR. EGLET: Yong is Tuesday.

MR. ROGERS: Take him out of order.

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

MR. ROGERS: Monday.

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

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

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

THE COURT: Uh-huh.

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

THE COURT: Uh-huh.

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

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

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

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

002090
002090
002090

schedule.

MR. ROGERS: I know. Now --

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

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

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

MR. EGLET: Yeah.

002091
002091
002091

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

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

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

MR. EGLET: And when's Yong?

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

MR. EGLET: Look.

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

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

THE COURT: No, he does not.

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

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

002092
002092
002092

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

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

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

THE COURT: Yeah.

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

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

MR. ROGERS: Okay.

[End Bench Conference]

[Jury In]

[Within the Presence of the Jury]

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

MR. EGLET: Yes.

MR. ROGERS: Yes, Your Honor.

THE COURT: Very well. Mr. Eglet.

MR. EGLET: Thank you, Your Honor.

BY MR. EGLET:

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

002093

002093

accident of April 2005. Do you agree?

A No.

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

A Yes.

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

A No.

Q For all the reasons you've already stated?

A Yes.

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

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

Q No, he just says any disc injury.

A No.

Q Okay. Why not?

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

002094
002094
002094

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

Q Yeah.

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

Q Yes.

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

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

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

A Yes.

Q Is that a rather typical presentation in your practice?

A Yes.

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

A No.

Q Why not?

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

Q Can you explain that?

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

002096
002096
002096

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

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

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

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

MR. EGLET: No.

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

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

MR. ROGERS: Just --

THE COURT: Sustained as to leading, only.

BY MR. EGLET:

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

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

A No.

Q Why?

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

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

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

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

Q And that would include injuries to the disc?

A Yes.

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

A No.

Q Why not?

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

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

A No.

Q Why?

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

Q Yes.

A -- not anesthesia?

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

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

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

002102
002102
002102

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

A No.

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

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

THE COURT: Noted for the record, please proceed.

THE WITNESS: No.

BY MR. EGLET:

Q And why?

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

Q Okay.

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

002103
002103
002103

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

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

A No.

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

A No.

Q Can you explain why?

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

002104
002104
002104

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

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

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

A Yes.

Q Can you explain what you mean by that answer.

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

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

A No.

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

002105

002105

002105

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

A No.

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

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

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

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

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

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

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

002106
002106
002106

A Yes.

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

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

Q Thank you, Doctor.

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

MR. ROGERS: Yeah. Just one.

RECROSS-EXAMINATION

BY MR. ROGERS:

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

A Again, it depends on the context.

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

THE COURT: Any follow, Mr. Eglet?

///

///

002107

002107

FURTHER REDIRECT EXAMINATION

BY MR. EGLET:

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

A Yes.

Q You went in and removed the disc?

A Two of them.

Q You have visualized the disc?

A Yes.

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

A The scrub tech did.

Q Well, you were the only surgeon?

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

Q Okay.

A I don't think I did.

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

A Yes. Yes.

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

A No.

Q Dr. Yong wasn't there. Right?

A No.

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

002108

002108

002108

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

A Yes.

Q Thank you.

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

Who's the next witness?

MR. EGLET: Dr. Grover, Your Honor.

THE COURT: Do you suppose he's here?

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

JASWINDER GROVER, PLAINTIFF'S WITNESS, SWORN

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

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

DIRECT EXAMINATION

BY MR. EGLET:

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

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

Q Are you board certified in orthopedic surgery?

A Yes, I am.

Q Can you tell us where you attended medical school?

002109

002109

002109

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

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

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

Q And did you do a fellowship following your residency?

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

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

A Yes.

Q Can you tell us about that.

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

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

002110

002110

002110

A The residency was five years.

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

A Yes.

Q And how long was the fellowship?

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

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

A Yes.

Q And what are those?

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

Q What is the UCLA Aesculapian Society?

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

002111

002111

002111

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

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

Q Do you have hospital privileges, Doctor?

A Yes, I do.

Q And where do you have hospital privileges?

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

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

A Yes.

Q Are you licensed in other jurisdictions?

A Yes. I maintain my license in California.

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

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

002112
002112
002112

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

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, I believe that I have.

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

THE COURT: Any objections?

MR. ROGERS: No, Your Honor.

THE COURT: So ordered.

BY MR. EGLET:

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

A Yes.

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

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

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

002113
002113
002113

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

A It was about three years.

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

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

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

A April 15th, 2005.

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

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

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

A He had temporary relief.

Q And how much pain relief did Mr. Simao experience

002114

002114

002114

with trigger point injections before your evaluation?

A He had some temporary relief.

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

A Again, temporary relief.

Q What is a tens unit?

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

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

A He had some temporary relief.

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

A No, he did not?

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

A No, he did not.

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

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

002115

002115

Q Did he document that anything made his pain better?

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

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

BY MR. EGLET:

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

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

MR. EGLET: Page 10, please, Brendan.

BY MR. EGLET:

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

A Yes, he did.

Q And what did he document?

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

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

002116

002116

002116

symptoms of chronic neck pain?

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

Q And explain that for us if you will.

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

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

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

002117
002117
002117

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

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

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

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

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

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

002118

002118

002118

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

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

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

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

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

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

A No.

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

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

Q Hypothetically, if someone told this jury that Mr.

002119

002119

002119

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

A No.

Q Why not?

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

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

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

MR. EGLET: Page 17, please, Brendan.

002120

002120

002120

BY MR. EGLET:

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

A Yes.

Q And what are nerve root tension signs?

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

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

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

MR. EGLET: Page 18, please, Brendan.

002121

002121

002121

BY MR. EGLET:

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

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

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

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

Q And what does that mean? Marginal quality study.

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

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

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

002122
002122
002122

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

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

002123

002123

002123

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

A No, it would not be accurate.

Q And why not?

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

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

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

002156
002156
002156

things.

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

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

A No.

Q Why not?

A Well, I think for the same reasons that I just mentioned. I -- and discography specifically isolate and occasionally identify pathology that is not picked up on an MRI scan. And to suggest that it's a false positive because the MRI scan is normal is incorrect. And in this particular case, the MRI scan, in fact, was not normal. There were abnormalities, actually, at C3/4 and C4/5 documented by the radiologist, but in my opinion relatively subtle abnormalities, some slight disc protrusions, northing overtly abnormal that one would look at the MRI scan and say oh, gosh, that's definitely the problem. But certainly, one would look at the MRI scan and say that's not perfectly normal. There may be something going on here. And that's when you employ discography to try to further evaluate that possible problem.

002157
002157
002157

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

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

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

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

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

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

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

002158
002158
002158

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

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

Q Was that important to you?

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

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

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

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

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

002159
002159
002159

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

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

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

Q Why?

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

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

MR. ROGERS: Objection, foundation, Your Honor.

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

THE COURT: I think you have. Overruled.

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

002160
002160
002160

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

BY MR. EGLET:

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

A Correct.

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

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

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

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

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

A Yes.

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

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

002161
002161
002161

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

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

Q Doctor, has the medical care and treatment rendered

002162
002162
002162

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

A Yes.

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

A Yes.

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

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

THE COURT: Yes.

[Pause]

THE WITNESS: Yes.

BY MR. EGLET:

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

A Yes, I believe they are.

002163

002163

002163

Q Okay.

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

BY MR. EGLET:

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

A Yes.

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

A Yes.

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

A Yes.

Q Is the amount for Nevada Anesthesia $500?

A Yes.

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

A Yes.

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

A Yes.

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

002164
002164
002164

right than wrong?

A They are wrong.

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

A No.

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

A No, I would not.

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

A No, I would not agree.

Q Why not?

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

002165
002165
002165

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

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

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

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

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

002166
002166
002166

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

A No.

Q Why not?

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

002167
002167
002167

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

A No, I do not.

Q Tell us why.

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

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

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

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

002169
002169
002169

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

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

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

A No, I would not.

Q Why?

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

002170
002170
002170

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

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

A Yes, they have.

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

A Yes.

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

THE COURT: Very well.

002171

002171

002171

Mr. Rogers.

MR. ROGERS: Very good. Just go forward?

THE COURT: I'm sorry.

MR. ROGERS: Just go ahead with it?

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

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

CROSS-EXAMINATION

BY MR. ROGERS:

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

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

THE COURT: Yep. Yes, I mean.

[Begin Bench Conference]

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

THE COURT: I understood his testimony.

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

002172
002172
002172

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

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

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

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

MR. EGLET: I don't --

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

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

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

THE COURT: He didn't perceive --

MR. ROGERS: These were his ways.

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

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

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

MR. ROGERS: -- testimony.

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

THE COURT: Uh-huh.

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

MR. ROGERS: The first day.

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

002174

002174

002174

002175

002175